STRATEGIES in Brief

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Issue # 5 | October 2011

Understanding Anogenital Injury in Adult Sexual Assault Cases

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Anogenital injury is often seen as the ultimate evidence in sexual assault cases. However, the reality is that anogenital injury evidence has significant limitations. Specifically, in the vast majority of cases we are limited in our ability to distinguish between injuries resulting from a sexual assault and those sustained during consensual sexual activity. This point may not be well understood by legal practitioners and clinicians alike, resulting in portrayal of anogenital injury as having clear and unambiguous significance. Understanding the emerging research on consensual sexual activity injury can therefore help us provide more accurate information to attorneys, judges, and juries in adult sexual assault cases.

RESEARCH ON INJURY RATES

Estimates for the frequency of anogenital injury in adult sexual assault cases vary widely in the literature. Studies provide us with a broad range of estimates based on varying exam techniques; some are as infrequent as 5% in examinations using only direct anogenital inspection, while others are as frequent as 87% using colposcopic magnification (Massey, et al., 1971; Slaughter & Brown, 1992).[1] The most recent literature suggests that the rates of anogenital injury resulting from sexual assault may range anywhere from 20-53%.[2] In many cases, injury will not be noted, but this could either be because there was truly no injury, or because there were no specialty evaluation techniques employed, such as toluidine blue dye or magnification. A finding of no injury could also be seen when the examination occurred after the anogenital injury had already healed. This can take place in as little as 36-48 hours; healing is often much quicker than the 72-120 hour timeframe for sexual assault medical-forensic exams.

SEXUAL ASSAULT VERSUS CONSENSUAL SEX

Contrary to widely held beliefs, anogenital injuries are not exclusive to non-consensual sex. In fact, the vast majority of injuries assessed during a medical-forensic examination are non-specific, meaning they could result from non-consensual sexual contact (either with or without applied physical force) or from consensual sexual contact. This contradicts the oft-touted theory of human sexual response, developed by Masters and Johnson almost 50 years ago.[3] The use of this theory has been frequently employed to explain anogenital injury in patients presenting after sexual assault. The theory holds that the normal physiologic changes, which take place during consensual sexual activity, are protective against injury. These changes include lubrication, lengthening of the vaginal outlet, and pelvic tilt, and they are theorized to take place in conjunction with mutual cooperation between sexual partners. Therefore, according to the theory, the presence of anogenital injury would be more likely in situations where the human sexual response did not occur, as in a sexual assault. However, recent studies have shed significant doubt on the veracity of this theory, and generally it should be avoided as an explanation for the presence or absence of anogenital injury in sexual assault cases.[4]

The prevalence of injury resulting from consensual sexual contact is beginning to be better understood, but the research remains limited by issues such as small sample sizes and discrepancies in inclusion criteria (e.g. whether or not to classify erythema/redness as an injury). As with the prevalence of anogenital injuries following sexual assault, the range of estimates for injury resulting from consensual sexual contact is broad: 5%-73%.[5] Yet the emerging research on injuries resulting from consensual sex provides us with more than just the general prevalence statistics. It also provides us with an understanding of the need for further research into issues such as the impact of skin tone on injury identification, the significance of location, type and number of injuries, and the specific type of anogenital injuries in women who engage in consensual sex with other women, as well as anogenital injuries among men. Unfortunately, it is currently difficult to draw distinctions between the quality and quantity of anogenital injuries in consensual versus non-consensual sexual contact with any degree of scientific certainty.

OTHER USES OF INJURY EVIDENCE

Even with the limitations on the ability to distinguish consensual versus non-consensual sexual contact, evidence of anogenital injury (or the lack thereof) is significant in its own right. As with all evidence in a sexual assault case, the goal is not just to present physical evidence of the sexual assault, but also to document evidence that can be used to corroborate statements made by the victim, including the history of the sexual assault. Because so many jurors and judges expect that anogenital injury will be the determining factor in deciding whether a sexual assault occurred, it is critical that prosecutors explain the significance of this evidence. For example, it is appropriate for prosecutors to ask clinicians to testify about the consistency of findings regarding the presence or absence of anogenital injury with the history provided by the patient. Clinicians should also be prepared to discuss the consistency of the injuries with alternative mechanisms, such as pathology or other types of trauma. Prosecutors may benefit from exploring these other possible mechanisms of injury during direct examination of the medical-forensic examiner. This allows prosecutors to acknowledge that the injuries alone are not conclusive, but to argue that they are powerfully corroborative in conjunction with other factors such as patient statements and presentation. When no injury exists, prosecutors can also use the medical witness to explain the fact that "no injury is not equivalent to no sexual assault." If the clinician who conducted the victim's medical-forensic examination does not have sufficient experience or qualifications to render this opinion, prosecutors can call a more qualified clinician as an additional witness to serve as an expert in the case.

USING EVIDENCE FOR PROSECUTION

If anogenital injury is non-specific, does it still have value as evidence in an adult sexual assault case? Without question, it does, especially in conjunction with other evidence that can be used to corroborate the victim's statements. Remember, identifying anogenital injury is only one part of the Sexual Assault Forensic Examination (SAFE). For prosecutors, it is critical to paint a more expansive clinical picture at trial, instead of solely focusing on anogenital findings. When determining what evidence to introduce, prosecutors should think about the entire SAFE process and the additional types of physical and testimonial evidence that can be obtained. Evidence such as external body injury, patient statements, and patient appearance and demeanor may help provide attorneys, judges and juries with a fuller understanding of the trauma to the patient. Such information can then bolster the significance of the anogenital injury evidence and increase the credibility of a victim's history of events. Additional evidence could include trace evidence that corroborates the victim's history of the sexual assault or non-genital photographs taken during the SAFE, depicting the condition of the patient's clothing or external body injuries, such as bruises or abrasions to the neck or extremities.

In addition to introducing evidence obtained during the SAFE, prosecutors should also consider questioning clinicians (depending on their level of experience) about common patient behaviors seen in their practice. This could include delayed presentation for medical care, reluctance to report to law enforcement, and self-blame or concerns about being believed.[6] This testimony can help judges and juries understand behaviors that may be perceived as being counterintuitive, and can further enhance victim credibility. As with the explanation of injury, if the practitioner who performed the SAFE is not sufficiently experienced to serve as an expert witness to address these issues, prosecutors can use the clinician's testimony to lay the foundation for a second witness who can render an expert opinion regarding the significance of common patient behaviors.

CONCLUSION

Clinicians who provide sexual assault medical-forensic examinations must be competent to evaluate anogenital injury and discuss the meaning of those findings with criminal justice professionals. This includes discussing the frequency of non-specific injury and distinguishing between injury, pathology and normal variants. Clinicians must also be able to provide ethical testimony related to the significance of injury findings, based in both clinical experience and the current science, avoiding overemphasis or over attribution of anogenital injuries. Because attorneys can use transcripts of testimony from prior cases to impeach a witness such as a SAFE and challenge their credibility in court, it is critical to remember that every case has the potential to impact a clinician's reputation.

Disclaimer: The views presented are those of the authors and do not necessarily represent the views of U.S. Department of Defense or its Components.

Special thanks to Sasha N. Rutizer, Captain, United States Army, Judge Advocate General's Corps, for her assistance with this article.

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ENDNOTES

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This project was supported by Grant No. 2009-TA-AX-K024 awarded by the U.S. Department of Justice, Office on Violence Against Women (OVW). The opinions, findings, conclusions, and recommendations expressed in this publication are those of the author(s) and do not necessarily reflect the views of OVW.

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