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Caring for young adolescent sexual abuse victims in a hospital-based children's advocacy center☆

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ABSTRACT

Objectives: This study compared health care assessments, referrals, treatment, and outcomes for young adolescent sexual assault/sexual abuse victims seen at a hospital-based Child Advocacy Center (CAC), to that provided to similar victims evaluated by other community providers. A second purpose was to document how common DNA evidence is found among such cases.
Method: A retrospective matched case-comparison design matched index CAC cases diagnosed with extra-familial sexual assault to non-CAC cases referred for prosecution in the same county, matched by age and sex of victim, age and sex of perpetrator, and type of assault ($N = 128$ pairs). Since the case-comparison design produces paired data, analyses used paired *t*-tests, McNemars test, and Wilcoxon signed-rank tests. Health care outcomes included whether victims received a health exam, indicated tests, findings of trauma on genital exams and counseling referrals; legal outcomes included whether cases were prosecuted, verdicts, and length of sentences.
Results: CAC cases were significantly more likely to receive a physical exam, a genital exam when indicated, and referral for counseling (all $p < .001$). In the CAC group 26.7% vs. 4.8% had positive genital trauma findings, and only 6.3% of CAC cases failed to get indicated sexually transmitted infection (STI) tests or prophylactic treatment for STIs vs. 80% of the comparisons ($p < .001$). There were no differences in decisions to prosecute, convictions, or sentence lengths between the groups. DNA was documented in only 27.3% of acute cases, although evidence kits were completed.
Conclusions: Young adolescent sexual abuse victims received markedly different health care in a hospital-based CAC compared to elsewhere. DNA is not commonly found in acute cases.
Implications for practice: Community health care providers and law enforcement should be encouraged to refer victims to hospital-based CACs for specialized examinations and treatment.

Introduction

Children's Advocacy Centers (CACs) are endorsed as using best practices to care for crime victims (Center for Crimes Against Children, 2004). There are various CAC models used to improve the delivery of care to sexual abuse victims, coordinate

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investigations, and reduce the harmful effects of sexual abuse or sexual assault on youth and families. Most CACs share the common elements of sensitive interviewing and multi-disciplinary team collaboration when abuse is suspected, but differ in their involvement of health care providers, obtaining medical histories, and assessing and treating the health needs of young crime victims. Although the terms sexual abuse and sexual assault are sometimes used to differentiate types of sexual victimization, i.e., incest vs. extrafamilial, or levels of violence involved in the events, in this paper, both terms are used interchangeably, as all types of sexual victimization among children and young adolescents fall within the scope of Children's Advocacy Centers.

Developmentally appropriate forensic interviews are an important part of sexual abuse care (Levitt, 1992), but victims need much more than skilled interviews (Adams et al., 2007). The diagnosis and treatment of sexual abuse should include a health examination to address the potential sequelae from the event. If the sexual abuse occurred within the past 72 h, the health examination includes assessment and treatment of injuries, collection of forensic evidence, including possible DNA, treating sexually transmitted infections (STIs), assessing for acute psychological trauma, and preventing pregnancy (Adams, 2004; American Academy of Pediatrics Committee on Adolescence, 2001). If there is a delay in disclosure of the abuse, the victim still requires a health examination to assess healed injuries, test for or treat STIs, and evaluate coping responses.

The hospital-based CAC generally provides recommended physical assessment, forensic interviewing, health care, and counseling referrals to abuse victims, but it is unclear whether the same levels of recommended care are offered to or received by victims whose abuse is investigated in other settings. Currently, the research literature does not document whether health care assessments and treatments provided by hospital-based CAC's are different from the medical evaluations and care adolescents provided by community providers. There is also limited research on the likelihood of abnormal genital findings or forensic evidence from sexual abuse examinations of younger adolescents, and how these health elements are related to the legal aspects of the criminal investigation, prosecution and sentencing of the perpetrator. A recent comparison of cases from a CAC with those from Child Protective Services [CPS] (Smith, Witte, & Fricker-Elhai, 2006) found improved outcomes for CAC cases, but the CAC in that study was not hospital-based, and the comparison investigations were from CPS, which is often not involved in extra-familial abuse cases. The current study adds new information about the prevalence of both physical and psychological findings identified when best practices are used by a hospital-based CAC, assessing sexual abuse or sexual assault either acutely or after a delayed disclosure, and comparing these results to care provided to adolescents by community providers.

Background

Adolescence is the key risk period for extrafamilial sexual abuse. In 2000, the sexual assault victimization rate for youths 12–17 was 2.3 times higher than for adults (Bureau of Justice Statistics, 2003). In a population-based study of high school students in Minnesota during the 1990s, 13–17% of girls and 3–5% of boys reported a history of sexual abuse (Saewyc, Magee, & Pettingell, 2003); the majority of those students reported extra-familial abuse. Most of the sexual assaults reported to the police occur to juveniles, but there is limited knowledge about the type of assaults experienced by very young teens, that is, those age 10–14 (Wordes & Nunez, 2002).

Although most sexual abuse victims have normal or nonspecific physical findings in their health assessments (Adams, Harper, Knudson, & Revilla, 1994; Adams & Knudson, 1996), sexual abuse patients still require health care. Providing health care reassures parents as well as victims about the patient's physical well being (Kerns, Terman, & Larson, 1994). Even though physical findings are uncommon, when they are present, they can be important to the criminal investigation (Adams, 2001; Adams et al., 1994).

The degree of experience of the health care provider doing sexual abuse exams influences the validity of their findings. Recently, a study found that when pediatric emergency medicine physicians completed a genital exam for possible sexual abuse they were more likely than the physician with child sexual abuse training to misinterpret normal findings (Makoroff, Brauley, Brandner, Myers, & Shapiro, 2002). Physical findings increase significantly in adolescent girls with a history of either abusive or consensual sexual intercourse. It becomes important to identify a history of painful sexual intercourse, age of sexual debut, and history of bleeding with intercourse among young adolescent victims who may also be consensually sexually active. Providers should take care not to mistakenly attribute possible physical findings caused by previous abusive or consensual sexual intercourse, if they are not relevant to the current event under investigation (Adams, Botash, & Kellogg, 2004; Adams & Knudson, 1996). It should be noted, however, that the overwhelming majority of adolescents under age 13 do not report consensual sexual activity; in the 2003 national Youth Risk Behavior Survey, for example, only 4.2% of girls reported sexual intercourse before age 13, and 11.3% of 9th grade girls (i.e., 14 year olds) reported forced sexual intercourse, suggesting the majority of girls having sex before age 13 have been forced (Grunbaum et al., 2004).

Regardless of whether or not physical evidence is likely to be present, obtaining a detailed verbal history of the abuse events is essential for the medical treatment of sexual abuse victims (Adams, 2004). It may also be key in criminal convictions. In some research, cases were more likely to be charged criminally if physical findings were present (Palusci et al., 1999); however, DeJong and Rose (1998) found that positive physical evidence was neither predictive nor essential for conviction in a sex crime, concluding that the quality of the history obtained by the interviewer was more important.

DiPietro, Runyan, and Fredrickson (1997) found that children interviewed by health care providers who also conducted a physical exam were more likely to disclose a history of sexual abuse than when social workers or forensic interviewers assessed the child in a non-medical setting. This finding raises a concern, because in CACs that are not hospital-based centers,