Observatori Català de la Justícia en Violència Masclista

Institute of Legal Medicine and Forensic Sciences of Catalonia protocol for medico-forensic intervention for victims of sexual violence

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Legal notice

Pacte d' Estat contra la violència de gènere

MINISTERIO DE IGUALDAD
SECRETARÍA DE ESTADO DE IGUALDAD Y CONTRA LA VIOLENCIA DE GÉNERO
DELEGACIÓN DEL GOBIERNO CONTRA LA VIOLENCIA DE GÉNERO

016 ATENCIÓN A VÍCTIMAS DE MALOS TRATOS POR VIOLENCIA DE GÉNERO

Activitat finançada a càrrec del crèdits rebuts del Ministeri d'Igualtat (Secretaria d'Estat d'Igualtat i contra la Violència de Gènere)

Index

GLOSSARY

C&A - Children and adolescents

CEJFE – Centre d'Estudis Jurídics i Formació Especialitzada (Centre of Legal Studies and Specialised Training)

CMF – Consejo Médico Forense (Forensic Medical Council)

CSA – Child sexual abuse

DIF – Departament d'Igualtat i Feminismes (Ministry of Equality and Feminism)

DSM – Diagnostic and Statistical Manual

FGE – Fiscalia General de l'Estat (State Attorney General)

FGM – Female genital mutilation

HIV – Human immunodeficiency virus

HPV – Human papillomavirus

IMLCFC – Institut de Medicina Legal i Ciències Forenses de Catalunya (Institute of Legal Medicine and Forensic Sciences of Catalonia)

LOGILS - Organic Law on the comprehensive guarantee of sexual freedom

LOPJ - Organic Law of Judicial Power

NIJ – National Institute of Justice

PTSD – Post-traumatic stress disorder

SAK - Sexual Assault Kit

STIs – Sexually transmitted infections

WHO - World Health Organisation

1. Introduction

Sexual violence is an attempt against the human rights of the people who suffer from it, at the same time it is a source of physical and mental health problems with serious personal repercussions, which obliges the public administrations and the professionals who provide services to identify, prevent and respond to these behaviours. As medical professionals with specialised functions in forensic medicine, we are in a key position to implement forms of intervention that allow us to improve the Justice's response to sexual violence.

This document aims to gather updated scientific information on the forensic procedures to follow from the moment the victim becomes aware of the possible criminal act, on the effects and impact that sexual violence may have on the victim and her health, so as to promote a forensic medical intervention that is adjusted to scientific evidence, protocolised and that responds to the requirements of the Courts. This intervention, while keeping the victim at the centre at all times, is careful and adjusted to her circumstances in order to minimise, as far as possible, the re-victimisation linked to the judicialisation of her case.

This document is based on the *Protocolo de actuación médico-forense ante la violencia sexual en los Institutos de Medicina Legal y Ciencias Forenses* (Protocol for Forensic Medical Action in Sexual Violence in the Institutes of Legal Medicine and Forensic Sciences), and adopts the requirements introduced with Organic Law 10/2022 on the comprehensive guarantee of sexual freedom (hereinafter, LOGILS) to design protocols for global and comprehensive action in cases of sexual violence. It also aims to follow the paradigm shift outlined in *Model for addressing sexual violence* and *Framework protocol for interventions with due diligence in situations of sexist violence* in order to focus the practice from the needs and human rights, recognising women as holders of rights, promoting autonomy for their exercise, making available to the victims the means necessary for their reparation.

Given that the ways in which sexual violence can be exercised, especially against women and children, are varied, this document is extensive, as it attempts to collect and update the main forms of violence, as well as the way in which they have an impact on the mental, physical and psychosocial health of the victims, and tries to describe the best practices to respond to each case, always from a victim-centred perspective.

It is a document that should serve as a guide for the development of forensic interventions carried out within the comprehensive forensic assessment units (Resolution JUS/3407/2023, of 2 October, which creates the Temporary Programme for the implementation of the Improvement Plan for the Comprehensive Forensic Assessment Units of the Institute of Legal Medicine and Forensic Sciences of Catalonia and reinforces the Technical Criminal Advisory Teams) and also in the deployment of the Barnahus model for the care of cases of child sexual abuse.

2. Sexual violence conceptual framework

Since the 1990s, the impetus of the women's and feminist movement, in parallel with progress in the field of human rights, has led to the realisation that violence is a form of discrimination, an attack on the dignity and a violation of the human rights of women and girls, a consensus that has been enshrined in various international instruments. It also made it possible to visualise the whole range of sexual violence that went far beyond vaginal penetration.

The conceptualisation and stereotypes about sexual violence that still survive today have deep historical roots (Toledo and Pineda, 2016). The evolution of the conceptualisation has also incorporated the idea that sexual violence cannot be conceived as an individual problem but as a social and cultural phenomenon of great prevalence (Toledo and Pineda, 2016). This consensus opens the door for the Public Administrations to consider sexual violence as a phenomenon that must be considered a matter of the State and, therefore, deserves its maximum involvement in the development and financing of public policies and in the creation of resources and itineraries In Catalonia, the 2022 Sexual Violence Approach Model (Ministry of Equality and Feminisms [DIF], 2022) is based on a comprehensive understanding of this violence as a social and political phenomenon and as a security and public health problem, and mentions that "*sexual violence is the most prevalent, the most invisible and the most naturalised form of violence against women. (...) Its eradication is a matter of freedom and of guaranteeing women's human rights*".
Beyond the accountability of the perpetrators, this means that the responsibility of states in the prevention, investigation and reparation of violence, based on the so-called principle of due diligence, comes into play. Broadening the view beyond the individual perpetrator also allows us to consider the role played by society in general and the community closest to women in the prevention of sexual violence, in support for aggravated and in the repair, at least symbolic.

2.1. The new paradigm of Organic Law 10/2022 on comprehensive guarantee of sexual freedom.

The LOGILS has led to the legal consolidation of the conceptualisation of sexual violence as a structural issue, based on the idea that it is not an individual but a social and structural issue, rooted in discriminatory cultural patterns, with the understanding that violence inflicts individual harm but has collective repercussions, sending a message of domination, insecurity and lack of State protection, and therefore, it is a State issue.

The reform has eliminated the distinction between abuse and aggression following the mandate of the Istanbul Convention which imposes structuring the crime of sexual violence based on the absence of consent. The newly drafted Law establishes a basic article of sexual assault, which includes all sexual conduct without consent, including the imposition of sexual acts through violence, intimidation or abuse of a situation of superiority or vulnerability of the victim, as well as those executed when they are deprived of meaning or their will is annulled. The distinction of greater gravity is maintained when the imposed sexual act involves carnal access. In addition to the generic crime, another crime is incorporated that includes a series of aggravated modalities such as the fact that it was committed in a group, sexual assault through the annulment of the victim's will or the fact of having been committed by the partner or by a family member, among others.

The Law also wants to break with the regulatory dynamic of considering the existence of "particularly vulnerable victims", depending on the quality of the person and understands and incorporates the notion that vulnerability also comes from the social circumstances in which victims can find themselves.

On the other hand, the Law emphasises the intersectional perspective, underlining that sexual violence affects and impacts women in a differentiated and aggravated manner according to the various forms of discrimination they face: age, origin, ethnicity, administrative situation, social class, physical or mental disability, sexual and gender diversity (DIF, 2022). It is therefore about

understanding that the complexity derived from the intersection of various forms of discrimination requires specific approaches.

Another of the structural changes in the law is to leave behind the paradigm of sexual violence understood as non-consensual access to women's bodies, to define that what the legislation protects is women's sexual freedom and autonomy. This vision offers much broader protection, focused on the well-being and autonomy of women, who are considered as subjects of rights and not just as bodies. This change also allows us to recognise the importance of a whole series of violent acts that until now were considered secondary, such as digital sexual violence and other violences such as female genital mutilation and forced marriages.

The LOGILS also makes an important turn by focusing on reparation, both because it involves institutions in the institutional, symbolic and public reparation of sexual violence, and because, for the first time, it defines what the dimensions of the damages that must be taken into account when assessing the impacts of sexual violence. The mention of social harm is particularly relevant as it implies the recognition of the social dimension of the consequences of sexual violence, in terms of stigma, damage to family or community ties, impact on life plans, sexuality, etc.

2.2. The conceptualisation of sexual consent.

Sexual consent is determined by a specific context in which gender mandates, the assimilation of many sexist behaviours and the naturalisation of sexual violence have a great impact. Furthermore, this concept is strongly determined by the relational setting in which sexual violence occurs, and is clearly different when the perpetrator is a known or unknown person: coercive mechanisms to bend the will of the woman (such as explicit or implicit threats to use physical or other forms of violence with the aim of conditioning her behaviour) are often used in the intimate partner setting, whereas in more community contexts, as in the case of female genital mutilation, coercion (such as argumentative persuasion, manipulation or emotional blackmail) is often used. A third determining element of consent will be the power structure that permeates that

situation: the imposition of sexual behaviour will be determined by the power situation in which the perpetrator finds himself, whether physical or social, and by personal and social circumstances of the aggravation that will result in greater or lesser resources to oppose it or to make one's own criteria prevail. Some authors have used the concept of *coercive persuasion*, which integrates strategies that act at different levels, cognitive, emotional and social on the aggravated. Far from the idea of intimidation mediated by the fear of being subjected to imminent physical danger, in reality multiple factors influence it, many of them social, which alone are sufficient to achieve the imposition of the sexual act.

In Catalonia, Law 17/2020 defines sexual consent as "*the express willingness within the framework of sexual freedom and personal dignity which leads to and endorses the performance of sexual practices. Sexual consent must be given freely, must continue to be valid throughout the entire sexual practice and is limited to one or more persons, to certain sexual practices and to certain precautionary measures to prevent unwanted pregnancy and sexually transmitted diseases. There is no consent if the perpetrator creates conditions or takes advantage of contexts that either directly or indirectly impose a sexual practice against the woman's will"*. As can be seen from this definition, freedom, information, reciprocity and will form defining elements of sexual consent.

The LOGILS takes this view and, in addition to violence and intimidation, equates, as mechanisms of sexual imposition, the abuse of a position of superiority or also the exploitation of the vulnerability of the victim, as for example in the case of chemical submission (whether proactive or opportunistic). The Law intends that the definition of sexual consent it contains is binding for legal operators, and for this reason, instead of incorporating it in the definitions section, it chooses to include it in the wording of article 178 of Criminal Code, to the basic crime of sexual violence.

The model of consent followed by the Law is that of the so-called *affirmative consent*, and this bet has very relevant practical consequences. The affirmative consent, or the "*only yes means yes*" ("només sí és sí" in Catalan), presupposes that one starts from the absence of consent and that only the

existence of elements that lead to think reasonably that consent exists, that is to say endorsement of sexual interaction, it will be understood that it is a sexual act and not a crime. The Circular of the State Attorney General 1/2023 on the reform of crimes against sexual freedom (Fiscalía General del Estado [FGE], Circular 1/2023, Spain), mentions that the legal good to be protected in crimes of sexual violence is that of sexual freedom, protecting the dynamic aspect of being able to exercise it with freedom and the negative aspect of not having to endure the imposition of unwanted sexual interactions. Sexual freedom ensures the person's right to personal autonomy, projected on the sexual dimension of one's own body or bodily sovereignty.

In its document, the FGE makes a strong position of great social significance, such as endorsing the affirmative consent on which the law is based, and discarding the social message according to which people have the responsibility to verify that consent exists sexual before initiating sexual interaction. The legal effects of the "*yes model*" suppose to equate, in terms of grief (legal concept), the action against sexual consent to that in which consent is dispensed with, corroborating that the silence or passivity of the aggrieved party allows the crime to be applied (consent cannot be inferred from the lack of resistance or opposition). The consent will be revocable at all times and is gradual, that is to say, the parties are bound by the precise terms that have been agreed, for this reason, acts such as the unilateral withdrawal of the condom (*stealthing)*, will be considered criminal.

2.3. The damage caused by sexual violence and recovery.

Sexual violence causes impacts on women, in various spheres or plans (Tarragona City Council [AT], 2021).

Firstly, they can cause physical injuries or have short- or long-term effects on the development of women's sexuality and reproductive functions, affecting their quality of life and life plans. Another issue is identity. These violent acts and the social construction that surrounds them, can cause changes in the victims that temporarily or irreversibly involve an alteration to their belief system and to their vision of the world and of themselves. This identity change has to

do with deep psychological aspects such as self-esteem and self-perception of security, trust in human beings, character, etc. At the relational level, sexual violence can lead to the breaking or deterioration of bonds with the partner or relatives, either because the trauma makes it difficult to maintain these bonds and emotional reciprocity and care, or because the misunderstanding of sexual violence and the fact of blaming the victim, damages the relationship. At the community level, the victim may suffer rejection or stigma, depending on the values of that social environment and the more or less stereotyped conceptualisation of sexual violence. On a broader plan, we can mention the so-called "*victim blaming*" or mockery of the victim, a social phenomenon in which victims who report (legally or publicly) the violence they face are judged in a negative way, discrediting them, making derogatory assessments of their physicality, judging their behaviour or personal process of assimilation, ridiculing them, making them responsible, denying that the facts are sexual violence or trivialising it. This social reaction can have an emotional impact on the victims, equal to or greater than the sexual violence itself. As for the professional or economic repercussions of sexual violence, victims may also suffer consequences, as their performance may suffer as a result of the trauma, or the stigma may be detrimental to their careers, for example in the case of disclosure of intimate images of them without their consent. Costs can also be generated that the woman has to bear, such as changes of address, expenses for therapeutic processes, and so on.

Three general aspects contribute to the recovery of victims: firstly, a critical and informed approach to sexual violence, which contributes to placing the responsibility on the aggressor, so that the experience is not perceived as a deserved fatality but as a manifestation of discrimination. Secondly, the fact that the woman's environment understands that violence provides her with personal and social support, and recognises her status as a victim, valuing her resilience in the recovery process. Thirdly, the response of the professionals who attend to the victim, who must show consideration, interest and respect for them.

2.4. Victim reparation.

With the LOGILS, the right to comprehensive reparation of the victims is addressed for the first time (art. 1.3 e) and, echoing the General Recommendation no. 35 of the CEDAW Committee, reiterates the obligation of due diligence, an obligation that also extends to reparation (art. 2 b). Until now, the reparation of victims of sexual violence (Faircom and Re-treat Project, 2022) has been conditioned by different factors, among them, the evaluation of the damage with a very restricted view that did not incorporate the gender or intersectional perspective. When applying due diligence to the right to reparation, sexual violence can cause significant harm to victims, affecting their identity, their life project and their relational network.

To this end, the LOGILS has sought to place the reparation of sexual violence in a prominent place, and to broaden the vision on the different levels that reparation must cover, requiring that the compensations contemplate not only the physical and psychological damage (including moral damage and dignity), but also the loss of opportunities, including educational, work or benefits; material damages and loss of income, including lost profits; social damage, understood as damage to the life project and therapeutic, social and sexual and reproductive health treatment.

Accordingly, the Law establishes that the reports on health and psychosocial damage will have to be carried out by the professionals of the comprehensive forensic assessment units, contributing to a paradigm shift in the carrying out of assessments, which from now on will have to address, assess and reflect the diversity of psychosocial impacts derived from the traumatic experience. To promote the assessment of all dimensions of the injury, the LOGILS establishes that the elements described above must be assessed (art. 53) and, therefore, must be reflected in the resulting forensic medical reports.

2.5. Guiding principles of practice.

The quality of professional practice should not only be measured in terms of technical correctness, but also in terms of ethics and care for the well-being and dignity of the people on whom we intervene.

Following this prism, the scientific literature (Office of the High Commissioner [OHC], 2022) (International Rehabilitation Council for Torture Victims [IRCT], 2009) (IRCT, 2007) has undertaken to systematise a series of basic guidelines on the therapeutic interventions in people who have experienced traumatic experiences that can be taken into account in forensic evaluations:

a. *Principle of beneficence and doing no harm*. Given that interventions can retraumatise the victim, by causing and/or exacerbating psychological suffering due to connecting with painful memories and emotions, several aspects must be considered:

   - Try to have obtained as much information as possible about the circumstances of their experience in order to avoid repeating questions about aspects that can be checked in other ways.

   - Facilitate the direct participation of the victim in the decision-making process of their recovery process, so it is important that they have sufficient information to understand the consequences of the decisions they make. Consensus must be the rule that guides all the intervention of the professional.

   - Non-directive style. During the interventions, it is necessary to avoid instructions and directive questions, instead trying to formulate open questions. In general terms, questions should be asked in a way that allows the victim to express themselves freely and that does not suggest the answer, and from the general information they provide, we can move on to specific questions on the concrete aspects that are considered most relevant.

   - Non-judgemental and non-accountable listening: avoid explicit or implicit value judgements about the victim's previous behaviour and coping strategies, and avoid doubting that the victim is not responsible for the violence suffered.

- Recognition of violence and its impacts: avoid minimising or relativising the violence suffered and its individual, family or community consequences.

b. *Principle of contribution to protection*. Beyond responding to the court's mandate, the intervention carried out should, as far as possible, also try to provide the victim with as much information as possible about the victim's needs, whether it is by explaining the existing public services, available material or other social resources.

c. *Principle of healing interventions*. The interventions of professionals with people facing sexual violence, even if they are of an evaluative nature, must not give up the objective of contributing to the recovery, empowerment and repair of the impacts caused by the violence experienced. This is why the following is recommended:

   - Value the coping strategies that have been followed, the capacity to overcome this violence, to rebuild oneself as a person, to carry out one's life project and to rebuild the links that have been damaged by the impact of the violence.

   - Guarantee a cross-cultural perspective, gender diversity and sexual orientation in the intervention in order to be able to work and re-signify the victim's experience without making her identity invisible.

3. Medico-forensic intervention during on-call duty

The medico-forensic intervention in the context of custody in cases of sexual violence has been conceptualised in the LOGILS (chapter one, articles 47 and 48), as a fundamental action for the accreditation of the crime, linked to the medical and gynaecological examination and the collection of samples. This regulation makes it explicit that the collection of samples and other evidence that may contribute to the accreditation of sexual violence will not be conditional on the filing of a complaint or the exercise of criminal proceedings and that the actions of the forensic doctor in relation to the examination of the victim and the actions of legal interest will have to be carried out without delay and in conjunction with the necessary gynaecological or medical examination.

Despite the fact that LOGILS makes no mention of it, we must place the psychopathological examination in the on-call forensic medical intervention in the same rank of importance as the medical and gynaecological examination and the taking of samples, although this aspect would not be linked to the accreditation of the crime, but rather to document the first reference of the psychological impact of the event. In fact, the knowledge of the immediate impact that traumatic events can have, as well as the type of response that victims can present, is key to clarifying doubts and countering, if this is the case, preconceived ideas and stereotypes that are widespread in our sociocultural environment on the basis of which the lack of consent could be questioned and the credibility of the victim called into question (Dhawan and Haggard, 2023).

The demonstrations carried out by the victims in these first moments will be very relevant at the time of prosecution. So much so that some of the aspects of the victims' response that are at the basis of doubts about consent and about credibility are, for example, not revealing or not immediately reporting the assault, the presence of inconsistencies in the story (especially in the story produced at different times), due to the presence of difficulties in remembering aspects of the event, and due to the emotional state shown by the victim in the initial moments. Therefore, in on-call assessments, the context and the

circumstances in which the victim has described the events, from the emotional state to the possible difficulty in describing the episode, are important to note. The biological underpinnings of trauma and how it impacts in the short term are necessary to provide this context.

3.1. Biological foundations of trauma and short-term impact.

The individual reaction to a threatening situation or an impact event is immediately conditioned by the activation of the defence circuit and the triggering of the stress response. The purpose of this activation is to try to guarantee the survival of the individual.

When faced with a threatening circumstance, the hypothalamic-pituitary-adrenal axis is activated, with the release of catecholamines and cortisol, and activation of the brain's defence circuitry. The defence brain circuitry is composed of, among other areas, the amygdala (especially the central nucleus and medial nucleus), the hippocampus, and the prefrontal cortex; the paraventricular nucleus of the hypothalamus, the ventral tegmental area and the nucleus accumbens also play a role. These are structures that are involved in learning, memory and decision-making (Godoy *et al.,* 2018).

Stress hormones interact with structures in the brain's defence circuitry by mediating (via specific receptors) the action of glucocorticoids and mineralocorticoids on the hippocampus, a critical structure in relation to episodic and spatial memory. Stress can also affect other brain areas related to memory formation, such as the insula, and indeed, acute stress can trigger a reconfiguration of neural networks on a larger scale (Schwabe, 2017).

Hormones of the defence axis also interact, via glucocorticoid and mineralocorticoid receptors, on the amygdala and prefrontal cortex, providing insight into how activation of the hypothalamic-pituitary-adrenal axis may influence higher mental functions (McEwen, 2017) (McEwen and Akil, 2020).

Norepinephrine also plays a key role in regulating the effects of stress on memory consolidation, mediated by its interaction on the amygdala

(Roozendaal *et al.*, 2009). The mechanisms involved in the effect of stress on structures beyond the hippocampus (mediated by glucocorticoids in interaction with noradrenergic arousal) would be similar to those of the effect on the hippocampus, enhancing the consolidation of memories and altering, at the same time, the memory retrieval capacity (Schwabe, 2017). This allows us to understand that the memory content associated with the traumatic event (traumatic memory), as a consequence of the high level of arousal triggered by the activation of the hypothalamic-pituitary-adrenal axis, may be fragmented and disorganised. On the other hand, as a result of the hormonal action on these structures, the content will be encoded in a predominantly sensory mode, so that the resulting memory may not be well fixed in the base (autobiographical) memory (Bryant, 2019).

These changes have a direct translation on the formation of the memory of the episode: attention will be focused on the central aspects and peripheral details may not be encoded, the encoding and consolidation of information following an ordered temporal sequence can see compromised, and, on the other hand, the consolidation of sensory content can be seen enhanced.

Apart from the cognitive aspects, the experience of an impact event can materialise in the form of various bodily reactions, shaping the immediate response to the threat. Some of the reflexes commonly observed in potentially threatening or stressful situations, from increased heart rate and respiratory rate to gastrointestinal distress, are mediated by the amygdala, by projections originating in the central and medial nuclei to other brain regions (Ressler *et al*., 2022). The experience of a traumatic experience can also materialise at a behavioural level, with a range of reactions ranging from confrontation (*fight*), on the run (*flight*), passing through tonic immobility, or blocking (*freeze*) and by passing out (*faint*) (Bracha, 2004).

Contrary to popular imagination and stereotypes in our society, the fight-or-flight reaction is not the most common reaction among victims of traumatic events, so the knowledge of the existence of the diversity of possible responses to a traumatic event will help to avoid erroneous judgements about consent and about credibility.

The influence of socio-cultural elements on the interpretation of the response to the traumatic event is also produced on the victim, so that she herself may doubt the validity of her own reaction, making it difficult for her to recognise herself as a victim of a non-consensual action, generating feelings of guilt or shame. These feelings and interpretations may therefore be at the basis of a delay in revealing the facts, of their denunciation, of a possible omission of part of the facts and even of the possible abandonment of the judicial procedure.

Thus, among the most frequent reasons for the delay in revealing the facts, the following are noted: states of activation, blockage or confusion in the initial moments, little or no self-perception of being a victim or of having been the object of aggression, feelings of guilt and shame or doubts and fear of not being believed. There is also the fear of possible reprisals by the aggressor/s, the emotional and economic dependence of the aggressor, distrust in the system, the desire to forget and not to relive the event through reporting, or the lack of competence or special vulnerability.

All in all, the dysfunctions described will be at the base of a possible acute reaction to stress; it is a transient disorder associated with initial psychopathological responses and which can appear between 3 and 30 days after exposure to a traumatic event; although not all cases in which an acute reaction to stress occurs will lead to post-traumatic stress disorder, the identification of the picture will be useful in assessing early post-traumatic symptomatology (Garcia-Esteve *et al.*, 2021).

3.2 Intervention in adults.

3.2.1. Preliminary considerations.

The questions raised so far motivate the need to raise a series of preliminary considerations to be kept in mind when approaching the on-call medico-forensic examination.

- It is necessary to facilitate an emotional environment in which the victim feels heard and not judged, bearing in mind that signs in the opposite direction can interfere with the anamnesis or even generate a negative effect.
- The most comfortable environment possible should be provided, in the context of the health care facility, to facilitate and ensure adequate privacy in these cases.
- During the evaluation by the forensic doctor, the victim has the right to be accompanied as provided for in article 4.c of Law 4/2015, of 27 April, on the Statute of Victims of Crime, where specifies as a basic right the accompaniment of the victim by a person of his choice from the first contact with the authorities and officials, which must be reflected in the forensic report. Nevertheless, the accompaniment may be limited by the demands of the professional performance, with particular importance regarding the time of the exploration and sampling (possible risk of contamination).

  In this sense, it will also be of particular interest to detect situations in which the accompaniment may imply a possible alteration of the anamnesis, such as if it involves a suspicion of coercion (for example in cases of human trafficking). Faced with the detection of these situations, an attempt should be made to separate the victim from his companion, and, in any case, record this in the medico-forensic report.
- As set out in article 48.1 of the LOGILS, the repetition of recognitions will be avoided in any case, unless it is indispensable for the investigation. It is therefore advisable to carry out the joint action of the professionals in a single act (anamnesis, examination and collection of samples) in order to avoid the phenomenon of victimisation as much as possible; however, it is necessary to respect possible changes in rhythm or the need for interruptions depending on the state and/or decisions of the victim.
- Keep in mind the possible specific requirements that may be presented by victims of different cultural origins: it is advisable to clarify the contents that have been expressed during the interview and ensure that there has been a good mutual understanding; it is necessary to pay special

attention to non-verbal communication (in order to avoid misinterpretations) and also bear in mind that personal cultural bias (of professionals) can influence first impressions during the evaluation, especially regarding observed attitude.

3.2.2. Informed consent.

Consent must be obtained before recognition and must include all its parts (anamnesis, physical and genital examination, taking samples and obtaining photographs, if applicable). It can be verbal or written consent, although there are publications that recommend that consent be obtained in writing.

The provision of consent to urgent interventions for sexual violence requires that, prior to starting them, information has been provided on the role of the professionals who intervene, what the intervention consists of and how it will be carried out, and which is the purpose of obtaining the samples. Victims must also be informed of their right to revoke consent at any time during the scan. In the case of people with disabilities who cannot understand the scope of the intervention, consent will be given by their legal representative (Medical-Forensic Council [CMF], 2021).

3.2.3. Anamnesis.

The forensic anamnesis at the time of the initial expert assessment of the victims of sexual violence is a fundamental part of the procedure since its result will guide both the physical examination and the collection of samples. In the case of adults with significant disabilities, it is recommended that both the person accompanying the victim and the victim herself be asked about the facts, because despite the possible difficulty in expressing herself, she is the one who has suffered the violence and she may want to explain what she has experienced and how.

Initially, start with questions aimed at obtaining general data (identification; residency, tourist, etc.). Information will be collected on the victim’s parentage,

age, sex and special circumstances such as pregnant victim, hormone treatment, gender reassignment or others.

You will be asked about general medical history (somatic and psychiatric) that may be relevant to the case, as well as possible usual pharmacological treatment.

Later, questions related to obstetric - gynaecological background information will be addressed: menarche, last menstrual period, pregnancies, births, abortions and pathological processes. If you have had previous consensual sexual relations, the date of the last one will be requested (specifying, given the possible influence on the interpretation of the analytical results, if it was a known person or not, and if a condom was used).

Once the general anamnesis has been completed, the information related to the event will be collected, trying not to interrupt her during the story. It is necessary to collect information as precisely as possible, as long as and when the situation of the explored person allows it. Important data in the account, which will guide the examination and collection of samples, will include: place, date and approximate time of the events, aggressor or number of aggressors, known or unknown, type of aggression (existence of penetration (type), use of barrier methods, ejaculation, etc.), existence of violence (physical, use of weapons, retention or physical restraint, threats, coercive persuasion, taking advantage of a position of superiority or vulnerability of the victim), behaviour after the events (hygiene, change of clothes, subsequent sexual relations, administration of pharmacological treatment, consumption of drinks or food, urination, bowel movements, vomiting, etc.).

Given that many episodes of sexual violence take place in leisure environments and situations, as information of interest it is necessary to collect data on the possible consumption of toxic substances by the victim: a research carried out recently in our environment has shown that 69.9% of the victims treated acutely in the hospital reporting being victims of sexual violence had consumed alcohol a few hours before suffering the event (Garcia Esteve, 2021).

Therefore, questions should be asked on this point in order to guide the toxicological analysis (type of substance consumed or suspected to have been administered, approximate time of consumption, route of entry and dose, as well as whether or not it was voluntary consumption). This aspect is described in more detail in the section corresponding to samples for toxicological study.

Information regarding possible intoxication will be necessary for the purposes of considering the influence of high levels of alcohol (or other substances of abuse), not only as factors of vulnerability, but also as elements that may have an influence to the quality of the memory related to the traumatic episode.

The victim's account of the events and their transcription in the forensic medical report should be concise and summarised. It should be noted that in no case can this description of the facts be considered a declaration, but rather it is the systematised collection of information that allows us to guide the case and the intervention.

3.2.4. Psychopathological examination.

At the time of the anamnesis, an initial psychopathological assessment will be carried out which will include, at least, the following elements: assessment of the general state (care/negligence, hygienic state, etc.), awareness, orientation and attention, course alterations and/or thought content, possible symptoms and/or signs that suggest intoxication derived from the consumption of toxic substances, assessment of possible memory disturbances (characteristics of remembering the sequence of events, etc.), possible intellectual deficits, possible effects on the psychotic sphere and/or in the affective sphere, autolytic ideation (limiting, if possible, whether or not it is linked to the facts), critical judgement (preserved or not).

This psychopathological assessment can also allow us to identify the first symptoms associated with the impact, such as the acute reaction to stress. This is a clinical picture that implies a psychological discomfort that exceeds the discomfort that would lead to an adaptive disorder. According to DSM-V, to meet diagnostic criteria for this disorder, it is necessary to present 9 or more

symptoms out of a total of 14, corresponding to the groups of intrusion, avoidance, hyperactivation, negative mood and dissociation (American Psychiatric Association [APA], 2013).

3.2.5. Physical examination in adults.

Before starting the physical examination, the victim should be told in detail what steps will be taken and for what purpose. It is necessary to minimise the sensations of discomfort as much as possible by trying to carry out the examination, in any case, by body regions. At all times, the scanned victim must have the possibility to determine the pace of the scan or even to refuse it.

The physical examination will take place in a hospital environment together with a specialist in Gynaecology if it is a female genital anatomy, or with specialists in Urology or Surgery in the case of male genital anatomy; always in conditions of correct lighting and with the help of appropriate techniques of increase in the case that it was considered necessary.

The examination must be complete, thorough and orderly, noting the location, dimensions and morphology of the lesions identified. The lesion description must be detailed, properly differentiating between types of lesion (ecchymosis, erosion, haematoma, wound, etc.), and mentioning, when necessary, those chromatic changes that will allow them to be oriented chronologically. The non-existence of injuries will also be recorded in their case. The precision in this aspect contributes to improving the expert quality at the time of the oral trial, especially to correlate or rule out the relationship between the injuries that have been noted and the facts. Therefore, the report shall record the production mechanisms reported by the victim if they remember them or if they are aware of them. Those injuries that the victim describes as prior to the events must also be recorded.

The physical examination will begin with the general observation of the entire body surface (extragenital) and continue with the paragenital and genital/anal region.

3.2.5.1. Examination of extragenital body surface:

It must be a full examination. The WHO* guide (World Health Organisation, 2003) recommends starting with the victim's hands and gradually establishing a climate of trust with the examiner. Both sides of the hands will be inspected, checking the nails and observing the wrists for possible signs of ligatures and/or compression injuries. The rest of the forearm, arm and armpit examination will then continue, looking for possible injuries or signs that suggest violence, struggle and/or defence or that may be compatible with immobilisation, restraint, compression, etc.

The facial and cranial region will be explored next. Further work will be done looking at the cervical region and breasts where there could be possible suggillations. The rest of the examination will be completed with visualisation of the abdomen, dorsolumbar region and lower limbs.

3.2.5.2. Paragenital examination:

This will include the lower abdominal region, inner thighs and gluteal region.

3.2.5.3. Genitoanal examination:

The examination must be appropriate to the anatomy of the victim.

The genitoanal examination can vary in relation to the anatomical characteristics; the most common position in female anatomy is the gynaecological or lithotomy position and in male anatomy the most common position is usually the foetal position.

In the same way as in the examination of the body surface, it is necessary to describe possible injuries in full detail (including those characteristics that make it possible to estimate the dating), as well as refer to whether they are recent or old. Their location must also be specified (making an analogy with the clock face), distinguishing them, in their case, from signs of natural pathology. Injuries may be detailed using the accepted standard patterns with the acronym TEARS (Tear; Ecchymosis; Abrasion; Redness; Swelling).

Examination of the anus should begin externally with a description of the characteristics of the skin, such as anal margins, symmetry of the anal folds, presence of lesions, etc. Possible injuries or alterations that are identified must also be located in the clock face. Should it be necessary to evaluate the internal and external sphincter, the muscle tone of the walls will have to be analysed (to identify paralysis of the sphincter) through movements of contraction and elevation of the anus, the sensitivity will be evaluated and possible lesions found on anal touch (which will be necessary or not depending on the case and medical criteria) (Navarro, 2001).

In the case of anal findings in men who have suffered sexual violence, it has been observed that it is statistically more likely to identify injuries when the examination has been carried out within 48 hours of the assault (Liautard *et al.*, 2022). The most frequently described anal injuries would be fissures, ecchymoses and superficial wounds (Naumann *et al.*, 2023). Other findings (old and recent) can be scars, fissures, hypotonia, inflammatory signs, dilations, infundibuliform anus ("funnel anus") or changes in the folds. In relation to these findings, it must be taken into consideration that some of them may be anatomical and/or pathological variants of the victim and not the product of penetration trauma.
It is not common to find injuries to the penis or scrotum in the context of sexual violence (Catanneo *et al*., 2022).

3.3. Intervention in children and adolescents (C&A)

3.3.1. Preliminary considerations.

Child sexual abuse is the involvement of children and adolescents in sexual activities that they cannot fully understand and to which they cannot consent as fully equal and self-determined participants, due to their early stage of development (Herrmann *et al*. 2014).

Very often the episode of sexual violence is not known until some time has passed. This aspect determines the urgency when acting from a medical and forensic point of view. In this way, we can find four situations (Adams *et al.*,

2016):

- Urgent. It is about evaluating a very recent sexual violence and it will have to be done without delay. It will be indicated if there are medical, psychological, or safety concerns, such as acute pain or bleeding, suicidal ideation, or suspected human trafficking; an alleged assault that could have occurred in the previous 72 hours, or up to 7 days in the case of teenagers, which requires the collection of samples for a forensic analysis; the need for emergency contraception and the need for post-exposure prophylaxis for sexually transmitted infections (STIs).
- Cases classified as priority, in which there is a suspicion or knowledge of sexual violence in the last two weeks, which do not meet the indications of urgent cases. It is recommended to perform the scan within 1 to 7 days.
- Non-urgent cases. Indications in these cases are disclosure of abuse by children, sexual behaviours, suspicion of sexual abuse by a multidisciplinary team or family concern about sexual abuse, but where contact has occurred more than 2 weeks previously and no emergency medical, psychological or security needs are identified.
- Follow-up assessment. Consideration should be given to the need for follow-up to reassess unclear or questionable initial findings, to perform additional testing for STIs which were not identified or treated during the initial examination, to document healing/resolution of acute findings, or to confirm the findings of the first examination, when this was performed by an untrained examiner.

In the following sections, we will refer to examinations in urgent cases, that is, when we are aware that an episode of sexual violence has occurred in the last seven days.

3.3.2. Obtaining consent.

The well-being of the child must always come before the examination, so we must request their approval/permission to conduct the interview and medico-legal recognition (Ministry of Justice [MJ], 2018), and it will be necessary to

spend some time explaining, in detail and in a language suitable to the child's ability to understand, what the examination to be carried out consists of and its purpose. You will also be asked if you wish to be accompanied by an adult, family member or companion (as long as there is no conflict of interest with the victim, arising or not from the fact under investigation), or if you prefer to be alone with the staff healthcare to be able to express themselves more freely (Vega and Navarro, 2021). If the victim does not access it or does not cooperate, it will not be possible to carry out the scan.

Under the age of 16, parents, guardians or legal representatives must give consent (taking into account that these children may have limitations in understanding the scope of the intervention); at the same time they can help and facilitate the cooperation of the minor. In case of doubt or discrepancy between the person to be explored and the legal representative, the situation must be brought to the attention of the judicial authority, so that the decision is adopted in safeguarding the best interests of the victim (CMF, 2021). The Code of Medical Ethics (General Council of Medical Associations [CGCOM], 2021) specifies in article 14 that the opinion of children under the age of 16 will be more or less decisive according to their maturity.

Victims over the age of 16 will be treated as adults in terms of their ability to give consent, according to Law 41/2002 on patient autonomy. If the physical recognition cannot be carried out due to the lack of collaboration and/or consent of the victim, this must be stated in the forensic report.

3.3.3. Anamnesis in C&A.

When conducting the interview, the child's age and cognitive development must be taken into account (MJ, 2018). We should try, if possible, to obtain information about the facts from someone other than the child so as not to victimise them and to avoid them having to give an account of the facts several times. This aspect is particularly relevant when it comes to small children (up to 10-12 years old); therefore, in these cases we recommend not questioning the child at the time of custody, but obtaining the information only from those who can provide it (especially from the person who expresses the suspicion of abuse (CMF, 2021), but also from the staff healthcare provider, parents, guardians or

other companions). It is also recommended to obtain from the informants the data relating to medical history, follow-up and/or treatment guidelines.

In the case of teenagers, the interview can be done in the same way as with adults (that is, a direct interview), although the peculiarities of their age must be taken into account; in any case, the victim cannot be forced to give information regarding the violence suffered unless they wish to do so (Catanneo *et al*., 2022).

With regard to children and adolescents with functional diversity, it is necessary to be informed of the disorder or type of disability that the victim presents in order to guide the approach. In general, in the case of children with functional diversity, the questions about the facts will be directed to the companions, just as for children without functional diversity.

Before starting the intervention, try to create a climate of trust, be in a calm environment and do not be in a hurry. The attitude of the forensic doctor must be friendly, open, understanding and without prejudice (MJ, 2018). Therefore, we should introduce ourselves and begin the interview by dealing with aspects of the child's life that are not related to sexual violence (their names, how old they are, what school they attend, who they live with, if they have friends or what their names are, if they have a pet, etc.).

If we ask children questions, they should be simple and not leading or suggestive, and answers should, as far as possible, be documented verbatim (MJU, 2018) (Vega and Navarro, 2021).

Among the elements to be investigated during the anamnesis is the possibility of general, anal or genital discomfort (bleeding, itching, genital discharge, presence of warts or lesions), urinary or defecation symptoms, or pelvic, abdominal, genital or anal pain (MJ, 2018).

3.3.4. Psychopathological examination.

In this initial assessment, the primary objective will be the physical examination, but we must also take advantage of the opportunity to collect psychological

aspects such as the description of behaviour, appearance, gestures, possible emotional symptoms, and the child's attitude (cooperative, inhibited/shy, anxious) (Vega and Navarro, 2021) (Vega *et al.* 2014) (CMF, 2021). In the case of adolescents, a complete initial psychopathological examination can be carried out to assess, in the same way as in the case of adults, if they present symptoms of acute stress, and especially to rule out risk situations that may require urgent intervention from mental health professionals (signs of intoxication and risky behaviour, such as self-harm or suicidal ideation).

3.3.5. Physical examination in C&A.

We need to explain what the physical examination will consist of in a simple and explanatory way to both the child and the accompanying persons (Jiménez *et al.*, 2013).

The protocols recommend performing the physical examination by an examiner specially trained in the assessment of sexual abuse, who remains up-to-date and is able to make a differential diagnosis of the possible injuries he finds; in case the examiner is not an expert, it would be necessary to review and evaluate the findings with an expert, as a quality control step (Adams *et al.*, 2016) (Jiménez *et al.*, 2013). In our case, the examination carried out jointly with the paediatrician and/or gynaecologist (depending on the age of the child and the hospital protocol) will provide the required level of expertise, while minimising secondary victimisation.

The physical examination will begin with the general observation of the entire body surface (extragenital) and continue with the paragenital and genital/anal region.

3.3.5.1. Examination of the extragenital body surface:

The physical examination will include an inspection of the entire body, just as in the case of adults. We must not forget to explore the mouth, looking for unexplained lesions or lesions of the palate, especially near the junction of the hard palate and the roof of the mouth (Kellogg *et al.*, 2023) and also the frenulum (Jiménez *et al.*, 2013). In the case of children and adolescents, we will

not only have to look for acute traumatic injuries but also pre-existing scars or other signs of physical abuse (Catanneo *et al*., 2022).

3.3.5.2. Paragenital examination:

The crural regions, the gluteus and the abdominopelvic region will be explored. Both on the body surface and in the paragenital region, all possible lesions that we find must be described in detail, providing data relating to the characteristics: colouration, dimensions, anatomical location or other peculiarities (for example, if they are figurative lesions). If no injury is found, the absence must also be noted.

3.3.5.3. Genitoanal examination:

Within the physical examination, the inspection of the anogenital region is the most relevant.

Recommendations for the genitoanal examination:

- At the start of the examination, cover the child with a garment from the abdomen to the knees before removing underwear and keep the child covered during the examination (Jiménez *et al.*, 2013).
- It is essential to have good lighting. Many authors recommend the use of the colposcope as a tool, which if available, allows for better illumination and magnification (Kvitko, 2012) (Jiménez *et al.*, 2013).

3.3.5.3.1. Position of the C&A for the scan:

In the case of prepubertal girls, the scan will be carried out in the supine position, on the stretcher or on the caretaker's lap, with "*frog legs*" (prone position, bringing the knees closer to the pectoral region, so that the genitoanal region is elevated) and also in the genupectoral prone position, which allows the back of the hymen to be visualised; the use of the paediatric speculum is not indicated except if the girl is sedated, this situation is reserved for cases with unexplained bleeding (Jiménez *et al.*, 2013) (Herrmann *et al.*, 2014).

In the case of pubertal girls, the examination can be done in the lithotomy position (classic gynaecological position); the use of a speculum is indicated if

the girl has a Tanner development equal to or greater than 3 (Adams *et al.*, 2016).

In children, anal examination can be performed with the child in the supine position with frog legs, in lateral decubitus or in the prone genupectoral position, with gentle retraction of the gluteal folds (Adams *et al.*, 2016) (Jiménez *et al.*, 2013).

3.3.5.3.2. Genitoanal findings:

To evaluate the hymen, especially in the supine position, it is recommended to pull the lips in order to better visualise it and access the vagina. This involves gently stretching the labia majora between the thumb and forefinger in the direction of the examiner and to both sides; this manoeuvre separates the mucosal folds that close the introitus and allows the hymen to be visualised (Jiménez *et al.*, 2013).

Another way to assess the hymen is to use a wet swab to gently move it around and observe its entire anatomy (especially in the case of a fimbriated hymen). A Foley catheter may also be used; the probe is inserted into the vagina, once inside, the balloon is inflated and, with a slight pullback, the hymen is pulled so that it is possible to observe traumatic wounds imperceptible to the simple inspection (Jiménez *et al.*, 2013). The same result can be achieved by asking the girl to perform a Valsalva manoeuvre (making the girl cough or strain as if to defecate), facilitating the protrusion of the hymen outwards.

Combining three standard techniques (such as labial separation and labial traction in supine position and genupectoral position) increases the yield of positive results. The combination of techniques is required, according to the Adams classification, for a finding to be considered definitive evidence of abuse (Adams, 2018) (MJ, 2018) (Herrmann *et al.*, 2014).

Regarding the hymen, the medical forensic report must collect data on its morphology (annular, labiated, crescentic, fimbriated, septate, cribriform, imperforate, double); state (inelastic intact, elastic intact, recent tear, old tear, congenital notches); and presence or absence of injuries.

In boys, the penis, perineum, scrotum and testicles, crural regions and anus must be assessed. The report should include data on the examination of the anus, in terms of shape (oval, circular); tone (normal, hypotonic); and description of fissures, oedema, fold flattening, tears or other lesions (Vega *et al*. 2014).

3.3.5.3.3. Differential diagnosis of lesions with variants of normality:

We must be familiar with normal prepubertal anatomy and anatomical variants (Jiménez *et al.*, 2013). Regarding the hymen, it must be remembered that it is a septum, in almost all cases incomplete, located at the lower end of the vagina, which separates the vestibular duct from the vaginal duct (Kvitko, 2012). The appearance of the external genitalia and hymen depends on age and constitutional and hormonal factors, which can vary at different stages of development. In the postnatal and neonatal period, the hymen is bright pink and prominent due to the effects of oestrogen. Subsequently, in the hormonal withdrawal phase, the hymen changes from an annular shape to a characteristic crescentic shape, which is maintained until prepuberty (MJ, 2018). In prepubertal girls, oestrogen makes the hymenial tissue thicker and more distensible, with a tendency to fold outwards. Kellogg *et al.* (2023), with reference to the updated table I of Adams, collects the characteristics of the different normal variants of the hymen.

The number and location of possible lacerations of the hymen depend on factors such as the configuration of the hymen, the thickness of the septum and the particular strength it offers. When the hymen has been torn, the edges (or lips) do not join at the end of the scarring process, it is not fully reconstituted and is already divided into a greater or lesser number of pendants, called hymenial caruncles (Kvitko, 2012). Scar tissue is not found in the hymen (Catanneo *et al*., 2022) (Herrmann *et al.*, 2014), so it will be necessary to distinguish between congenital hymenal cleavage and post-tear caruncles.

It is important to learn to differentiate between normal or abnormal findings, accidental findings and findings compatible with a situation of abuse to ensure

correct interpretation. For example, we currently know that the width of the hymen opening has no informative value. Tampons can widen the opening of the hymen but in no case cause an injury. Doing gymnastics, running, jumping, stretching or doing splits does not injure the hymen, nor does masturbation (MJ, 2018).

To facilitate the differential diagnosis, we have the classification of Adams and his group, as the main globally accepted guide for the evaluation and interpretation of findings in cases of suspected child sexual abuse; this guide has been updated over the last few years since its first publication in 1992, and it is the latest version, that of the year 2023 (Kellogg *et al*., 2023). This table differentiates into three sections: section 1 physical findings (includes normal variants, findings with a medical explanation unrelated to abuse, findings due to other conditions that may be misinterpreted as abuse, findings without expert consensus, and findings caused by trauma and highly suggestive of abuse), section 2 for infections and section 3 for diagnostic findings from sexual contact.

3.3.5.3.4. Considerations regarding the genitoanal examination:

- In the medico-forensic report, the position in which the examination is carried out must be documented (Jiménez *et al.*, 2013), describe the morphology of the hymen in the case of girls (Catanneo *et al.*, 2022), describe in detail all the lesions present in the anogenital region following the clock face (considering the urethra at 12 o'clock and the anus at 6 o'clock (Jiménez *et al.*, 2013) and describe the state of development of secondary sexual characters (Vega *et al*. 2014).
- It is recommended to collect photographs (or video recordings) in case of seeing positive findings and for the purpose of confronting them with other experts, when necessary, as an expert quality control, although they should never replace a detailed description of the findings of exploration (Adams *et al.*, 2016) (Kellogg *et al.*, 2023). Regarding obtaining photographs, we recommend following the guidelines indicated in this protocol, in the corresponding section (page 42).

- It should be noted that normal examination with absence of anogenital lesions is most common in victims of child sexual abuse, with or without penetration, acute or chronic, so this result does not allow us to prove or rule out sexual abuse (Adams *et al.*, 2016) (MJ, 2018). This is partly explained by the rapid regeneration of anogenital tissues, which usually progresses to complete regeneration, which authors such as Kvitko describe in 10 days, and others, such as Cataneo, note that in most publications, hymenal abrasions, petechiae and mild submucosal haemorrhages and haematomas heal completely in 2-3 days; moderate or marked submucosal haemorrhages may persist for 15 days, and deep lacerations of the posterior fourchette may require 2-3 weeks to heal.

  Another explanation has to do with the time elapsed between the sexual violence and the physical examination (the percentage of findings is higher if the examination is carried out within the first 24 hours up to 72 hours) (Adams, 2018) (MJ, 2018).

  On the other hand, given that the most common abuse is non-violent (it usually consists of touching) there is less chance of physical injury (Vega and Navarro, 2021); but even penile penetration of the anus or hymen in girls at the onset of puberty may, in fact, not cause injury due to the high elasticity of the tissues (Catanneo *et al.*, 2022); in the case of the hymen, in these cases we would speak of a compliant hymen.

  All of this means that the anogenital findings are very variable because they depend on the type and frequency of abuse, in addition to the objects used, the degree of force applied, the age of the victim and the intensity of self-defence. Referred pain, vaginal bleeding, and time since last traumatic episode are the only factors significantly correlated with diagnostic findings (MJ, 2018).

- It should be mentioned that the anatomy of girls under the age of six, as the subpubic angle is very sharp, makes penetration impossible since the angle represents a bony barrier. Between the ages of six and eleven, penile penetration can be achieved but there is a risk of perineal or

rectovaginal injury, because in some cases the girl has small genitalia (Kvitko, 2012).

- Sometimes, younger girls (under 12) have not acquired the concept of what “inside” means with respect to their external genitalia; with pubertal development adolescent girls acquire a clearer idea of the “inside” with respect to the “outside” of the external genitalia (Adams, 2018).
- It is important to pay attention to the findings described in section 1, part E of the Adams classification (Kellogg *et al.*, 2023), which currently generate consensus among experts as highly suggestive of sexual abuse, even in the absence of a disclosure from the child, unless the child and/or caretaker provides a timely and plausible description of accidental anogenital straddle, crush or impalement injury, or past surgical interventions that are confirmed from review of medical records.
- Findings that may represent residual/healing injuries should be confirmed using additional examination positions and/or techniques.
- In the case of isolated/few/superficial injuries that appear to be bruises or petechiae should be confirmed as traumatic injury by showing resolution on follow up examination.

Below we highlight table 1 of the updated approach in 2023 for the interpretation of medical findings in cases of suspected child sexual abuse (Kellogg *et al.*, 2023).

Table 1. Updated approach in 2023 for the interpretation of medical findings in suspected child sexual abuse.

Section 1. Physical findings.

A. *Findings Documented in Newborns or Commonly Seen in Non-abused Children* (these findings are normal and are unrelated to a child’s disclosure of sexual abuse). They are considered normal variants.

1. Normal variations in appearance of the hymen:

a. Annular hymen: hymenal tissue present all around the vaginal opening including at the 12 o’clock location.

b. Crescentic hymen: hymenal tissue is absent at some point above the 3 to 9 o’clock locations.

c. Imperforate hymen: hymen with no opening.

d. Microperforate hymen: hymen with one or more small openings.

e. Septate hymen: hymen with one or more septae across the opening.

f. Redundant hymen: hymen with multiple flaps, folding over each other.

g. Hymen with tag of tissue on the rim.

h. Hymen with mounds or bumps on the rim at any location.

i. Any notch or cleft of the hymen (regardless of depth) above the 3 and 9 o'clock locations.

j. A notch or cleft in the hymen, at or below the 3 o'clock or 9 o'clock location, that does not extend nearly to the base of the hymen.

k. Smooth posterior rim of hymen that appears to be relatively narrow along the entire rim; may give the appearance of an enlarged opening.

l. Asymmetry in width of posterior hymenal rim.

2. Periurethral or vestibular band(s).

3. Intravaginal ridge(s) or column(s).

4. External ridge on the hymen.

5. Diastasis ani (smooth area).

6. Perianal skin tag(s).

7. Hyperpigmentation of the skin of the hymen, labia minora or perianal tissues.

8. Dilation of the urethral opening.

9. Normal midline anatomic features:

- Groove in the fossa, seen in early adolescence.

- Failure of midline fusion (also called perineal groove).

- Median raphe.

- Linea vestibularis (midline avascular area).

10. Visualisation of the pectinate/dentate line at the juncture of the anoderm and rectal mucosa, seen when the anus is fully dilated, as with passage or presence of flatus or stool in the anal canal.

11. Reflex anal dilation that occurs during examination maneuvers, such as traction applied to perianal tissues or positioning the patient, particularly in prone or supine knee-chest positions.

12. Anal dilation, causing visualisation of the dentate/pectinate line, anal columns, and/or anal crypts, any of which may be mistaken for anal laceration or abrasion.

B. *Findings commonly caused by conditions other than trauma or sexual contact* (these findings require that a differential diagnosis be considered, as each may have several different causes).

13. Erythema, inflammation, fissuring and/or maceration of the perianal, perineal or vulvar tissues related to poor hygiene or other irritant dermatitis.

14. Increased vascularity of vestibule and hymen.

15. Labial adhesion.

16. Friability of the posterior fourchette.

17. Vaginal discharge that is not associated with a sexually transmitted infection.

18. Anal fissure(s).

19. Venous congestion or venous pooling in the perianal area.

20. Complete/immediate anal dilatation in children with predisposing conditions, such as current symptoms or history of constipation and/or encopresis, or children who are sedated, under anaesthesia or with impaired neuromuscular tone for other reasons.

C. *Findings due to other conditions, which can be mistaken for abuse.*

21. Irritative/non-infectious: erythema, inflammation, and fissuring of the perianal, perineal or vulvar tissues due to irritant dermatitis, including Jacquet's dermatitis.

22. Inflammatory: aphthous ulcers, inflammatory bowel disease (anal fissures/prominent anal tags, rectal discharge), Behcets disease (painful ulcers).

23. Dermatologic conditions: lichen sclerosus et atrophicus, folliculitis, vitiligo, angiokeratomas,and hemangiomas.

24. Immunologic causes: pyoderma gangrenosum (painful ulcers).

25. Multifactorial/idiopathic: urethral prolapse, rectal prolapse, anal funneling.

26. *Post-mortem* changes: anal dilatation, red/purple discoloration of the genital structures (including the hymen) from lividity or other rare systemic conditions. Histologic analysis needed for confirmation.

D. *Findings without expert consensus on meaning regarding possible sexual contact or trauma* (these physical findings have been associated with a history of sexual abuse in some studies, but at present, there is no expert consensus as to how much weight they should be given with respect to abuse. Findings 28 and 29 should be confirmed using additional examination positions and/or techniques, to ensure they are not normal variants (findings 1.i and 1.j) or a finding of residual traumatic injury (finding 38).

27. Complete and immediate anal dilation with relaxation of the internal as well as external anal sphincters, in the absence of other predisposing factors such as constipation, encopresis, sedation, anesthesia, and neuromuscular conditions.

28. Notch or cleft in the hymen rim, at or below the 3 o'clock or 9 o'clock location, which extends nearly to the base of the hymen, but is not a complete transection. This is a very rare finding that should be interpreted with caution unless an acute injury was documented at the same location.

29. Complete cleft/suspected transection to the base of the hymen at the 3 or 9 o'clock location.

E. *Findings caused by trauma.* (These findings are highly suggestive of abuse, even in the absence of a disclosure from the child, unless the child and/or caretaker provides a timely and plausible description of accidental anogenital straddle, crush or impalement injury, or past surgical interventions that are confirmed from review of medical records. Findings that may represent residual/healing injuries should be confirmed using additional examination positions and/or techniques. Isolated/few/superficial injuries that appear to be bruises or petechiae should be confirmed as traumatic injury by showing resolution on follow up examination. Photographs or video recordings of these findings should be taken, then evaluated and confirmed by an expert in sexual abuse evaluation to ensure accurate diagnosis.

1) Acute trauma to genital/anal tissues

30. Acute laceration(s) or bruising of labia, penis, scrotum, or perineum

31. Acute laceration of the posterior fourchette or vestibule, not involving the hymen.

32. Bruising, petechiae, or abrasions on the hymen.

33. Acute laceration of the hymen, of any depth; partial or complete.

34. Vaginal laceration.

35. Perianal bruising or perianal laceration with exposure of tissues below the dermis.

Residual (healing) injuries to genital/anal tissues

36. Perianal scar (a very rare finding that is difficult to diagnose unless an acute injury was previously documented at the same location).

37. Scar of posterior fourchette or fossa (a very rare finding that is difficult to diagnose unless an acute injury was previously documented at the same location).

38. Healed hymenal transection/complete hymen cleft- a defect in the hymen below the 3 to 9 o'clock location that extends to or through the base of the hymen, with no hymenal tissue discernible at that location.

39. Signs of female genital mutilation (FGM) or cutting, such as loss of part or all of the prepuce (clitoral hood), clitoris, labia minora or labia majora, or vertical linear scar adjacent to the clitoris (Type 4 FGM).

3) Acute trauma to oral tissues

40. Acute oral trauma, such as unexplained injury or petechiae of the lips or palate, particularly near the junction of the hard and soft palate.

Section 2: Infections

A. Infections not related to sexual contact.

41. Erythema, inflammation, fissuring of perianal, perineal, or vulvar tissues due to bacteria, fungus, virus or parasites that are transmitted by non-sexual means, such as *Streptococcus Type A or Type B, Staphylococcus sp., Escherichia coli, Shigella* or other gram-negative organisms.

42. Genital ulcers caused by viral infections such as Epstein Barr Virus.

B. Infections that can be spread by (or are associated with) sexual transmission as well as non-sexual transmission. Interpretation of these infections may require additional information, such as mother's gynaecologic history (HPV) or child's history of oral lesions (HSV), or presence of lesions elsewhere on the body (*Molluscum*) which might clarify likelihood of sexual transmission.

43. *Molluscum contagiosum* in the genital or anal area. In young children, transmission is most likely non-sexual. Transmission from intimate skin-to-skin contact in the adolescent population has been described.

44. Condyloma acuminatum (HPV) in the genital or anal area.

45. Herpes Simplex Type 1 or 2 infections in the oral, genital or anal area diagnosed by culture or nucleic acid amplification test.

46. Urogenital Gardnerella vaginalis (associated with sexual contact but also found in prepubertal and adolescent vaginal flora).

47. Urogenital Mycoplasma genitalium or ureaplasma urealyticum; while sexually transmitted in adolescents, prevalence and transmission of these infections in children not well understood.

C. Infections caused by sexual contact, if confirmed by appropriate testing, and perinatal transmission has been ruled out.

48. Genital, rectal or pharyngeal *Neisseria gonorrhea* infection.

49. Syphilis.

50. Genital, rectal or pharyngeal *Chlamydia trachomatis* infection

52. *Trichomonas vaginalis* infection isolated from vaginal secretions or urine.

53. HIV, if transmission by blood or contaminated needles has been ruled out.

Section 3: Findings diagnostic of sexual contact

54. Pregnancy

55. Semen identified in forensic specimens taken directly from a child's body.

3.4. Obtaining photographs.

If you wish to illustrate the findings graphically, diagrams or photographs can be used, but it should be borne in mind that they will not replace the professional's written description of the same in any case. It must be taken into consideration that the main purpose of the images is descriptive and the professional will decide if it is necessary to incorporate them into the forensic report.

When it is considered that graphic elements should not be added to the forensic report, they may be incorporated in the institute's computer application as an attached document for internal use, and this circumstance will be recorded in the report. Under no circumstances must the images corresponding to intimate areas be included in the report: they will be included in the action as an attachment, and this circumstance will also be noted in the forensic report.

If the images are included in the report, the privacy of the victim must always be guaranteed in order to avoid being recognised, so it will be necessary to process the images by pixelating or hiding the face. Among the basic requirements that must be met by the photographs that must be used, it is necessary to consider: identification system (for example initials, file number, action number in the history of ejCat), date and time, dimensions/use of metric token, close-up plan and general plan that facilitates location and overview.

3.5. Collection of samples

Forensic examination and sampling are very important tools in the investigation and prosecution of sexual crimes. (Forr *et al.*, 2018). The sampling takes place after the anamnesis and at the same time as the examination of the victim. It must be performed by trained medical examiners. Although it is a very important part of the procedure, it is always a choice of the victim (National Institute of Justice [NIJ], 2017).

Samples can be taken for biology analysis and for toxicology analysis. The purpose of the evidence collected during the examination can help the investigation: identifying the perpetrators, corroborating the facts or exonerating suspicious persons (NIJ, 2017).

The displays will include the informed consent of the victim and following the public recommendations, among them, the *Order JUS/1291/2010, of 13 May, approving the rules for the preparation and submission of samples for analysis by the National Institute of Toxicology and Forensic Sciences* (CMF, 2021).

All cases referred to any forensic laboratory must be accompanied by the following documentation:

- The request or standardised data collection form (which will contain different information, depending on the type of analysis requested).
- The chain of custody. The chain of custody of a sample is a concept of great legal importance; it consists of the demonstration of the path taken by the sample, from its origin to its destination (in this case, the

laboratory), with the documentation of all the people who have been in contact with it, the moment (date and time) and their signature (Lowe *et al.*, 2009).

The moment of taking the sample and everything related to it (identification, packaging, sending to the laboratory, etc.) constitutes what is called the *pre-analytical phase*; this phase, which is considered as a part of the analysis itself, is crucial in order for the analyses to be carried out in the most correct way.

3.5.1. Samples obtained by health centres, without the participation of the forensic doctor.

Article 48 of the LOGILS specifies the possibility that biological samples and other evidence can be collected by a health centre, for subsequent referral to the Institute of Legal Medicine and Forensic Sciences (IMLCF), and establishes that the term and the other conservation conditions will be determined through scientific protocols by the competent bodies.

Sampling by health centres, without the presence of a forensic doctor, with subsequent referral to the laboratory should be a very exceptional practice. Both the medico-forensic examination and the taking of samples must be carried out by professionals specifically trained in the collection of this evidence (NIJ, 2017).

The IMLCFC has drawn up a protocol in order to manage these cases should they occur, in which the following points stand out:

- The health centres that send samples must send them correctly labelled (name and surname of the victim, date and time of taking the sample).
- The samples will be accompanied by a chain of custody document and a hospital report. The health centre must issue the corresponding statement of injuries to the corresponding court of inquiry.
- The Forensic Laboratory Service of the IMLCFC will receive the samples, only if they are sent correctly. Subsequently, he will contact the

competent court in order to inform about the receipt of samples, and will request their analysis, custody or destruction.

The Forensic Medicine Council's Guide to action recommendations for the Institutes of Legal Medicine and Forensic Sciences with the biological samples and evidence that are collected and processed by health centres, is expressed in the same direction.

3.5.2. Kits for taking samples in cases of sexual assault.

The importance of sexual assault kits (SAK) has been emphasised in recent years in order to protocolise and improve sampling in cases of suspected sexual assault. They consist of a set of materials that are used in taking samples from victims or suspects in cases of sexual assault, packaged in a uniform way (NIJ, 2017). The contents of the kits vary between countries and between areas within the same country (Newton, 2013).

The use of SAK specifically designed for the collection of evidence in these crimes allows to adapt to the rules of collection and submission of samples and improves the quality of the process, which will facilitate the obtaining of biological traces and genetic profiles, despite the samples containing critical amounts or traces of DNA (CMF, 2021). There are recommendations for the material these kits must contain.

The first SAK in Spain was developed by the National Institute of Toxicology and Forensic Sciences. It incorporated material such as flocked nylon swabs, human DNA-free material (manufactured in accordance with ISO 18385, from which the risk of human DNA contamination during the manufacturing process has been minimised), etc. (CMF, 2021).

The Institute of Legal Medicine and Forensic Sciences of Catalonia has created its own SAK, which will contain:

Product	Quantity per kit
Flocked swabs doubted samples	8
Flocked swabs undoubted samples	2
Non-sterile urine pot 60 ml	1
Sterile urine sample container 60 ml	3
Single-dose saline pot	2
EDTA tube	1
Potassium oxalate blood tubes	1
Medium zip-lock bags for samples	3
Medium paper envelopes for clothes	3
Gloves S, M, L	12
Label sheet	1
Kit instructions	1
Diagram for victim assessment	1
Large paper bag to store the kit	1

3.5.3. Biology analyses.

The purpose of taking samples for biological analysis is the determination of sperm, mainly, or epithelial cells of the possible aggressor subject, which may be the subject of genetic analysis (genetic profile of the aggressor and genetic comparison).

In this way, samples can be obtained for biological study in cases of penetration with and without ejaculation, penetration with barrier methods, penetration of parts of the body (fingers), penetration with objects or touches in the genital

area, among others. Each type of aggression will condition the results that can be obtained with the samples.

The presence of sperm is the crucial evidence for some sexual crimes (caused by men), and the success of its detection depends on the pre-analytical phase (taking samples, sending and receiving them to the laboratory) and analytical procedures. A negative result in sperm does not rule out a sexual offence by a man since there are several circumstances that can affect its detection: the time elapsed until the sample was taken, the vasectomy or orchiectomy, the lack of ejaculation, the use of condoms or spermicidal agents, menstruation, etc. (Suttipasit, 2019).

The medical examiner will decide in each case the type of samples to be obtained, and this decision will be taken on an individual basis, according to the account of the events, the findings of the examination and the time elapsed since the events (CMF, 2021). In case of total absence of report, the recommendation is to take a broad sampling, directed by the physical examination. Although there is a standard sampling procedure, it is necessary that this be adapted to the needs of the particular case (NIJ, 2017).

The samples obtained must be properly preserved until they are sent to the laboratory. They must be accompanied by the following documentation:

- Request or standardised data collection form.

  This document must include:

  - Victim data: first and last name, age, gender (in cases where the victim is a transgender person, it is recommended to specify, if deemed necessary, the sex chromosomal endowment in order to avoid misinterpretations of the biological profile obtained from the samples), sexual relations before or after the events (type of relationship with special relevance if barrier methods are used).
  - Data on the assault: place, date and time, type of assault, number of aggressors, relationship with the aggressor, hygiene after the assault.

- Sample data: detailed list of samples collected, type of analysis requested, date and time of sampling, identification of the professional who collected or supervised the collection (CMF, 2021).
- The corresponding chain of custody sheet.

All samples from the same case must be sent to the same laboratory. In no case, during the time of sampling, will samples be taken in duplicate (double the recommended samples for the case) in order to duplicate the shipment of the case to more than one laboratory.

Smearing or preparing specimens on slides at the site of sample collection is unnecessary and should not be carried out; preparations made in these contexts have many epithelial cells, bacteria, and other elements that can interfere (NIJ, 2017).

A minimum amount of water-soluble lubricant (non-spermicide), water or serum can be used for the vaginal or rectal examination, in order to make the examination and the taking of the samples more comfortable. It is recommended that it be single-use in order to minimise contamination (NIJ, 2017).

3.5.3.1. Samples for biological analysis:

All possible seminal evidence must be taken, in all cases, since at the time of collection of the sample, the specific circumstances of the case are often unknown (Suttipasit, 2019). Also, they must be collected regardless of the subsequent activities the victim has had: showering, swimming, drinking, having sex, etc. (González, 2018).

The sampling must take place as soon as possible, avoiding possible contamination. To avoid contamination, the following is recommended:

- Professionals who take the samples use: a mask and double gloves, with a change of external gloves when changing the sampled body region, a gown or protective clothing, and that they avoid talking or sneezing during the collection and packaging of the samples (CMF, 2021).

- That the work areas at the time of sampling are cleaned regularly, and that there is a record (Newton, 2013).
- At the time of taking the samples (Suttipasit, 2019): take care not to transfer secretions from the vagina to the anus, do not place different swabs in the same container, collect anal samples with an anoscope (reduces the possibility of contamination), place the speculum with extreme caution, to avoid facilitating the contamination of external regions inside the vagina.
- The support person/companion of the victim is placed outside the sample collection environment (for example near the victim's head) (González, 2018).
- Extreme cross-contamination precautions in the case of sampling from different cases (Newton, 2013).

The most common samples for biological determinations are:

- Cavity washes: vaginal, rectal and oral.
- Cavity and surface swabs.
- Clothes.
- Objects: condoms, tissues, tampons, etc.

On the other hand, it is necessary to distinguish:

- *Doubted samples*: those in which it is suspected that there is the presence of genetic material alien to the person examined. They are the object of the search for sperm, epithelial cells or genetic material of the aggressor subject.

  They are the washed areas and swabs of the body regions involved in the sexual assault, according to the victim's account.

- *Undoubted samples* (also called *reference samples*): those in which it is certain that there is no genetic material alien to the person examined. They are used in the genetic study of doubted samples, in the framework of comparative genetic material. They can be taken from both the victim and the aggressor. They could also be taken as subjects with whom the

victim had sexual contact close to the events, in order to rule them out as aggressors.

Oral swabs are taken in those cases where there has been no oral sexual contact; if there has been this type of contact, the undoubted sample is the blood sample, preferably with EDTA anticoagulant.

3.5.3.2. Deadlines for taking biology samples:

Forensic evidence degrades over time, so it is imperative that samples from suspected sexual assault cases are taken as soon as possible. While post-event sampling viability times used to be about one, DNA detection techniques have greatly improved sensitivity in recent years, resulting in a widening of temporal ranges (NIJ, 2017).

There are different feasibility studies to find sperm in the victim's samples. Although the best results are obtained by collecting the samples in the first 72 hours for vaginal samples, 48 hours for anal and 15 hours for buccal (González, 2018), it is possible to find spermatozoa in the following samples (CMF, 2021):

- Vaginal: up to 7-10 days later.
- Anal: up to 72 hours.
- Oral: up to 48 hours.

Body surface samples can be taken up to 7 days later, if there has been no cleaning of the surface (Suttipasit, 2019).

In cases of prepubertal children, since ejaculation is not usually internal, the recommendation is to take samples from the body surface, optimally before 72 hours (Hazelwood and Wolbert, 2008)

3.5.3.3. Recommended sequence for taking biological samples:

The collection of the samples must follow an order to avoid contamination between the different body areas.

The recommended sequence is (CMF, 2021):

1. Oral samples, it is recommended that they be the first since the remains of sperm disappear faster there.
2. Anorectal samples: the outermost samples first.
3. Samples of external genitalia, prior to the digital scan or the introduction of the speculum. In the case of female external genitalia, take the samples in order from outside to inside.
4. Vaginal samples: the most external samples first.
5. The rest of the samples (clothes, objects, etc.) can be taken at the moment considered.

It is recommended to record the methodology and sequence of taking the samples in the medico-forensic report. If for some reason it could not be followed, it is also advisable to record the reason (Faculty of Forensic Legal Medicine [FFLM], 2021).

3.5.3.4. Doubted sample collection:

3.5.3.4.1. Washed areas:

They consist of the introduction of a sterile liquid into a cavity and its subsequent collection.

Obtaining washes will always be preceded by that of swabs.

- In the case of *vaginal wash*, 10-20 ml of sterile physiological serum will be introduced into the vaginal cavity, with subsequent collection and introduction into a sterile jar.

  There are different procedures for obtaining it; it is most recommended that both instillation and collection be done using a syringe attached to a sterile cannula.

- In the case of *rectal washing*, we will proceed with the introduction of around 10-20 ml of sterile physiological serum into the rectal cavity and its subsequent collection and introduction into a sterile jar.

There are different procedures for obtaining it; the most recommended is that both instillation and collection are done using a syringe attached to a sterile cannula.

- In the case of *mouth wash*, we will proceed with the introduction of 10-20 ml of sterile physiological serum into the oral cavity and its subsequent collection and introduction into a sterile jar.

  The most appropriate procedure to obtain it is to administer to the examined person 10-20 ml of serum in the sterile jar, for the person to gargle it so that they reach all the spaces in the mouth and then return them to the sterile jar original

3.5.3.4.2. Swabs:

The use of swabs for the collection of biological evidence is the standard procedure; they are the samples that can be obtained and transported more easily (Ferreira-Silva, 2019). Swabs for the collection of samples in the forensic field are different from those used in the clinical field (Newton, 2013).

There are different types of swabs sold; the most used are cotton and synthetic (foam, nylon, etc.). The most recommended for taking samples in cases of recognition of sexual assaults, currently, are flocked nylon swabs. These swabs have a design that allows for higher performance as the sample adheres to the surface and is not absorbed (in cotton swabs, part of the sample is retained in the cotton and is not released, which has repercussions in the smallest amount of final available genetic material); they also have more fibre surface and the elution process in the laboratory is more efficient. The technology they have is called *Floq* (Ferreira-Silva, 2019) (CMF, 2021).

In order to take samples with swabs, it is necessary to place the swab in the sampling area and rotate it, including the apex part (Ferreira-Silva, 2019).

Samples from the cavities and secretions present on the body surface will be collected with a dry swab. Spots or samples from dry body areas will be collected using the double-swabbing technique, which consists of first applying

a swab moistened with a drop of water or sterile serum (to moisten the area to be sampled), then applying a dry swab (Suttipasit, 2019).

It is recommended to take two swabs per area to be sampled: ideally one of them would be left over in case of need to carry out a counter-analysis. Furthermore, there is no guarantee that all biological material can be taken with a single swab (Ferreira-Silva, 2019). Collecting more than two swabs from the same anatomical area can dilute the sample (NIJ, 2017).

- In the case of obtaining *swabs of external genitalia*, two wet swabs will be taken from the area, which will in any case include:

  Female external genitalia area: up to vaginal introitus, included. Sampling will be done in order from outside to inside.

  External male genital area: swabs of the penis (glans, corpus, corona and base), especially if there are dry secretions. Take a sample from the front part of the scrotum, around the base of the penis in cases of fellatio by the aggressor (González, 2018).

- In the case of *vaginal swabs*, two dry swabs will ideally be taken, one before the introduction of the speculum into the vagina, and one after. It will be necessary to clearly mark each of them. Samples can be taken from the outermost part of the vagina and from the innermost part (endocervical).

  If for some reason the speculum cannot be placed, two vaginal swabs will be obtained from the innermost part "*blindly*" and will be identified as such (FFLM, 2021).

- In the case of *anal and rectal swabs*, two moistened sterile swabs will be taken from the anal margins, and two other swabs from the anorectal canal (CMF, 2021) by inserting the swabs about 2 cm and making circular movements. In the case of men, it is recommended to take samples in the left lateral position (foetal position) (González, 2018).

- In the case of *oral swabs*, two swabs will be collected that will be passed, carefully and without excessive rubbing, under the tongue, around the gums and through the palate, up to the throat.

- In the case of *body surface swabs*: in cases of contact with the body surface in which the presence of sperm, the transfer of epithelial cells, presence of sperm or blood (especially in areas of the skin close to the genital area and hands) or in cases of bites or sugilations (presence of saliva), swabs will be taken; if the surface is dry the double brush technique will be used (Newton, 2013).

3.5.3.4.3. Clothes:

The clothes the victim was wearing at the time of the sexual assault may be subject to analysis. Therefore, it is recommended to collect the underwear (knickers and bra) and those items that can be considered of interest (that have ejaculate stains, for example) (CMF, 2021).

In order to obtain the clothing, it may be necessary to cut it, in such cases, if there is any part of a piece of clothing torn, the cut must preserve the area to be sampled. Photographing the piece of clothing on the body, before obtaining it, can be useful in order to record the placement of the clothing and the location of the torn parts (Newton, 2013).

They must be collected in paper envelopes and separately (CMF, 2021).

3.5.3.4.4. Other samples:

- *Fingernails* (Newton, 2013). During a sexual assault, material can be left on the fingernails: pieces of skin, fluids, hair, fibres, etc. There are different techniques for obtaining analysable material from the nails: cutting them, scraping them or passing a swab under their surface.
  In the case of obtaining cut nails, the nails of each hand will be placed in an envelope (CMF, 2021).

Given that the use of artificial nails or acrylic paints can make it difficult to obtain them by cutting or scratching, and that this can be a source of additional stress for the victim, sampling using swabs is recommended. A swab will be collected from each of the hands (right hand and left hand), with the exception of if there is a damaged or broken nail, from which a separate swab will be taken indicating the relevant finger and hand. In these cases, it is recommended to take a photograph of the nail before taking the sample.

The possibility of finding alien DNA is low and focuses on the first 24 hours after the events.

- *Pubic hair.* It is typically taken in cases of sexual assaults towards women; this transfer is usually minimal (Newton, 2013).

  Hairs can be found up to 7 days later, as long as the area has not been cleaned.

  They will be obtained by gently combing the area so as not to pull hairs from the victim and will be collected on a piece of tissue; the used comb will also be sent to the laboratory (CMF, 2021).
- *Pads, tampons, condoms.* They will be collected in sterile containers, separately and correctly identified.

3.5.3.5. Undoubted samples:

Undoubted samples can be taken from the victim and the aggressor, mainly. Both victims and aggressors can be men or women (NIJ, 2017).

The taking of undoubted samples, especially from the aggressor subject, must be carried out with extreme precautions in order to avoid contamination with the victim’s samples. For this reason, if they are taken in the same space and time, the professional will have to change their gloves, mask and clean their hands between taking both samples. In addition, undoubted samples must be packaged separately from those of the victim and must be properly labelled (NIJ, 2017).

In our environment, the taking of undoubted samples is usually deferred in time, so that they are usually taken in the course of judicial proceedings. These samples can be obtained by medical examiners or law enforcement agencies.

- *Oral swabs:* two oral swabs will be taken from the inner area of the cheeks (rub the swab); a sip of water can be taken beforehand, especially if food has been eaten recently.

  Oral swab samples are considered suspected only if there has been no oral penetration (in these cases the undoubted sample is blood) (CMF, 2021).

- *Venous blood:* collect a tube of blood by venipuncture with anticoagulant (preferably EDTA) with about 2-5 ml of venous blood.

  This sample will be additional to the one taken for toxicological analysis.

3.5.4. Toxicology analyses.

The purpose of taking samples for toxicological analysis is to identify substances that the victim may have ingested voluntarily (chemical vulnerability) or involuntarily (chemical submission).

Hospital laboratories usually do not have the appropriate techniques to carry out toxicological analyses with expert validity. (Newton, 2013) For this reason, samples must be collected and sent to laboratories specialised in forensic toxicology.

As such, samples can be taken in cases where there is clinical suspicion or when the victim or companions refer to the ingestion of substances or the suspicion is described (MJ, 2022).

It is recommended to obtain the samples as soon as possible. If the first samples have been obtained by the health centre for clinical reasons, it is recommended that they be considered, as long as their traceability, authenticity and integrity are guaranteed (MJ, 2022).

It is very important to gather information about times (time of administration or consumption of the substance and time of sample taking) and that this information reaches the laboratory in order to be able to establish the most appropriate analyses in the different samples, and be able to make a correct interpretation of the results. A negative result does not tell us that no substance has been administered or consumed, but that it could not be detected. The detection time of the substances depends on the dose supplied or consumed and the sensitivity of the detection method (Centre of Legal Studies and Specialised Training [CEJFE], 2019).

The samples obtained must be properly preserved until they are sent to the laboratory. They must be accompanied by the following documentation:

- Request or standardised data collection form.

  This document must include:

  - Victim data: first and last name, age, gender.
  - Relevant toxicological data: date and time of the events, consumption of toxic substances and time of consumption, usual prescription of drugs, administration of drugs at the health centre after the events and time of this administration.
  - Sample data: detailed list of samples collected, type of analysis requested, date and time of sampling, identification of the professional who collected or supervised the collection (CMF, 2021).
- The corresponding chain of custody sheet.

3.5.4.1. Samples for toxicological study:

Given the suspicion (during the anamnesis or examination) of a context of submission or chemical vulnerability, it will be necessary to take samples for a toxicological study.

In general, it is not recommended that routine toxicological tests be carried out, and that they be limited to cases of drug and/or alcohol intoxication, when the victim explains having ingested substances or when the victim describes symptoms compatible with this fact (MJ, 2022).

The recommended samples are (MJ, 2022):

- *Venous blood.* Two 5 ml tubes of venipuncture blood, one with EDTA as an anticoagulant (purple cap), and another with sodium fluoride as a preservative and potassium oxalate as an anticoagulant (grey cap). The colour of the tubes is standardised and is common in the vast majority of healthcare facilities. The tubes must be full to the maximum to minimise the air chamber.

  Disinfection of the venipuncture area (if the subject does not wear a via) must be done with a non-alcoholic disinfectant solution; in the event that the subject wears a catheter, the blood sample will be obtained directly from the catheter without the need for disinfection.

  The samples will be kept refrigerated (2-8°C) until they are sent to the laboratory. They allow the determination of substances up to 48 hours after consumption.

- *Urine.* It is the sample of choice in these cases. You will get everything possible in a plastic container of up to 50 ml. Vacuum urine pots are for collection and transfer to a tube, for this reason you must absolutely avoid sending urine samples in vacuum urine jars, as there is a very high risk of spillage.

  The urine sample will be kept refrigerated (2-8°C) until it is sent to the laboratory. In cases where its analysis is delayed, it can be frozen.

  They allow the determination of substances up to 5 days after consumption.

- *Hair.* It is the sample to be considered in cases where the examination has been postponed for more than 5 days, or in which it is suspected that the toxin is no longer in the blood or urine. Taking the sample will have to take about 4-6 weeks, enough time for the hair to grow.

  A pencil-thick strand of hair will be collected, preferably from the occipital area, as close to the scalp as possible. It will be fixed on a piece of paper

indicating the end corresponding to the root and the one corresponding to the tip.

The sample will be kept at room temperature.

3.5.5. Packaging and delivery of samples to the laboratory.

Not only the taking of samples, but the packaging and transport to the laboratory must meet a series of criteria in order to guarantee the traceability of the process and maintain authenticity and integrity, necessary requirements so that the results obtained in the analyses have reliability and validity for their subsequent presentation as judicial evidence (CMF, 2021).

For the packaging of the samples, the following principles must be followed (CMF, 2021):

- Each sample must be packaged individually.
- The primary containers will be sealed and correctly labelled (type of sample and subject of origin).
- The undoubted samples of the victim will be individualised (in different envelopes) from the doubted ones.

In order to avoid contamination by microorganisms, the following is recommended (CMF, 2021):

- Let the wet samples dry at room temperature and in a protected place before packaging them.
- Preferably pack in paper or cardboard containers.
- Keep samples refrigerated.

There are different methodologies for sending samples to the laboratory; the recommended ones are:

- Send the samples in a secondary container (container, box or envelope) and the documentation (request and chain of custody) in a separate envelope.
- Send the samples and the request in a secondary container (container, box or envelope) and the chain of custody on the outside of the

container. In these cases, if more than one case is sent in the same shipment, it is necessary to correctly identify each of the chains of custody (with the first and last name of the victim or the court and procedure).

4. The assessment of the impact of trauma on adults

Suffering an impact or traumatic event is not something exceptional (Crespo and Gómez, 2012; Koenen *et al.*, 2017). Given the epidemiological dimensions of violence against women and its impact on health, especially on mental health, it can be considered a public health problem (Oram *et al.*, 2016). Sexual violence, among other forms of interpersonal violence, are among the types of traumatic events with the greatest potential to lead to post-traumatic stress syndrome (Kessler *et al.*, 2014). At this point it is appropriate to refer to Circular 1/2023, of 29 March, of the FGE, on the criteria for the action of the Public Prosecutor after the reform of crimes against sexual freedom operated by the LOGILS, which establishes that it is necessary to offer identical legal treatment of the injuries that have been caused, regardless of their physical or psychological nature, and, consequently, from the prosecutor's office it will be possible to collect the sources of evidence that are precise to accredit the entity, characteristics and result of the undermining psychic, as well as the need for medical, psychiatric or psychological treatment for a more appropriate cure or faster improvement (or the finding that the lack of treatment has prevented or made it difficult to obtain an improvement or cure). It is therefore essential to understand the origin and development of the post-traumatic response, as well as the ways in which this response can be expressed and the factors that can modulate it.

The post-traumatic response can develop when a situation is witnessed or experienced that is life-threatening or may result in serious risk to physical integrity, experienced with intense fear, panic or helplessness, and the neuro-hormonal systems that they regulate the response to threat are chronically dysregulated (Sherin and Nemeroff, 2011). It occurs, therefore, when, in the face of an impact event, the victim's biological and psychological mechanisms to cope/assimilate/adapt are overcome. Contributing to the traumatic potential of the events are those factors that make them unpredictable and uncontrollable for the victim.

Manifestations or maladjustments resulting from sexual aggression or violence can involve from physiological alterations to alterations in the cognitive, emotional, behavioural and relational areas, generally depending on the characteristics of the victims and their age (Echeburúa and Guerricaechevarria, 2011). Research on the impact of trauma on mental health highlights the difficulty in establishing a unique psychopathological pattern associated with the experience of a victimisation situation or critical event, and we frequently detect a wide variability of signs and symptoms, sometimes of little specificity and which do not always fit the diagnostic manuals or international classification criteria but which, on the other hand, cause great discomfort, suffering and disharmony in the life of the person who suffers from it.

It should also be borne in mind that resilience and recovery are common outcomes in trauma, without forgetting that there may also be a chronification, a torpid evolution, or a delayed onset of symptomatology or clinical manifestations. The implementation of past and present coping resources, personal, family and environmental protective factors and the victim's resilience can explain the absence of psychopathology as well as "benign" clinical presentations. Among the vulnerability factors associated with a greater likelihood of developing post-traumatic symptoms we can find a history of anxiety-depressive symptoms, or previous victimisation (such as adverse early experiences and other psychological scars).

Post-traumatic stress disorder (PTSD) is the most common diagnosis related to trauma or stress, was first introduced in the DSM-III (APA, 1980) as a diagnostic category and has since several subsequent revisions. The most notable relate, firstly, to the total number of symptoms comprising the disorder and, secondly, to the number of symptom clusters. The latter has been widely debated over the years and in previous editions of the DSM, particularly with regard to the categorisation of PTSD symptomatology. The most recent edition of the DSM, the DSM-5 (APA, 2013), characterises PTSD as consisting of 20 symptoms, each belonging to one of four symptom groups: intrusion, avoidance, negative alterations in cognitions, and state mood, and alterations in arousal and reactivity (Soberón *et al.*, 2016). The DSM-5 includes acute stress

disorder, post-traumatic stress disorder, and adjustment disorder as disorders related to trauma and stressors.

People who have experienced repeated or long-term traumatic situations are likely to develop PTSD complex (with a consistent correlation); for the diagnosis of this disorder it is required to have been subjected to traumatic stressors, and the type of stressor will be considered more as a risk factor than as a requirement for the diagnosis. Unlike PTSD, complex PTSD is configured with 6 groups of symptoms: 3 typical of PTSD (avoidance, reexperiencing and hyperactivation) to which are added the difficulties in establishing/maintaining interpersonal relationships, affective dysregulation, and a persistent situation of extremely negative self-concept (Maercker *et al*., 2022). For more extensive information regarding this disorder, and especially focused on victims of intimate partner violence, we recommend reading Miguel Pérez García and Carmen Fernández Fillol (University of Granada).

In any case, it is important to bear in mind that not all post-traumatic responses present themselves in the form of PTSD; they can also be expressed as generalised anxiety disorder, in the form of eating disorders or in the form of substance use problems, among others.

In the case of problematic substance consumption, it usually develops as part of inadequate coping strategies, in which consumption takes place with anxiolytic purposes and/or evasion of discomfort or memories. This problem, beyond the repercussions on physical and mental health that may arise, can also lead to a greater risk of being victimised again in successive episodes of intake/consumption.

Beyond the appearance of symptoms that can constitute some type of psychiatric disorder, the impact can also materialise in psychological aspects, such as in the form of feelings of guilt and low self-esteem (common among victims of sexual violence in childhood and/or when the aggressor is a person close to them), or as the presence of greater psychological discomfort in those cases in which there are difficulties in self-recognition as a victim (Sarasua *et al.*, 2012). The difficulties (or the lack) in self-recognition as a victim of violence

are also associated with risky alcohol consumption and the maintenance over time of the relationship with the partner/aggressor (Jaffe *et al.*, 2021).

Regarding the impact on the mental health of male victims, it is necessary to know from the outset that sexual violence against men is also subject to myths and prejudices, in their case based on social and cultural ideas about the concept of masculinity and the traits that are considered typical of a hegemonic masculinity. In the same way, aside from the development of post-traumatic disorders, psychological effects must also be considered. Among these affects, high rates of mood alterations have been observed, with anxiety, suicidal ideation and behaviour, self-harm, grief and mourning, changes in self-perception, shame, low self-esteem or hostility; problems related to the sexual sphere are also described, in terms of the development of doubts about orientation, and also at a functional level (from impotence to promiscuity as a form of validation of sexual orientation) and the presence of somatisations (Thomas and Kopel, 2023).

In the case of male victims, it is also common for them to develop feelings of guilt; in their case it is common for them to adopt externalising coping strategies, such as the consumption of substances, carrying out risky sexual activity, or in the form of aggression (Widanaralalage *et al.*, 2022) (Forde and Duvvury, 2017).

All in all, and in order to guarantee a quality forensic intervention with victims of sexual violence, this must be approached and carried out from the knowledge of the impact of the trauma (trauma informed approach), recognising and identifying the mechanisms through which traumatic events impact the subject, and identifying the effects that these events may have had on the victims, from the possible influence on the quality of the story, through the repercussions on mental health and general operation. The purpose of this form of intervention is twofold, since, on the one hand, it helps to minimise re-victimisation, and, on the other hand, it facilitates a better understanding of the impact of trauma and helps to counter the preconceived ideas that they can have any of the legal operators (Ellison, 2017; Haskell, 2019).

4.1. Aspects to bear in mind in the medico-forensic evaluation

It is appropriate to start the interview with a presentation and information about who we are, what our role is, and how we will conduct the intervention; it can be a way of generating an atmosphere of trust and security that helps the victim in the event that attending the medico-forensic assessment leads to insecurity, worries or fear.

The assessment should be carried out from the minimum intervention necessary, avoiding duplication of visits. In this sense, depending on the characteristics of the case, it would be necessary to assess the convenience of carrying out the examination together with the forensic psychologist. During these explorations, spontaneous narration should be encouraged and facilitated, reserving questions for the resolution of doubts at the end of the exploration.

The clinical interview with the victim of sexual violence must serve, fundamentally, to gather information about the current clinical situation, probing the general functioning and also about the possible affectation in more specific areas. From a victim-centred perspective, questions relating to the facts should be ruled out in this interview and it is recommended that the information relating to the facts be gathered, preferably prior to the interview, from documentary sources linked to the judicial procedure such as the police report, statements, medical-forensic reports corresponding to the interventions during the guard, or even from the viewing of the pre-constituted evidence (if it has taken place). Obtaining this information prior to the examination will help to identify the elements that may have been at the origin of the traumatic response and also to guide the interview and identify the specific aspects about the which should be deepened.

However, if the victim provides information about the event and makes it easier to be questioned, it is advisable to be careful with the questioning and avoid expressions or questions that could be incriminating, that could be interpreted

as a questioning or that minimise the violence or its impact. Furthermore, if the victim mentions the presence of traumatic background information, the survey on the characteristics of the same and the eventual impact must also be careful.

In addition to the exploration of the impact, the interview must allow us to identify the presence of vulnerability factors and the current psychosocial situation of the victim, focusing especially on the social support and means of support available to him, already that these factors are relevant to estimate the prognosis.

With regard to the psychopathological exploration, the examination must go beyond the basic functions in order to characterise the possible affectations and identify, where appropriate, the signs and symptoms that make up the post-traumatic response and the extent of the affectation.

It is therefore necessary to explore the possibility of avoidant behaviours (what has stopped doing following the events), the presence of intrusive symptoms (thoughts, images, memories or sensations that relate to the events), and if so, if they come from spontaneously or motivated by some stimulus that you can recognise, if these memories remain in your thoughts for a long time or if they pass quickly, if they are accompanied by physical or mental discomfort and in what way, if you need to do something to get them out of the mind. It can also be probed if this discomfort is lasting and how it affects his subsequent activities.

Despite the difficulties, an attempt should be made to explore the presence of dissociative symptomatology, such as experiences of being or feeling like a dream, a film, experiences of feeling out of body.

Another aspect to focus on (since they can be the basis of important behavioural changes) is the exploration of cognitive changes and changes in the belief system: alterations to identity, loss of confidence in people (either in general or for some specific aspect, such as aspects of gender, ethnic or cultural origins similar to or associated with that of the aggressor), if he presents feelings or experiences of the impossibility of redoing his life. It must be

explored if he presents feelings of guilt or shame towards the events, if there have been established changes in family and social dynamics after the events. Furthermore, it is appropriate to question the format of emotional expression, especially if the tendency is to suppress the expression.

Since one of the possible presentations of the post-traumatic response can be in the form of somatisations, it will be relevant to ask about the existence of usual pains, such as muscle pains, joint pains, headaches (in the absence of another cause that justifies them). For the same reason, it will also be important to ask about eating habits and/or the presence of gastrointestinal symptoms: if she is hungry, more or less than she used to (and if, as a result, there have been changes in weight), how are the digestions (describe the symptoms).

One of the ways in which the impact of traumatic events can most frequently be observed is in the impact of sleep, so it is considered highly recommended to also explore this function: difficulties in conciliation, maintenance or awakening early, presence of interruptions and how they evolve later, or presence of habitual nightmares.

It is appropriate that the forensic assessment on the impact of traumatic events is complemented by the administration of complementary tests by forensic psychology professionals integrated into the psychosocial teams of the Integral Forensic Assessment Units Improvement Programme. It should be noted, among the various complementary tests that can be administered, the *Cuestionario del Impacto del Trauma (Trauma Impact Questionnaire) - CIT* (TEA ediciones), whose benefits are found, among other aspects, in that it has a validation scale for the answers that make it very suitable to administer in the forensic environment.

Given that the impact of traumatic events can go beyond the consequences on mental health and affect psychosocial aspects, it is necessary to evaluate the possible repercussions in this area, in a relevant way for the purposes of providing information that allows all the damages that the victim has suffered. To carry out this assessment we will have social work professionals who, together with forensic psychology professionals, make up the teams of the

Improvement Programme for the comprehensive forensic assessment units, which will allow us to carry out a comprehensive forensic assessment of the case from a biopsychosocial approach. The format of the comprehensive forensic assessment will therefore make it possible to characterise the presence or absence of an impact, the intensity of the impact and its scope on mental health, and also the consequences and damages on the psychosocial aspects and the functioning of the victim.

4.2. Aspects on the preparation of the report

According to article 52 of the LOGILS, victims of sexual violence have the right to be compensated for the damages they have suffered and this reparation includes, among other actions, compensation; article 53 breaks down the concepts that are susceptible to compensation (described in point 1.3).

Thus, with regard to the preparation of the report after the examination, it is relevant to consider some basic aspects that the document should include in order to facilitate the understanding of how the traumatic event will have influenced the person examined, and to provide the courts with the necessary elements to estimate the valuation of the damage and calculate the compensation for civil liability derived.

The resulting medico-forensic report should include the characterisation of the impact whether in the form of temporary or permanent damage, clarifying whether it is a psychological impact or consequences that configure a mental disorder, with an indication of the period of time that has required until clinical stabilisation, and, finally, in case of permanence of sequelae, assimilate by analogy to the sequelae contemplated in the scale of Law 35/2015. The future prognosis and the treatments that may be required must also be indicated, as well as the psychosocial aspects that are observed to be affected.

The medico-forensic report must, on the other hand, be the element that allows us to describe the possible presence of previous traumatic events and/or vulnerability factors in the biography of the person examined, in order to conclude whether this background information has led to a situation of greater

vulnerability to present post-traumatic symptoms before the event under investigation.

The appearance at trial will be another relevant moment to facilitate understanding about the impact, especially in response to questions that may be raised about the quality of the testimony.

4.3. Intervention of party experts.

Article 471 of the Criminal Procedure Law foresees the possibility for the parties, prosecution and defence, to appoint an expert of their confidence to intervene in the preparation of the expert report agreed by the Court. Beyond this generic forecast, the concreteness and scope of its practical application is a disputed issue that is being resolved case by case and on which there are no sufficiently consolidated criteria. The rights at stake are, firstly, the right to effective judicial protection, which includes equality of arms between the parties and the principle of contradiction; secondly, the right of victims to dignity and not to suffer re-victimisation; thirdly, the right of forensic doctors to be able to carry out their professional duties, and finally the general interest in the correct development of judicial procedures about crimes In this complex balance of rights at stake, we cannot fail to mention the potential negative effect that psychopathological examinations can generate on victims, being able to prolong or even worsen the sequelae of the trauma.

In the case of the psychopathological examination of minors, the legal system already provides for the indirect intervention of the professionals involved in the judicial procedure. In the case of adults, however, the psychopathological examination is carried out directly by forensic doctors. To do so, it is necessary to create a framework of trust that encourages the collaboration of the victim. This will share the account of the facts under investigation, the existence of any relevant background information and their effects, only if it feels in an environment of trust and respect. The establishment of the necessary conditions to guarantee the adequate exploration of the victim, can be seriously difficult with the presence of a professional that the victim identifies as an active agent in favouring the situation of the person responsible or even all as a

transmission belt for the violence suffered, depending on the type of intervention carried out. This consideration is particularly valid in the case of particularly vulnerable victims; in fact, Law 4/2015, of 27 April, on the Standing of Victims of Crime, mentions the specificity of minor victims, victims of sexual violence and victims with disabilities (art. 26).

In its Statement of Reasons, the Standing of Victims of Crime contains a very clear mandate addressed to all legal operators, when it mentions that “the protection of and support for victims is not only procedural, nor does it depend on their position in proceedings, but rather it has an extra-procedural dimension. It is based on a broad concept of recognition, protection and support, in order to safeguard victims comprehensively”. (...) “recognition and protection of and support for victims is not limited to material aspects and financial redress, but rather it also extends to the emotional dimension.” Law 4/2015 provides for a series of specific measures to protect the physical and moral integrity and the privacy and dignity of the victims, such as those in article 19, which asks officials in charge of investigating the crime, among which are the forensic doctors and that, although it is focused on judicial statements, other proceedings are not exempted in which the victims have to give their account of the events or provide other relevant data for the investigation, such as forensic examinations.

Other rules that we cannot ignore are Law 17/2020, of 22 December, amending Law 5/2008, on the right of women to eradicate gender-based violence, which contains an express prohibition of the re-victimisation of women, and that if it is part of a recurring practice by an Administration, it could be considered institutional violence (art. 76 bis). Whereas, Organic Law 10/2022, of 6 September, on the comprehensive guarantee of sexual freedom, together with its modification operated by Organic Law 4/2023, of 27 April, establishes that the victims are holders of rights and places professionals as guarantors of these rights (art. 2.a).

Given the above considerations, in the event that it has been decided by the judicial authority that a party expert should intervene in the psychopathological examination of the victim, when the victim expresses his/her refusal to undergo

the examination in the presence of the forensic expert, or when the forensic doctor considers that his/her intervention may make it impossible to carry out the examination, or may lead to re-victimisation, the possibility of suspending the examination in order to inform the judicial authority of this circumstance should be considered, so that the latter may adopt the appropriate measures.

5. The assessment of the impact of trauma on children and adolescents

We are currently in a moment of paradigm shift and model transition in terms of care (in general) for children and adolescents who have experienced sexual violence, and, more specifically, in terms of assessment of the impact for forensic purposes, with the development of the Barnahus strategy.

5.1. Barnahus. The Integrated Care Unit for children and adolescents who are victims of sexual abuse.

The Barnahus strategy for the comprehensive approach to sexual abuse against children and adolescents is a project of the Government of Catalonia, promoted by the Ministry of Social Rights, in coordination with the ministries of Health, Education, Justice, Interior and Equality and Feminisms, to set up integrated care units for children and adolescents who are victims of sexual abuse. This model places the needs and specificities of minors at the centre of the interventions, so that all the actions in which they must participate as victims of sexual violence will take place under the same roof, in facilities designed and prepared to generate a friendly environment, which will be served by multidisciplinary and specialised teams, following the guidelines and standards of the Promise Network.

The actions within the Barnahus project are focused on reducing the number of assessments and interviews. Among its functions is the promotion of support for judicial exploration and the provision of care to the child by specialised professionals (police, forensic doctors, doctors, criminal technical advisory team, psychologists, etc.) in a welcoming environment, multidisciplinary and with a victim-centric perspective. Other functions of the Barnahus strategy consist of informing, advising and accompanying victims of child sexual abuse (hereafter, CSA) and their families, and the interdepartmental management of cases to guarantee the coordination of the various professionals in each intervention.

In this project, forensic medicine professionals are part of the medical services, together with paediatrics and gynaecology professionals, with the aim of carrying out paediatric and medico-forensic examinations.

The government agreement that defines the public service of the integrated care unit for children and adolescents who are victims of sexual abuse (Agreement Gov/72/2024, of March 26) includes both the objectives of the service and its functions and the organisation. It is in this last aspect that the governing agreement includes the competences of each of the departments involved and where, therefore, the specific functions of forensic medicine are included.

In the case of sexual violence against children and adolescents, it will be necessary to differentiate the intervention of forensic doctors in two situations: the suspicion of acute or recent sexual violence (during the first 72 hours and up to 7-10 days depending on the case) and the suspicion of non-acute sexual violence.

In the first case of acute sexual violence, the medico-forensic intervention will be carried out in the emergency department where the case has been notified, together with the corresponding health teams. The conditions and characteristics that this intervention must have been described in the section corresponding to on-call interventions.

In the second case, the intervention of forensic medicine professionals will take place in the premises of the Barnahus. This will be a scheduled and coordinated intervention with professionals from the Ministry of Health, members of the Functional Teams of Experts (Equips Funcionals d'Experts, EFE) (equipped with specialists in paediatrics, gynaecology, psychologists and social workers). Following the indications of the government agreement, in this case, the intervention will be aimed at a medical examination to identify the possible physical sequelae resulting from sexual violence. For the detection of sequelae and physical indicators of abuse, a complete physical examination will be necessary, as well as the examination of the areas of sexual access (in accordance with the facts that have been reported). At this point, if more than

72 hours have passed, the collection of samples for forensic analysis is ruled out.

However, the document contemplates the competence to prepare the expert reports requested by the judicial authorities or the Public Prosecution Service, a context in which our intervention may be required to report not only on the physical aspect of sexual violence, but also on the impact on mental health since, in the same way as for adults, it is not only important to characterise the impact, but to translate it into terms that facilitate its recovery.

The intervention of forensic medicine professionals within the Barnahus strategy can take place in cases that are prosecuted, but also in cases where the violence has not yet been reported, setting up an “extrajudicial” action. In this second case, the medical forensic action will be aimed at the identification of findings derived from sexual violence as early as possible and the preservation of evidence, documenting the information that, in the future, can be used in the case of prosecution.

Both for the assessment of physical sequelae and for the assessment of the impact on mental health, it will be essential to examine all available medical documentation, as well as the documentation linked to the monitoring and psychosocial interventions, and the therapeutic interventions carried out.

Since the focus of the strategy is to avoid the unnecessary repetition of the story about the facts, it will be necessary to reduce the number of interviews that the children have to do. This circumstance, therefore, requires coordination between the various operators, with the aim of carrying out joint explorations, of a multidisciplinary nature, which allow collecting as much information as possible simultaneously. Specifically, in the case of the assessment of the impact on mental health, it may be necessary to establish coordination with the professionals of the Criminal Technical Advisory Teams (Equips d’Assessorament Tècnic Penal, EATP).

All together, and in the same way as in the case of victims in adulthood, it is necessary to carry out the approach from the knowledge of the impact of the

trauma, and from the knowledge of the specificities of its development in childhood. These aspects are listed below in point 5.2.

5.2. Trauma impact assessment.

The assessment of the impact of trauma on children and adolescents deserves special attention and dedication, given that it has different peculiarities from the impact on adults, both for its characteristics and for its short-term consequences, and more especially in long term.

The basic principles of the pathophysiology of trauma have been described in the adult section, and are also applicable to children. But in the case of boys and girls, it is also necessary to know the factors that are specific to them.

When a child suffers an episode of sexual violence, there are a series of elements that can influence the evolution of the child both positively (as a protective element) and negatively (as an element of worse prognosis) and that we must take into account when we have to carry out an examination. The socio-familial context would act as a network of protection and containment, but it can also act as a risk factor in cases of neglect or because of its direct intervention in abuse. The fact that the aggressor is part of the family nucleus/closest environment has several implications: the nucleus ceases to be the safety framework for the child, which can lead to alterations in their internal belief system, as well as alterations in the development of the bond/attachment. It also leads to difficulties in identifying the behaviour of the abuser as violent, and more difficulties when identifying oneself as a victim.

At the extreme of the response to the trauma, alterations can occur in the development of the personality, in which the elements of vulnerability prior to the traumatic event will play an important role: among them we will find the maturational state of the child, the presence of underlying pathology (psychiatric or neurological), functional diversity and the unstructured socio-familial environment. Another possibility at the extreme of the traumatic response is the development of complex PTSD.

5.3. Aspects to bear in mind for the forensic evaluation.

The medico-forensic task is carried out in conditions that can be victimising; in order to reduce the negative influence of our intervention, it will be basic and essential that the interview is carried out with as much information as possible about the facts reported to avoid directly questioning the child about them. Alternative sources of information are available to do so, such as the court file with the certificate; it is highly recommended to also request the court to view the pre-constituted evidence using the Arconte system. https://www.mjusticia.gob.es/es/AreaTematica/DocumentacionPublicaciones/InstListDownload/Gu%C3%ADa_buenas_pr%C3%A1cticas_web.pdf

The fundamental tool of the intervention will be the clinical interview (adapted to the characteristics, age and needs of the child), together with the psychopathological examination, with which all spheres of functioning will need to be explored to identify if there is an affectation of any of them. We will also need information that does not come directly from the children and adolescents. There will be many cases where, either because of the child's age, because of situations of functional diversity or for other reasons, this direct information will be insufficient. It will then be essential to obtain information from all the sources surrounding the C&A. Parents/legal guardians are one of the main sources of information, all depending on whether the person being investigated in this case is one of the parents (a situation in which the other will have to be questioned). In any case, the information sought is the behaviour of the minor at home in recent times: if there have been notable changes in compliance with the rules at home, in daily routines, in sleep or loss of acquired skills/regressions.

The school is another important source of information: if there have been changes in behaviour prior to the events (if the dates are known at that time, even if only approximately); changes throughout the school year that can be considered noteworthy; changes in the relationship with their peers or with classmates in higher years, or with their teachers and adults related to the school, and changes in school performance.

Psychologists and/or psychiatrists will also be helpful with this information. Most likely, by the time we are asked to make an assessment of the impact, the minor will have already undergone, or will be in the process of, psychotherapeutic treatment by the corresponding mental health professional. The documentation linked to the care process that has been followed will be very useful, whether there is a diagnosis, or to assess the evolution they have presented with the treatment and, consequently, to estimate the prognosis.

5.4. Anamnesis with children and adolescents.

5.4.1. Considerations regarding the specificities of children.

To carry out an interview with children and adolescents, it must be taken into account that the determining element is age. It is not the same to interrogate a preschool child as a primary school child or an adolescent; in short, each C&A is at a different evolutionary level.

5.4.1.1. Evolutionary differences in the acquisition of cognition:

We can see the differences according to the ages of children and adolescents in terms of language, knowledge, understanding and memory as established by Bravo, Guil *et al. AJUDA'M A EXPLICAR-HO* (HELP ME EXPLAIN IT) (2023), Acosta and Moreno (2007), Juarez and Sala (2011) CEFJE grant, Lamb, La Rooy *et al.* (2011) and Garcia and Delval (2019).

- *Children aged 3 to 5 years* present egocentric thinking and language. Their narrative skills have improved, they are involved in long dialogues and show progress in the social aspects of discourse. They can express negative sentences. They understand and remember details of a story, they can anticipate. They understand the when and the how, and 100% of their speech is intelligible. However, they still have difficulty distinguishing right from wrong or still have magical thinking (believing that their thoughts are enough to make things happen).
- *From 5 to 7 years*, children can start new topics of conversation and respond to the clarifications that the interlocutor asks for. They can also interpret moods in others. The expressive vocabulary has about

500 words and they can define them. They include long verbal instructions, descriptive words, and number concepts.

- *Children aged 7 to 9* begin to use language to establish and maintain a social status; there is an increase in taking the other's perspective, successfully increasing persuasion. They can make conversational clarifications to define terms and provide additional information, while maintaining conversations about specific topics and understanding the point of view of the interlocutor. There is also an increase in the ability to produce figurative language and they understand that some words can have more than one meaning. In this period is when metacognitive skills (ability of people to reflect on their thought processes and the way they learn) begin to emerge.
- *The range from 7 to 11 years* leads to an exponential advance in the evolution of the child/pre-adolescent, since the stage begins to develop in which they acquire a greater capacity to structure their ideas and develop better logical, rational and operational thinking. They develop, among others, skills such as serialisation (ability to establish an order between elements that can be counted) or transitivity (ability to find the existing relationship between two elements, which allows ideas to be linked). Although they can begin to express arguments and analyse situations, they still have difficulty taking other people's needs into account. Therefore, their decisions are made for self-interest (to avoid negative consequences or gain from them).
- *Between the ages of 9 and 12*, children/pre-adolescents can already present alternatives to a specific situation, they begin to understand metaphorical language, irony and proverbs. Around the age of 10, they can talk about abstract topics or topics that could have happened (they make inferences).
- *Between the ages of 12 and 14*, they can already understand ambiguous situations and make more abstract use of words and greater knowledge of definitions. They can now analyse the situation and better understand the consequences.

- *In the range of 15 to 18 years*, adolescents present an increase in the use of language for social purposes with an increase in argumentation. There has been a qualitative evolution in the cognitive abilities of adolescents with the emergence of new ways of thinking such as the ability to analyse the whole, raise hypotheses, make use of propositional logic or combine the parts to obtain the best result adapt to your needs. At the same time, adolescents must develop self-esteem, autonomy, identity, the acquisition of values, among others, taking advantage of these new cognitive skills.

5.4.1.2. Memory: Capabilities and Limitations

When dealing with a forensic examination with children and adolescents, it is not only necessary to know the process of language development, it is also necessary to know the development of memory. The determining factor of a child's memory capacity is age. As they grow, they are increasingly able to remember their experiences for longer periods of time: children aged 3 to 6 can remember details of an event up to a year later, between the ages of 7-8 they could remember events of two years ago It must be borne in mind that younger children will forget faster than older children; it is also important to know that children under the age of 3 have their ability to remember linked to the acquisition of language, so recovering memories prior to the beginning of verbal communication is practically impossible (Lamb, La Rooy *et al.*, 2011).

Despite studies, it remains unclear whether stress can positively or negatively influence children's memory, with results suggesting that it can lead to difficulty or inability to remember, and results suggesting that it can act to enhance recall (Lamb, La Rooy *et al.*, 2011, and Juárez and Sala, 2011). What is known is that the memory of a stressful or traumatic event is subject to the same patterns of encoding, storage and retrieval as memories of irrelevant events, which means that because an experienced event is traumatic, children have no reason to remember it in more detail and that all memories can be contaminated (Lamb, La Rooy *et al.*, 2011).

As such, we cannot expect children to remember in great detail the interactions with the aggressor, especially if the interactions were brief, confusing and happened a long time ago. Studies indicate that we actually remember much less than we might think and that the amount of information we can remember also depends on the relevance of the experiences. Events that are experienced first-hand and understood by the child, or that they are previously familiar with (i.e. if they have had similar experiences before), will be better remembered (Lamb, La Rooy *et al.*, 2011) and (Juárez and Sala, 2011).

As for the forgetting of memories, a rapid loss has been seen in the first days, then the amount of information remembered remains stable.

5.4.2. Anamnesis.

An appropriate atmosphere is necessary and the interview should be conducted in such a way that the children feel comfortable and we can empathise with them. It is very important to explain clearly and comprehensibly the purpose of the interview from the outset. Children are less likely to fail to explain everything they know because they are unaware of the evaluator's intentions (Lamb, La Rooy *et al.*, 2011).

An example of a forensic interview is the structured investigation interview protocol of child victims and witnesses (NICHD protocol). This forensic interview model, designed to elicit C&A's statements, improves the quality, quantity and accuracy of information and minimises the risk of contamination of the child's account (Lamb, La Rooy *et al.*, 2011; and Lamb, Brown *et al.*, 2018). The first part of the interview describes how to establish the relationship between interviewer and interviewee and can serve as a guide and help for our explorations. Other forms of interview, such as the one proposed by Juárez and Sala (2011), can also be valid as long as they allow establishing a climate of empathy, trust and control over suggestibility.

The next steps will be, first of all, to introduce ourselves with our name and our function. We will worry about the child's well-being by asking the child if they need anything. Next, we will give a brief explanation about the work we do with

children and/or teenagers and we will deepen the concept of truth and the importance of telling it, both on the part of the child and us, the interviewers, reinforcing the correct answers.

In any case, we must also bear in mind that the assessment of the trauma is not an interview in which we have to find out or interrogate about the facts. We will not start the interview by asking “What happened to you?” (this information will have been previously obtained by reading the report, the certificate and the rest of the documentation relating to the facts found in the judicial procedure). What we are interested in knowing is how they are, how they were before the events and before the complaint, what their life was like, what their life has been like after the events and the complaint, and how they have evolved up to the time of this interview in order to identify what changes have taken place in the victim’s life as a result of the episode or episodes experienced.

During interviews, language and vocabulary beyond the child’s or adolescent’s cognitive abilities should preferably not be used, as this can create a stressful situation due to the fact that the child or adolescent does not understand what is being asked, which, at the same time, could result in the information obtained not being correct.

In general, children have more difficulty retrieving memories than adults, which is why they need more notes or key words to produce the story of their memories.

If at some point it is necessary to talk about the events experienced, either because they are necessary to understand the emotional state of the victim, or because the victim begins to talk about them, they can be questioned, but always with the same care with which having conducted the interview up to that moment, limiting the questions to the fact narrated by the victim and giving sufficient space and time to be able to express as best possible.

We will use open questions, or if necessary, with an invitation, “what, when, how?” trying not to use multiple choice questions or yes/no questions. If there is

no other option but to use them, then open questions should be asked to clarify the information.

We will then begin to build the “rapport” per se. We want the child to explain things about themselves, things they like to do, to say what they are and describe them. We will also ask about things that they do not like or have not made them feel good, but that do not have to do with the facts. However, if the minor spontaneously begins to explain the facts at this time, we will let them do it.

If, during this initial phase, the child finds it difficult to answer the questions or gets nervous, an element that facilitates relaxation is to give them paper and colours to draw something (never, however, related to the facts that have motivated the present exploration). If, despite the attempts, it is not possible to get the child to agree to speak, the best option will be to postpone the examination for another day when they are more comfortable and more receptive.

When the child feels comfortable enough and answers these questions, you can delve deeper into their current and past feelings. We will let them know that we will change the topic of conversation to start talking about how they are feeling after the events they had to go through, how they have been living through it since it happened.

We will not stop reinforcing their behaviour and courage to talk about things that affect them. We will end the interview talking about neutral topics and thank them for the effort made.

In the case of teenagers, depending on their age, we can either use the same tools used for children or do the interview we usually use with adults. It is important to treat them like adults and make them feel like we are doing it, but not forgetting that they are not.

5.4.3. Psychopathological examination.

We have a wide range of symptoms that can guide us towards the emotional state of the child or adolescent. The first thing that must be clear is which situation and which victim we are facing. A victim who has suffered recent sexual violence, whether acute or chronic of short duration, will not be the same as a victim who has suffered for some time (years), whether it has been long-term or because of an affective referent but who has not yet reached adulthood. On the other hand, the symptoms can also be different between a child and an adolescent.

5.4.3.1. Variables that influence the emotional aspect of the CSA:

It is also necessary to know which variables influence the emotional impact on the CSA:

- Individual profile, in which we find psychological stability, age, gender and family context.
- Characteristics of the abusive act: Frequency, severity, existence of violence or threats, chronicity, etc.
- The existing relationship with the abuser. In this case, the degree of kinship is not as important as the degree of emotional intimacy between the victim and the aggressor. The greater the degree of intimacy, the greater the impact. Another element that also influences is the difference in age: the older the aggressor, the experience is usually more traumatic than in the case of adolescent aggressors.
- The consequences associated with the discovery of the abuse. Parental support, believing in the children and adolescents (especially mothers), is key to a return to normality, or to the recovery of the general level of adaptation prior to the declaration.
- Additional situations, derived from the disclosure of the abuse, can also greatly affect the emotional stability of the victim: breakup of the partner, and secondarily of the family nucleus. Also participation in the judicial process and secondary victimisation can worsen this stability.

The severity of the consequences will be found depending on the frequency and duration of the experience, the use of force or threats, the existence of the violent act and the relationship with the aggressor. For example, chronic and intense abuse by an emotional referent will generate a greater feeling of helplessness and vulnerability and therefore a more than likely appearance of severe symptoms.

5.4.3.2. Children:

In general, children will be more likely to experience school failure and specific socialisation difficulties, as well as aggressive sexual behaviour.

In the case of children, many of the symptoms will be related to their developmental stages, presenting themselves in the form of regression of the milestones achieved (appearance of nocturnal enuresis when he already had complete control of the sphincters, for example). We can also find encopresis, headaches, stomach aches, anxiety (in the form of irritability) and withdrawal. However, perhaps the most important and suggestive sign of an episode of sexual violence in this age group is sexualised behaviour, which is completely inappropriate for the age of the child (Cantón and Cortés, 2015).

For children at school, in addition to those already mentioned, other externalising problems (e.g. aggression and behavioural problems), dissociative disorders, peer relationship problems, poor school performance and dysregulation of cortisol levels and other psychobiological disorders caused by dysregulation of the hypothalamic-pituitary-adrenal axis can be added. Feelings of guilt and shame are also common.

In some cases, at first, it may seem that there is no affect from sexual violence, but there are many children and children who suffer from dissociation, which allows them to continue with their lives despite the sexual violence that they are suffering (Pereda, 2023). This dissociation occurs when the stress of the situation experienced exceeds the tolerance of the child victim of these events, and can cause amnesia or discontinuity in memories (Juárez and Sala, 2011).

One aspect to consider, when the offender is a parent, may be the development of a disorganised or insecure attachment between the child and the parents (attachment theory). According to Pereda (2023), this has been associated with emotional dysregulation and these two variables have been seen to influence the development of dissociative symptoms.

In children, it is necessary to consider the difficulties of self-recognition as a victim at the time of the examination, and bear in mind that the awareness of having been a victim of CSA can reach adulthood, and that, therefore, will be the time when the impact could materialise. This would be a possibility that our impact assessment report should pick up as foreseeable damage (sleeper effects) (Cantón and Cortés, 2015).

5.4.3.3. Adolescents:

In adolescence, the symptoms described above may also appear in boys, and behavioural disturbances may also appear in girls, especially if they have been subjected to penetrative sexual abuse, with a predominance of risky behaviour for themselves such as running away from home, abusive consumption of alcohol and other drugs, sexual promiscuity, self-harm, and even suicide attempts.

The existence of previous pathology will force us to make an effort to determine the origin of the symptoms we are seeing.

Below we can see a table by Echeburúa y Corral (2006), which summarises the main symptoms and the evolutionary stages in which short-term consequences can occur.

Table 2. Symptoms by evolutionary stages.

Types of effects	Symptoms	Evolutionary Period
Physical	Sleep problems (nightmares)	Childhood and adolescence
	Changes in eating habits	Childhood and adolescence
	Loss of sphincter control	Childhood

Types of effects	Symptoms	Evolutionary Period
Behavioural	Drug or alcohol use	Adolescence
	Running away from home	Adolescence
	Self-harming or suicidal behaviour	Adolescence
	Hyperactivity	Childhood
	Low academic performance	Childhood and adolescence
Emotional	Generalised fear	Childhood
	Hostility and aggression	Childhood and adolescence
	Guilt and shame	Childhood and adolescence
	Depression	Childhood and adolescence
	Anxiety	Childhood and adolescence
	Low self-esteem and feelings of stigmatisation	Childhood and adolescence
	Rejection of one's own body	Childhood and adolescence
	Distrust and resentment towards adults	Childhood and adolescence
	Post-traumatic stress disorder	Childhood and adolescence
	Complex post-traumatic stress disorder	Childhood and adolescence
Sexual	Precocious or inappropriate sexual knowledge for their age	Childhood and adolescence
	Compulsive masturbation	Childhood and adolescence
	Excessive sexual curiosity	Childhood and adolescence
	Exhibitionist behaviours	Childhood
	Sexual identity problems	Adolescence
Social	Deficit in social skills	Childhood
	Social withdrawal	Childhood and adolescence
	Antisocial behaviours	Adolescence

Source: Own adaptation.

5.4.3.4. Additional tests:

Specific psychometric questionnaires for this age group are administered with control scales, which are useful in the forensic field, in order to delve deeper into aspects of personality and adaptive and post-traumatic symptomatology.

Currently the most used tests are: SENA, an instrument aimed at detecting a wide spectrum of emotional and behavioural problems, with different versions according to the age range, which ranges from 3 to 18 years; MACI-II, which is the clinical inventory for adolescents, and PAI-A, which is useful for the assessment of traits and symptoms of adolescent psychopathology in various contexts.

5.4.3.5. Long-term sequelae:

With regard to long-term sequelae, or “sleeper effects”, as we have already mentioned, they usually occur in adult life. They are already described in the section on adult assessment, so here we will give an overview in the form of a table of symptoms.

Their possible development implies that, in the forensic medical assessment of the case, we must include them in the resulting report, as foreseeable sequelae that may very possibly appear in adolescent or adult life (depending on the time in the victim’s life at which the assessment was carried out).

Table 3. Possible sequelae.

Type of sequela	Symptoms
Physical	- General chronic pains - Hypochondria and somatisation disorders - Sleep disturbances (nightmares) - Gastrointestinal problems - Eating disorders, especially bulimia
Behavioural	- Suicide attempts - Drug and/or alcohol use - Dissociative identity disorder

Type of sequela	Symptoms
Emotional	- Depression - Anxiety - Low self-esteem - Post-traumatic stress - Complex post-traumatic stress - Mistrust and fear of men - Difficulty expressing or receiving feelings of tenderness and intimacy
Sexual	- Sexual phobias or aversions - Lack of sexual satisfaction - Changes in sexual motivation - Disorders of sexual activation and orgasm - Belief of being valued by others solely because of sex
Social	- Problems in interpersonal relationships - Isolation - Difficulties in children's education

Source: Own adaptation of Echeburúa and Corral (2006)

5.5. Aspects on the preparation of the report.

We must not forget to include in the report the pathological background information, nor the result of the examination carried out, as well as the sources consulted (interview with the caretakers who accompany the child, and documentary of other professionals).

It is necessary to collect a subsection, within the psychopathological examination, in relation to the experience of the trauma: mention will be made of the situation of the victim in everything related to the emotional discomfort and its evolution, as well as the repercussion of the events in the various spheres of his life (social, academic, work, sexual, family, etc.).

The assessment of the sequelae requires a specific section, which includes both the current affect (either in the form of a disorder or in the form of a psychological alteration), as well as the possibility of a modulation of the basic personality, or the appearance of the sequels of future appearance that have been indicated a few lines above.

As health and psychosocial damage, the description of the consequences should be accompanied by the assessment of the damage. For this assessment we can resort to the scale of Law 35/2015, of 22 September, on the reform of the system for the valuation of damages caused to persons in traffic accidents, indicating that the sequela has been selected by analogy or assimilation. It will also be necessary to include the possible moral damages suffered by both the victim (e.g. moral damage due to loss of quality of life) and by the members of the family nucleus.

6. Medico-forensic intervention in cases of female genital mutilation

The World Health Organisation (WHO) defines Female Genital Mutilation (FGM) as “all procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons”. FGM is therefore considered to be any procedure that involves partial or total removal the external female genitalia or other injuries to the genitals for non-therapeutic purposes.

FGM is a violation of the Human Rights of girls and women. It is usually carried out on girls from 0 to 15 years of age, for cultural or religious reasons, but also on adult women, in which a situation of violence, intimidation, abuse of trust, superiority or vulnerability can mediate, taking advantage of the victim’s mental state, of being deprived of meaning or of having their will annulled.

Law 17/2020 considers this practice a type of sexist violence in the social or community sphere, “regardless of the woman’s explicit or tacit consent”.

The Spanish Criminal Code typifies the FGM as a Crime of Injury, art. 149.2: ”Whoever causes to another person a genital mutilation in any form shall be punished with a sentence of imprisonment from six to twelve years. Should the victim be a minor or person requiring special protection, the punishment of special barring from exercise of parental rights, guardianship, care, safekeeping or fostership shall be applicable for a term from four to ten years, should the Judge deem it appropriate in the interest of the minor or of the person requiring special protection”.

The 2014 reform of the LOPJ confers on the Spanish State powers to judge crimes classified in the Istanbul Convention, among which FGM is included. The crime can be prosecuted when the procedure is directed against a Spanish person, against a foreign person who habitually resides in Spain; and when the crime has been committed against a victim who, at the time of the commission of the acts, had Spanish nationality or habitual residence in Spain, provided that the person to whom the criminal act is attributed is in Spain.

Finally, the LOGILS considers FGM as a type of violence with an impact on a woman's sexual life; calls on the public authorities to establish and procure the specific training of the various professionals for the prevention, detection or assessment of this type of violence from all areas; and establishes the victim's right to compensation for the following concepts: damage (physical, psychological, moral, social (understood as damage to the life project)) and treatment (therapeutic, social, sexual and reproductive health).

6.1. Identification of the type of mutilation

Since 1995, the WHO has established 4 typologies of FGM:

Table 4. Types of female genital mutilation.

Type I- ***Clitoridectomy***. Removal of the clitoral prepuce, with or without partial or total removal of the clitoris.
Type II- *Ablation / Excision*. Partial or total removal of the clitoris and the labia minora. Labia majora intact.
Type III- ***Infibulation.*** Removal of the clitoris, labia majora and minora. Later, they are sutured on both sides of the vulva, leaving a small opening that allows the flow of urine and menstrual blood.
Type IV- ***Other types of procedures***, which involve partial or total removal of female genitalia, such as: pricking, piercing, ringing or incising of the clitoris and/or labia. Stitching or tightening of the clitoris and/or labia and cauterisation of the clitoris and surrounding tissue. Scraping of the tissue around the vaginal opening (*angurya* cuts) or cutting of the vagina (*gishiri* cuts). Introduction of corrosive substances in the vagina to cause bleeding or introduction of herbs with the aims of narrowing the vagina. Any other procedure that falls under the broad definition of female genital mutilation.

Types I, II and III are schematically represented below (figures 4, 5 and 6).

Figure 4. Type I FGM. Clitoridectomy.

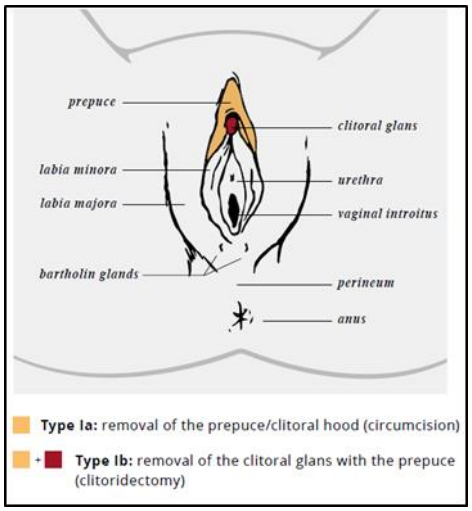
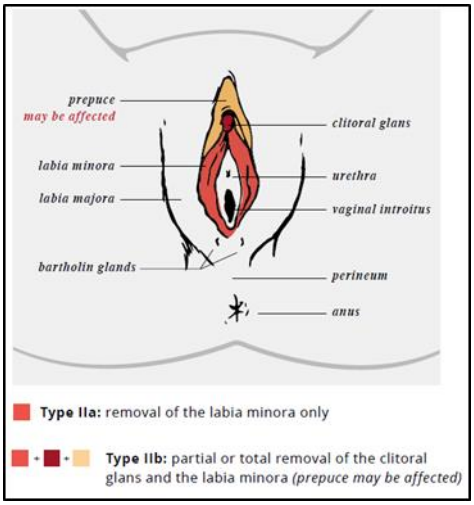


Figure 5. Type II FGM. Ablation / excision.



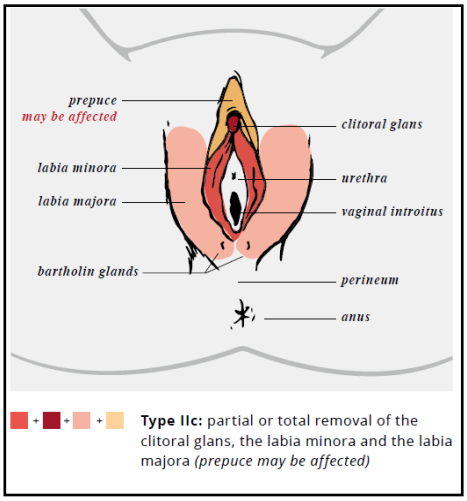
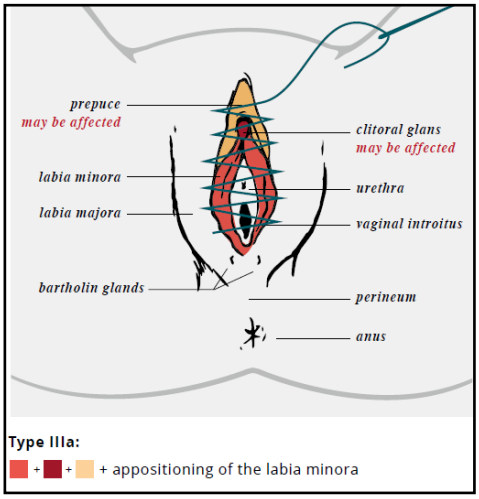
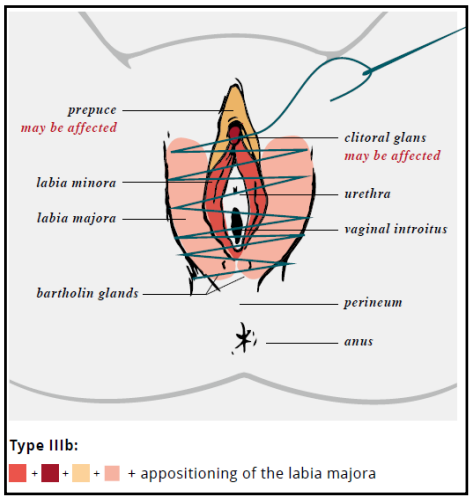


Figure 6. Type III FGM. Infibulation





Source: Diagrams obtained from publication *Care of girls and women living with female genital mutilation: a clinical handbook.* World Health Organisation, 2018. Licence: CC BY-NC-SA 3.0 IGO.

6.2. Predictable consequences of female genital mutilation.

FGM is a procedure that brings no benefit to the health and well-being of girls and women. On the contrary, it causes damage to healthy tissues, alters physiological functions and can have expected negative physical, psychological, sexual and/or obstetrical consequences, which vary according to their state of health, the type of mutilation, the hygienic conditions in which it has been practised, the instrument used and the skills of the person who performed it.

Some of the expected consequences or complications will be immediate. And others will appear in the short or long term (WHO, 2013).

6.2.1. Immediate expected consequences or complications.

- Haemorrhage, with secondary anaemia.
- Severe pain.
- Infection (local or generalised in the urinary, genital and/or reproductive tract. Abscesses, ulcers, sepsis, septicaemia).
- Reflex urinary retention, due to pain when passing urine through the edges of the wound or to the injury of the urinary tract after the cut/section.
- Shock (hypovolemic, septic).
- Death caused by haemorrhage or infection.
- Psychological impact: sadness, fear, anxiety, feelings of shame, night terrors.

6.2.2. Expected consequences or complications in the short and long term.

6.2.2.1. Physical scope:

- Transmission of infections such as HIV, hepatitis or tetanus, through the use of unsterilised instruments.

- Recurrent genitourinary infections.
- Chronic pain: at the secondary vulvar level; damage of the genital tissue; at the pelvic level due to infections of the reproductive tract; when urinating due to obstruction and infection of the urinary tract.
- Dysmenorrhoea and hematocolpos. Menstruation can last for weeks as the exit hole is very small, causing blood retention that causes bad smell, vaginal, uterine and reproductive system infections and, sometimes, infertility.
- Abnormal vaginal discharge and/or vaginal itching caused by chronic infections of the genital tract.

6.2.2.2. Psychological scope:

- Alteration or mood disorders: depression, anxiety.
- Post-traumatic stress disorder.
- Psychosomatic disorders: eating disorders, sleep disturbance, concentration and learning difficulties.
- Behavioural changes in minors, related to the loss of trust in caretakers and in themselves.

6.2.2.3. Sexual scope:

- Decreased sexual sensitivity which in many cases causes anorgasmia.
- Dyspareunia (greater in type III FGM).
- Decreased sexual drive/arousal.

6.2.2.4. Obstetric scope. Related to pregnancy, birth and post-partum:

- Gynaecological sequelae (genital tract infections) can persist over time and produce sterility or infertility.
- Loss of elasticity due to the formation of keloids and dermoid cysts in the healing of the skin that make childbirth difficult.
- Perineal sprains and fistulas in vaginal parts are increasing.

- Labour dystocia. Prolongation of labour with increased foetal suffering and even greater risk of foetal or neonatal death; increases the need for instrumented and caesarean delivery.
- Post-partum hospital stay extension.
- Post-partum bleeding can occur due to atony and urinary infections caused by retention.

6.3. Therapeutic options for female genital mutilation. Handling and treatment.

There are women who have undergone FGM and request to recover the original anatomy and functionality of the genitals for different reasons: to recover their identity as a woman, to repair the visible stigma of FGM, to improve their sex life or to eliminate dyspareunia. In all these cases, the bet in the care field is the comprehensive approach by gynaecology and plastic surgery, psychological support and sex therapy.

6.3.1. Psychosexual approach.

A multidisciplinary approach must be offered to women affected by FGM, which is adapted to their sexual and health problems arising from the mutilation, as well as to their social and cultural context. Psychological support must be provided, an environment where the woman can express her wishes, preferences and fears (of family or community marginalisation or exclusion) when she decides to undergo restorative or restorative treatment.

From the point of view of sexual health, adequate information, counselling and sexual therapy must be given to women who request it. It is essential to assess the woman's current sexual life and her expectations before offering her the most appropriate personalised treatment, especially in those situations where FGM is asymptomatic.

6.3.2. Surgical options.

The indication for surgical treatment must be evaluated by the different professionals who make up the medical team and the woman, taking into account the objectives pursued and focused on expectations.

Among the most commonly performed surgical techniques are:

- *Deinfibulation*. It consists of making an incision that allows opening the closed vaginal opening of the woman, who has previously been subjected to infibulation, the removal of adhesions and scar tissue. This technique is necessary in cases of Type III FGM, to allow menstrual hygiene, vaginal intercourse and vaginal delivery.
- *The reconstruction of the clitoris*. It is performed by removing scar tissue, recovering the inner part of the internal clitoris and placing it externally, in an anatomical position. With this surgery, full recovery of sensitivity in the affected area is not always achieved. The public health system guarantees clitoris reconstructive surgery to all women resident in Catalonia who have suffered female genital mutilation.

6.4. Medicoforensic intervention in cases of female genital mutilation.

In application of the legislation currently in force, when a case of FGM is suspected or detected from the health, educational, social or police fields, the professionals of these groups have the obligation to bring it to the attention of the competent judicial authority (Court or Public Prosecution Service).

The intervention of the forensic doctor in these cases will be at the request of the judicial authority and in relation to one of the following cases (Gallego and López, 2010).

- *Bodily damage assessment*. For the preparation of a report of injuries and sequelae, based on the medical documentation available on the victim or prior recognition of the same. Explicit reference must be made to the type of mutilation practised as well as the physical and psychological sequelae that can be objectified or that can be foreseen in the short or long term.

- *Precautionary judicial measures*. In the face of suspicions, on the part of relatives or professionals, due to an imminent trip of the family to the country of origin where FGM is culturally an accepted practice, as a precautionary measure it can be agreed:
    - Periodic review of the minor, by the forensic doctor, in order to detect possible injuries resulting from this practice.
    - Preventive disempowerment procedure - suspension of parental authority. Psychopathological assessment of the minor's parents to determine their legal competence. This extreme is very difficult to assess due to the influence of socio-cultural factors and the low perception of risks on the minor's health by her parents.
- *Forensic autopsy*. In the case of the death of a girl or woman in the context of FGM or as a result of its consequences, the intervention of the forensic doctor would be mandatory in order to carry out the judicial autopsy and establish the causes and circumstances of the death, being of particular interest to rule on the causal link with FGM.
- *Medical practice*. Elaboration of a medico-forensic report in relation to the medical practice of centres and professionals who have been able to carry out this practice in our country.

6.5. Protocolisation of the medico-forensic examination in cases of FGM.

The medico-forensic action protocol in cases of FGM is a guiding document that describes, in detail, the activity that will be carried out to assess the bodily harm of this victim, as well as the specifics that may be necessary.

6.5.1. Preparation

6.5.1.1. Place of recognition:

It is essential to have a suitable, discreet and quiet place to carry out the reconnaissance. It is necessary to manage to establish a climate of safety and trust as well as guarantee the privacy of the minor/woman and have the necessary material means available. Therefore, it is recommended that scans

are carried out, preferably, in a hospital environment and with the participation of specialised professionals.

6.5.1.2. Joint assistance and expert action:

The possibility of a joint action will be determined by the way in which the facts are brought to the attention of the judicial authority and its decision. To avoid duplication of examinations and secondary victimisation, the examination by the paediatrician (paediatrician/gynaecologist) and the examination by the forensic doctor should preferably be carried out in a single act.

6.5.1.3. Presence of a trusted person during the examination:

It is recommended that the victim is accompanied at all times by a trusted person, who, depending on the victim's age or particular circumstances, can be: the person exercising parental rights, guardianship, care, safekeeping, fostership, assistance or a qualified health worker.

In the case of adolescent girls under the age of 16, their wishes should be respected if they do not want their parents present. The explicit consent of the tutors must be obtained to continue with the exam, with another person present. In the context of these explorations, it may be the case that the legal guardians have an interest contrary to the exploration. As such, in case of doubt or discrepancy, it will be brought to the attention of the judicial authority in order to assess the appointment of a judicial defender or adopt the decision that corresponds to the best interest of the minor or the disabled woman.

6.5.1.4. Participation of an interpreter and/or cultural mediator:

In each case, it must be assessed whether the presence of an interpreter or cultural mediator, preferably a woman, is necessary. Family members will not be valid for this purpose. It is important that the professional who performs this function is not in favour of FGM and does not influence according to his personal perceptions and/or prejudices.

6.5.1.5. Information prior to recognition:

Before starting the recognition, you must introduce yourself and explain to the woman, child and/or legal guardian what the reason for the recognition is and what it will consist of, using understandable language, in comprehensible terms, that adapts to their age and educational level.

6.5.1.6. Informed consent:

Once information has been provided about the purpose and aims of the examination, as well as the actions that will be carried out, the woman's consent must be obtained to start the examination. If the victim is a minor, or has a disability that prevents them from understanding, it will be their guardian or legal representative who will give consent. In the event that the interests of the guardian or legal representative come into conflict with those of the victim, the competent judicial authority will be notified. For more information, review section 3.2.1.

6.5.2. Data collection.

The time of data collection must allow us to establish a bond of trust with the victim. Clear and colloquial language must be used.

In the case of minors or victims with disabilities, prior to the collection of data and whenever possible, an attempt has been made to obtain information from those people who have detected the injuries or raised the suspicion of the case and/or review those documentary sources where it has been stated (medical care reports).

6.5.2.1. Anamnesis:

- Personal description: name, age, date of birth, place of residence, school year (minors, teenagers), work activity, marital status.
- Family history that may be of interest.
- Personal medical, surgical, gynaecological and psychological pathological background information. Toxic habits.

- *Specific anamnesis in relation to FGM*. It may be a good time to ask about this practice when taking a surgical or gynaecological history. The tone should be neutral and avoid verbal or non-verbal expressions of disapproval, embarrassment or disgust. It may happen, depending on the age of the woman, that she does not remember this background and/or the legal guardians do not want to explain it. If the background information is remembered and admitted by her, we can ask her to explain how she lived the experience and what her current state is, a fact that will be useful for us to assess the impact it has had on her physically, psychologically and sexually.

  Examples of questions related to FGM: Do you know if you have suffered any cut or injury in the genital area? Are you aware of any cultural practice, ritual or procedure that you have received in the genital area? Some women/girls in your community or country have experienced cuts in the genital area. Can you tell me if this is your case? How does the experience of having suffered genital cuts/incisions currently affect you? Have you experienced any physical or mental problems stemming from this practice? Has it affected your relationship with your partner? How? Has your body image been affected? Do you think we can help you in any way?

6.5.2.2. Physical examination:

If you have a medical report that sufficiently describes the injuries presented and allows you to answer the questions required by the courts, it will not be necessary to proceed with a new physical examination in order to avoid secondary victimisation.

If this is not the case, it will be necessary to proceed with the exploration of the victim. It is advisable to start with a general examination that makes it easier to establish a bond of trust with the victim, especially in minors and teenagers, and that, at the same time, allows to evaluate signs of abuse and other diseases. Afterwards, the anogenital region will need to be explored. It is advisable to

cover the person’s body and expose only the area that needs to be explored at any time, avoiding that the girl or woman is completely naked.

The scan will be carried out in the following order:

- *Complete examination of the extragenital body surface,* with special interest in the areas of resistance - defence or subjection (wrist, forearms, ankles). Describe location, shape, size (using a metric token) and evolution of erythemas, erosions, excoriations, lacerations, haematoma, burns or scars.
- *Paragenital examination.* The lower part of the abdominal wall, inner thighs and gluteus are inspected.
- *Genitoanal examination.* In paediatric or prepubescent victims, the examination of this region can be performed by placing the minor in the “*frog position*”. In the rest of the cases, the recognition will be done with the victim in the gynaecological position. The existence of any type of injury, ecchymosis, tearing, abrasion, erythema, inflammation, infection, extirpation, excision or infibulation is described. It is necessary to detail the location and type of lesions, size, period of evolution and mechanism of production. However, it is also important to report in the opposite direction, if no type of injury is objectified.

If you wish to graphically illustrate the findings, diagrams or photographs can be used, but it must be borne in mind that they will in no case replace the written description of the injuries objectified by the professional. The photographs that have been taken, especially those affecting particularly intimate areas, will not be included in the forensic report. They will be left as a document attached to the institution’s computer application, stating in the report that they have been collected, that they are kept at the IMLCFC, and that they can be provided to the judicial authority at the time that it considers necessary (CMF, 2021).

Below are some illustrations by way of example (WHO, 2018):

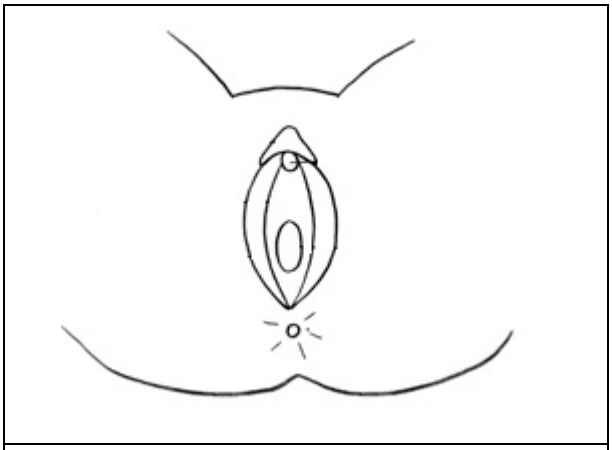


Illustration 1. Basic chart outline (blank)

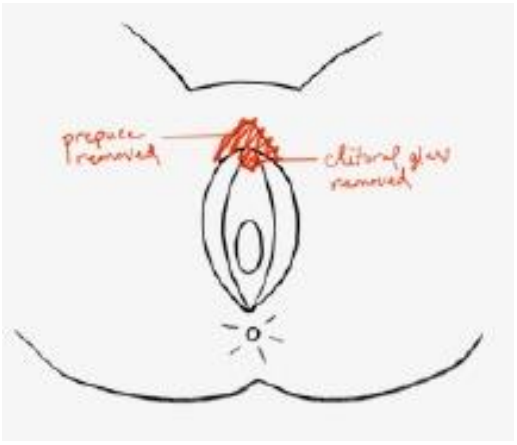


Illustration 2. Representation of type I FGM: removal of the clitoris and its prepuce

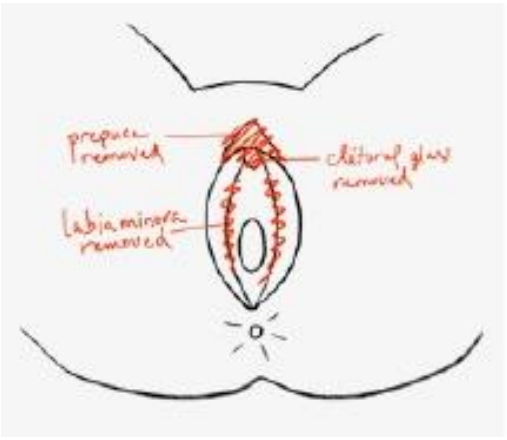


Illustration 3. Representation of type II FGM: removal of the clitoris, prepuce and labia minora

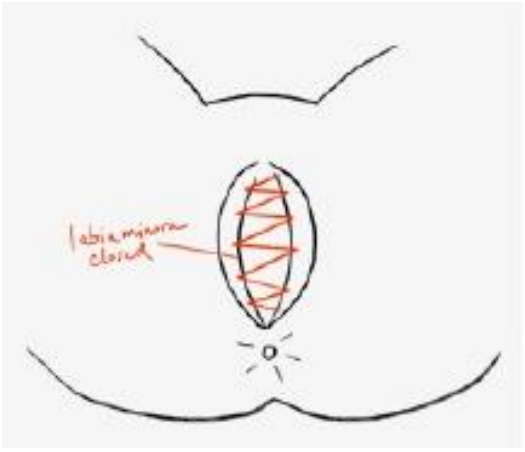


Illustration 4. Representation of type IIIa FGM. Suture of the labia minora.

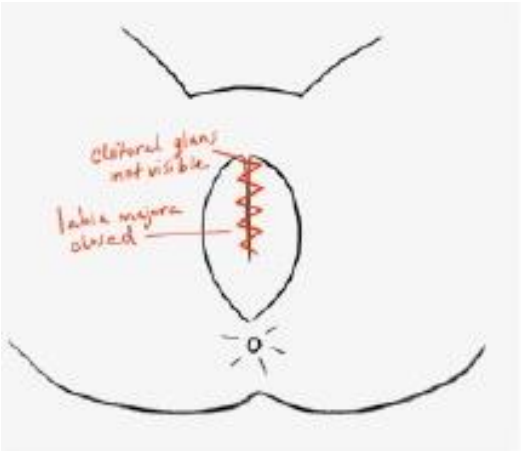


Illustration 5. Representation of type IIIb FGM. Suture of the labia majora.

Source: Illustrations 1 to 5 objectives of the publication *Care of girls and women living with female genital mutilation: a clinical handbook.* World Health Organisation, 2018. Licence: CC BY-NC-SA 3.0 IGO.

6.5.2.3. Psychopathological examination:

The purpose is to determine if psychopathological symptoms or factors that involve risk or vulnerability (present or future) are present and to what extent these derive from the experienced situation of mutilation. It should be borne in mind that in the case of minors, the dependence of the parents obliges us to collect information through them, who may be involved subjects.

The information collected in the course of the exploration must include: physical appearance and maturational development, contact, the way to bond with parents, relatives and/or people around them, awareness and orientation, self-regulation, affect, mood, emotions and feelings (fear, anger, shame, frustration in relation to female identity), thought (form and content), sense perception, language and communication, attention, cognitive level, motor behaviour (level of activity, coordination, minor neurological signs, presence of tics or stereotypes), family and school social adaptation, assessment of sphincter control, feeding and sleep (insomnia, difficulty falling asleep, nightmares). An assessment of personality/character traits can be carried out based on the verbal interview, the game or the drawing (for minors) and if it is considered appropriate, complementary psychometric tests can be carried out.

In sections 4 and 5 of this document you can find detailed information on the assessment of the impact of trauma on children, adolescents and adults.

6.5.2.4. Medical documentation / Review of the documentation:

It is necessary to review the available medical reports and/or additional reports from the school, organisations or specialised entities that have attended to the victim prior to recognition, in order to obtain more information about the case and/or better assess some sections of the recognition such as the sequels.

6.6. Elaboration of the forensic report on the assessment of bodily harm in cases of FGM.

The forensic report in cases of FGM must include, first of all, a brief description of the facts that motivated the investigation and the purpose of the report.

Below we will describe the methodology we followed to draw up the report: documentation to which we had access (care or other professionals) and the recognition of the victim.

If reconnaissance is carried out, the place, date and time, professionals participating in the exploration and person/s accompanying them must be recorded. We will leave a written record of obtaining consent from the victim or legal representatives to carry out the exploration and the photographic report (if we think it necessary).

If a report is made without recognition, in order for the injuries to be sufficiently accredited, it must be stated unequivocally.

In the medico-forensic recognition section, it is necessary to collect the data resulting from the anamnesis, general physical and gynaecological examination in particular and the psychopathological state of the minor/woman.

With respect to physical bodily injuries, it will be necessary to describe their location, size (using a metric token), evolution and mechanism of production.

Finally, the conclusions section will inform about the existence or not of findings compatible with FGM, sequelae present at the time of recognition and foreseeable future sequelae, the possibility of medical or surgical treatment with a restorative or reparative purpose (therapeutic treatment, social and sexual and reproductive health) and the existence or not of moral damage due to loss of quality of life resulting from the sequelae.

The existence of findings compatible with FGM will be reported according to the WHO classification. In practice, it can be difficult to determine the type of FGM since the anatomical alteration of the female genital morphology will depend on the skill of the person who has practised the technique, their anatomical

knowledge, the type of instrument used and the state of sedation (or not) of the victim at the time of carrying out the intervention. In these cases it is recommended to make a description, as accurate as possible, of the injured anatomical structures and record them using a graphic and/or photographic scheme.

In relation to the sequelae present at the time of the medico-forensic recognition or foreseeable in the future (immediate or distant), it will be necessary to describe them, referring to the anatomical, functional, aesthetic and psycho-emotional alteration it entails for the victim. Given that we do not have a specific scale to qualify sequelae derived from this type of crime, they can be assessed by analogy with the consequences included in Law 35/2015, of 22 September, on the reform of the system for the valuation of damages caused to persons in traffic accidents. For example:

Anatomical and/or functional alterations:

- Clitoridectomy with or without anorgasmia, partial or total removal of labia minora and/or labia majora... by analogy --> *Destructuring of the penis (including erectile dysfunction) 30 - 40 points.*
- Anatomical and/or functional changes related to the female system, including chronic pain... by analogy --> *Vulvar or vaginal injuries that make intercourse impossible (according to functional impact) 20 - 40 points.*
- Reflex urinary retention due to pain and/or recurrent genitourinary infections... by analogy --> *Chronic cystitis 2 - 8 points; Chronic retention of urine: forced probes 10 - 20 points.*

Psychoemotional changes: It is important to make a detailed description of all the emotional symptoms presented by the victim and establish the sequel by analogy with:

- Neurotic disorder. Sequel derived from post-traumatic stress (mild, moderate, severe) 1 - 15 points.
- Other neurotic disorders 1 - 5 points.

- Permanent mood disorders. Chronic major depressive disorder (mild, moderate, severe) 4 - 25 points
- Dysthymic disorder 1 - 3 points.
- Aggravation or destabilisation of other mental disorders 1 - 10 points.

Aesthetic damage: This is understood as any deformity or alteration of the body image that we can perceive through the senses. The large subjective component will make quantification difficult (slight, moderate, medium, important, very important, very important). It can help us to take into account the fundamental characteristics of aesthetic damage to award a score: physical irregularity or external bodily alteration; permanent; visible; that there is morphological disfigurement of a derogatory nature; that causes suffering to the victim felt as a moral injury.

Non-pecuniary damage due to loss of quality of life: The loss of quality of life refers to the limitations or impossibilities due to essential activities and/or personal development activities derived from all the sequelae. These activities are included in articles 51 and 54 of Law 35/2015. Enjoyment or pleasure, relationship life and sexual activity, among others, are considered personal development activities. In the case of appreciating the existence of this damage, it will be necessary to determine its significance and grade it (very serious, serious, moderate, mild) following the recommendations contained in the law for its qualification.

7. Other forms of sexual violence

Apart from the violence described, there are other forms of which it is useful to know the underlying mechanisms and dynamics in order to understand how they operate and what are the elements that we must bear in mind when evaluating the impact that can be derived from it.

7.1. Sexual violence within couples

Often there are forms of violence that take place within the framework of the couple, which are not identified as such and are not exposed to the complaints or emerge during investigations, among which are sexual violence. It is influenced, for example, by cultural factors linked to the conception of sexual relations as conjugal duties implicit in the marriage contract; it is also influenced by the fact that, usually, neither violence nor intimidation is used to impose unwanted sexual interactions, but rather a wide range of coercion mechanisms such as victimisation of the person responsible, emotional blackmail, the threat of restriction of rights or economic conditioning among others.

In the field of gender violence, coercive behaviour becomes a behaviour that is clearly representative of this violence, which has its genesis in the unequal power relationship that is exercised or attempted to be exercised by men over the woman.

Coercive control in gender violence has been widely described by the American psychologist *Leonore E. Walker* as a way of maintaining dominance over the partner, this coercive control being a determining element when assessing the psychological sequelae of this type of violence and which she herself described in *battered woman syndrome*. The variability of these behaviours is extensive: they can be shown explicitly, as in the case of threats and extortion, but also in the form of pressure tactics, persistent insistence, psychological intimidation, manipulation and control, which could be misinterpreted like behaviours of proximity and love associated with the patterns of patriarchal structures and/or romantic love. (Waldner *et al.*, 1999).

In 2022, a research project, funded by the CEJFE and developed by a team of forensic doctors and a psychologist from the IMLCFC, was carried out to explore sexual coercion in a sample of women victims of gender-based violence, describing three basic strategies to obtain unwanted sexual relations within the couple, based on the studies of *Goetz* and *Shackelford* (2004, 2006):

- Commitment manipulation: Whoever exercises coercion-sexual coercion argues that, if there is affection, and if there really is a commitment, the other must have sexual relations based on the partner's desire.
- Threat of disaffection: It is a form of emotional blackmail in which the other is threatened with taking his affection if he does not have sexual relations.
- Resource manipulation: The refusal to have sexual relations has consequences in economic resources, such as cutting back or threatening not to fulfil commitments of another order.

Therefore, the result of coercion-sexual coercion on the victim can be their unwanted participation in any type of sexual behaviour within the framework of the couple relationship. We can find that sexual violence is modulated by the interpersonal relationship or that it becomes a specific action in the context of a deteriorated relationship. Sometimes this aggression can be a warning sign of a greater risk of violence.

Sexual violence within the couple, due to the fact that they occur within an intimate relationship, they present special characteristics in terms of form, impact and consequences (Goetz, Shackelford, 2006). As a consequence of this form of violence, psychological responses of great intensity may appear, inadequate, in appearance, with the event, to which the concept of specific psychological injury as a reaction to a specific event is blurred.

Precisely to subvert this reality, Organic Law 10/2022 considers sexual violence committed by the partner or ex-partner as an aggravated modality.

The minimisation, ambivalence and loss of reference of the victims is a common denominator in this type of violent stories. When the forms of violence used are

presented in the form of coercion, insinuations or subtle behaviours, their identification and possible assessment is even more imprecise, being in many cases difficult to identify. As an example, it has been observed that women who have suffered sexual violence in the context of their partner are less likely to consider this experience as a violent action and consequently, underestimate the partner's responsibility in these events; in these circumstances they are more likely to maintain the relationship with the aggressor despite the violence (Jaffe *et al.*, 2021).

Therefore, within the framework of the comprehensive forensic evaluations, it will be necessary to explore the sexual violence committed by the couple. Given the circumstances underlying this form of violence, especially with regard to the difficulties in identifying some of these behaviours as violent, it may be difficult for victims to express themselves spontaneously on the subject, so it will be necessary to probe or ask actively Precisely the research project previously referenced in this same section provides a proposed scale, as a resource to complement the anamnesis and improve the obtaining of information related to the existence of sexual coercion (Annexe III).

7.2. Group sexual violence.

These violent acts can be understood as actions in which the group engages in disruptive behaviour to experience power, to test the adherence and loyalty of its members or even as a way to validate, through a collective ritual, its identity or way of understanding masculinity. When the group commits sexual violence, there has been a process prior to which the group has converged on the dehumanisation of the victims and on the legitimacy of exercising power over them and dynamics have been established in which the members of the group they have already lost their individuality and have been seized by the logic of punishment (rejection and belonging) reward. The strength of these social mechanisms means that those who may not share or even be against the violence committed by members of the group, do not dare to express their opinion in order not to disappoint the expectations of the group, not to break the fraternal bond and do not contradict the group's codes of conduct, and act as

spectators of the same. Organic Law 10/2022 considers group sexual assault as an aggravated form of crime.

7.3 Digital sexual violence.

Digital sexual violence is becoming more and more common. They may consist of insults or discriminatory expressions of a sexual nature, threats and/or blackmail related to sexual activity (sextortion), or non-consensual disclosure of intimate content (DIF, 2022). Depending on the stage of life, there are a number of prevalent patterns, depending on whether children, young people or adults are affected. Analogue and digital sexual violence come from the same discriminatory root, but they are distinguished by the area in which they occur or by the tools through which they are committed, and by some of the impacts they cause. It should be noted that many digital sexual assaults do not require sophisticated technological knowledge. Violence in the digital environment can consist of a single action or the repetition of actions, which generate a cumulative effect and can have a single person responsible or consist of a collective or adhesive attack. The anonymisation (concealment of elements that could allow the identification of the user) of the profiles, the viralisation and permanence of the content are factors directly linked to the impacts they provoke. Its harmful potential is also increased, given that a single person responsible can be assaulting multiple women at the same time and without geographical limitations. As with sexual violence in general, the latent threat of confronting sexual violence in itself has a deterrent or inhibiting effect on free decision-making that may pose difficulties or constraints to disclosure or reporting.

Social ignorance about these types of violence often causes both the women affected, their environment and society in general to blame the victims for having exposed themselves unnecessarily in the virtual space. These violent acts are not always identified as such, or they are usually trivialised because they operate in a space that is still understood as less real or transcendent. Despite this widespread perception, digital violence causes numerous effects in “real” life due to the social consequences they entail. In the case of sexual violence, a stigma and a social devaluation of the victims is usually generated

which can severely affect their life project and their identity. The lack of support or even the social judgement of the victims are some of the elements that explain the severity of the impact caused by these acts of violence, but also the impotence of not being able to identify the person responsible or not knowing what to do to stop that situation, and to see themselves thrown into the feeling of losing control of their lives. There can also be a generalised feeling of helplessness because they feel that that violence irreversibly conditions their identity, that the authorities will not be able to protect them and that social judgement will be harsh on them, instead of recognising the damage they have suffered.

For more extensive information on the support and assessment of digital violence, against women we recommend reading the *Guia sobre l'impacte de les violències masclistes digitals* (Guide on the impact of digital violence against women) by the Government of Catalonia, Ministry of Equality and Feminism, 2024.

7.4 Sexual violence facilitated by chemical substances.

Sexual violence can be committed by taking advantage of a situation of chemical vulnerability of the victim or by provoking intoxication by supplying the victim with these substances (violence known by the acronym DFSA - drug facilitated sexual assault). Both behaviours are punished in the current version of the Criminal Code, but in the case of the administration of substances to the victim to achieve the imposition of sexual interaction, LOGILS considers it as an aggravated type of crime.

This type of behaviour is often under reported due to the total or partial absence of memory of what happened and also due to the victim's culpability, either by herself or by those around her, for having put herself at risk and not having articulated self-protection mechanisms.

Vulnerability can also occur in situations where the intoxication has not led to a state of unconsciousness, but has produced a lesser degree of impairment, with a reduced capacity for active reaction. In fact, Circular 1/2023 of the FGE on the criteria for the action of the Public Prosecutor after the reform of crimes against

sexual freedom operated by the LOGILS, refers to a sentence of the Supreme Court which points out that *"for there to be sexual abuse, a total absence of consciousness is not required, but the loss or inhibition of intellectual and volitional faculties, to a degree of intensity sufficient to ignore or devalue the relevance of their determinations (...) and requires consideration, also, of those cases in which the loss of consciousness is not total but strongly affects the ability to react actively (...)*". In this way, the presence of substances (following Circular 1/2023 of the FGE, in its point 8.7: *medicine, drugs, or any other natural or chemical substance*) to samples obtained from the victim could be interpreted as a factor causing the loss or inhibition of their faculties regardless of the intentionality of the poisoning and the type of toxic substance in question.

In the context of sexual violence facilitated by chemical substances, there can be the circumstance that there are victims who will never know the type of sexual interaction that has been imposed on them, or they can know it some time later with the results of the analyses of the samples obtained in the medico-forensic examination.

The absence of memory can not only affect the quality of the story about the events, but it can also hinder the personal process of integrating the experience and emotional recovery. These difficulties can damage their self-perception and self-esteem, and negatively influence their recovery process.

For more information, see section 3.5.4, related to toxicology analysis.

8. Bibliography

Acosta Rodríguez, V., Coello Marrero, A. R., Fariña Hernández, N. M., Lorenzo Pérez, M., Mesa Suárez, J. L., Moreno Santana, A. M., Novoa Viñuela, T., Pérez Caramés, A. M., Oropesa Caballero, F., Quevedo Rodríguez, I. (2007). Guía de actuaciones educativas en el ámbito de la comunicación y el lenguaje. Ministry of Education, Universities, Culture and Sports. Government of the Canary Islands.

Adams, JA., Kellogg, ND., Farst, KJ., Harper, NS., Palusci, VJ., Frasier, LD., Levitt, CJ., Shapiro, RA., Moles, RL., Starling, SP. (2016). Updated guidelines for the medical assessment and Care of Children who may Have Been Sexually Abused. *Journal of Pediatric and Adolescent Gynecology, 29*(2), 81–87. https://doi.org/10.1016/j.jpag.2015.01.007

Adams JA., (2018). Understanding Medical Findings in Child Sexual Abuse: An Update For 2018. *Acad Forensic Pathol., 8*(4), 924-937. DOI: 10.1177/1925362118821491

American Psychiatric Association (2013). Manual Diagnóstico y Estadístico de los Trastornos Mentales (DSM-5), 5ª ed. Médica Panamericana, pag 265-290.

Bracha, HS. (2004). Freeze, flight, fight, fright, faint: Adaptationist perspectives on the acute stress response spectrum. *CNS spectrums*, *9*(9), 679-685

Bravo Correa, M., Guil Román, C., Martín González, F., Rodríguez Sáez, J. A., Riva Aníes, V., Tabarés Cabezón, M. A. (2023). Puc fer-ho, m'ajudes a explicar-me? Bon tracte en l'exploració judicial a nens, nenes i adolescents víctimes de violència sexual. Ministry of Justice, Rights and Memory. https://cejfe.gencat.cat/ca/publicacions/destacats-recerca/recomanacions-victimitzacio-delictes-sexuals/index.html

Bryant, RA. (2019). Post-traumatic stress disorder: a state-of-the-art review of evidence and challenges. *World psychiatry*, *18*(3), 259-269

Cantón-Cortés, D., Rosario Cortés, M. (2015). Consecuencias del abuso sexual infantil: una revisión de las variables intervinientes. Anales de psicología, 31(2), 552-561. https://doi.org/10.6018/analesps.31.2.180771

Catanneo C, Gibelli D, Ruspa M (2022) Sexual Abuse. En: Madea B. (Ed), *Handbook of Forensic Medicine vol. 2*, (pp. 919-937). Wiley

Centre of Legal Studies and Specialised Training (2019). *Drugs of abuse in forensic toxicology: recommendations and interpretation for medical-legal purposes*

Circular 1/2023 of the Attorney General's Office on the criteria for the action of the Public Prosecutor after the reform of crimes against sexual freedom operated by the Organic Law 10/2022, of 6 September

Crespo, M., & Gómez, M. (2012). Posttraumatic Stress Assessment: Introducing the Global Assessment of Posttraumatic Stress Questionnaire (EGEP). *Clínica y Salud*, *23*(1), 25-41.

Dhawan, E., & Haggard, P. (2023). Neuroscience evidence counters a rape myth. *Nature human behaviour, 7*, 835–838

Echeburúa, E., & Corral, P. de. (2006). Secuelas emocionales en víctimas de abuso sexual en la infancia. *Cuadernos de Medicina Forense*, (43-44), 75-82.

Echeburúa, E., & Guerricaechevarría, C. (2011). Tratamiento psicológico de las víctimas de abuso sexual infantil intrafamiliar: un enfoque integrador. *Psicología conductual*, *19*(2), 469.

Ellison, L., & Munro, V. E. (2017). Taking trauma seriously: Critical reflections on the criminal justice process. The International Journal of Evidence & Proof, 21(3), 183-208.

Faculty of Forensic Legal Medicine (2021). *Recommendations for the collection of forensic specimens from complainants and suspects*

Faircom & Re-Treat Project (2022) - compensation victims of sexual violence.https://sexualviolencejustice.eu/?lang=es

Ferreira-Silva, B., Porto, MJ., Magalhaes, T., Cainé, L. (2019) Contribution to the development of guidelines in the analysis of biological evidence in sexual assault investigations. *Journal of Forensic Sciences, 64*(2), 534-538

Forde, C., & Duvvury, N. (2017). Sexual violence, masculinity, and the journey of recovery. *Psychology of Men & Masculinity*, *18*(4), 301

Forensic Medical Council (2018). Performance in the care of child victims at the Institutes of Legal Medicine and Forensic Sciences. Ministry of Justice.

Forensic Medical Council. (2021). Protocolo de actuación médico-forense ante la violencia sexual en los Institutos de Medicina Legal y Ciencias Forenses

Forensic Medical Council (2024). Guía de recomendaciones de actuación de los Institutos de Medicina Legal y Ciencias Forenses con las muestras biológicas y evidencias que se recojan y remitan por los centros sanitarios en el contexto de la Ley Orgánica 10/2022, de 6 de septiembre, de Garantía Integral de la Libertad Sexual

Forr, C., Schei B., Stene, LE., Ormstad, K. (2018). Factors associated with trace evidence analyses and DNA findings among police reported cases of rape. *Forensic Science International, 283*, 136-143

Gallego MA., López MI. (2010). Female genital mutilation: Review and aspects of medical-legal interest. Cuad. med. Forense, 16(3), 145-151

Garcia-Esteve, L., Torres-Gimenez, A., Canto, M., Roca-Lecumberri, A., Roda, E., Velasco, ER., Echevarría, T., Andero, R., Subirà, S. (2021). Prevalence and risk factors for acute stress disorder in female victims of sexual assault. *Psychiatry Research*, *306*, 114240

García García, C., Bertomeu Ruiz, A., Corrons Perramon, J., Matas Heredia, G., Mateu Vidal, A., Vilella Sanchez, M. (2024). Coerció sexual en la violència de gènere. Utilitat de la sexual coercion in inmates relationship scale (SCIRS) en les valoracions medicoforenses. Centre for Legal Studies and Specialised Training, Government of Catalonia.

García Madruga, J. A. & Delval, J. (Eds.) (2019). Psicología del Desarrollo I. 2nd Edition. Madrid: UNED. ISBN: 978-84-362-7554-4

Godoy, LD., Rossignoli, MT., Delfino-Pereira, P., Garcia-Cairasco, N., de Lima Umeoka, EH. (2018). A comprehensive overview on stress neurobiology: basic concepts and clinical implications. *Frontiers in behavioral neuroscience*, *12*, 127

Goetz, A-T., Shackelford, T-K. (2006). Sexual Coertion in Intimate Reationship: A Comparative Analysis of the Effects of Women's Infidelity and Men's Dominance and Control. Arch Sex Behav (38). 226-234

http:/dx.doi.org/10.1007/s10508-008-9353-x

González J. (2018). La toma de muestras biológicas. Los plazos. In: González, J. (Ed) *Manual de atención y valoración pericial en violencia sexual. Guía de buenas prácticas*, (pp. 267-282). Bosch Editor

Haskell, L., & Randall, M. (2019). The impact of trauma on adult sexual assault victims. Justice Canada.

Herrmann, B., Banaschak, S., Csorba, R., Navratil, F., Dettmeyer, R. (2014). Physical examination in child sexual abuse— approaches and current evidence. Dtsch Arztebl Int, 111, 692–703. DOI: 10.3238/arztebl.2014.0692

International Rehabilitation Council for Torture Victims. (2007). *Medical physical examination of alleged torture victims. A practical guide to the Istanbul Protocol – for medical doctors. International Rehabilitation Council for Torture Victims*

International Rehabilitation Council for Torture Victims. (2009). *Psychological evaluation of torture allegations. A practical guide to the Istanbul Protocol – for psychologists.*

Jaffe, A. E., Steel, A. L., DiLillo, D., Messman-Moore, TL., Gratz, K L. (2021). Characterizing sexual violence in intimate relationships: an examination of blame attributions and rape acknowledgment. *Journal of interpersonal violence*, *36*(1-2), 469-490

Jiménez MT., Aragó, J., Hurtado, F., Loño, J. (2013). Abuso sexual infantil: desafío multidisciplinar. Un abordaje integral del problema para mejorar su detección y la atención a la víctima. *Acta Pediatr Esp., 71*(10), 302-314

Juarez López, J. R., Sala Berga, E. (2011). Entrevistant infants pre-escolars víctimes d'abús sexual i/o maltractament familiar. Eficàcia dels models d'entrevista forense [working paper]. Centre for Legal Studies and Specialised Training. https://hdl.handle.net/20.500.14226/122

Kaplan, A. Interdisciplinary Group for the Prevention and Study of Harmful Traditional Practices (GIPE/PTP). Autonomous University of Barcelona (2017) *Female Genital Mutilation. A Handbook for Practitioners*

Kellogg, ND., Farst, KJ., Adams, JA. (2023). Interpretation of medical findings in suspected child sexual abuse: An update for 2023**.** *Child Abuse Negl., 145*, 106283. DOI: 10.1016/j.chiabu.2023.106283

Kessler, RC., Rose, S., Koenen, KC., Karam, EG., Stang, PE., Stein, DJ., Heeringa, SG:, Hill, ED., Liberzon, I., McLaughlin, KA., McLean, SA., Pennell, BE., Petukhova, M., Rosellini, AJ., Ruscio, AM., Shahly, V., Shalev, AY., Silove, D., Zaslavsky, AM., Angermeyer, MC., Bromet, EJ., Caldas, JM., de Girolamo, G., de Jonge, P., Demyttenaere, K., Florescu, SE:, Gureje, O., Haro, JM., Hinkov, H., Kawakami, N., Kovess-Masfety, V., Lee, S., Medina-Mora, ME., Murphy, SD., Navarro-Mateu, F., Piazza, M., Posada-Villa, J., Scott, K., Torres, Y., Viana, MC.(2014). How well can post-traumatic stress disorder be predicted from pre-trauma risk factors? An exploratory study in the WHO World Mental Health Surveys. *World Psychiatry, 13*(3), 265-274

Koenen, K. C., Ratanatharathorn, A., Ng, L., McLaughlin, K. A., Bromet, E. J., Stein, D. J., ... & Kessler, R. (2017). El trastorn per estrès posttraumàtic en les enquestes mundials de salut mental. *Medicina psicològica*, *47* (13), 2260-2274.

Kvitko, LA (2012). Agresión sexual. Morfología del himen y signos de desfloración. Diagnóstico de la penetración o introducción de objetos anal y vaginal. Peritación médico-legal. In: Delgado Bueno S (Ed).

Tratado de Medicina Legal y Ciencias Forenses, Tomo IV, (pp. 301-331). Editorial Bosch

Lamb, M. E., La Rooy, D. J., Malloy, L. C., & Katz, C. (Eds.). (2011). Children's testimony: A handbook of psychological research and forensic practice. John Wiley & Sons.

Lamb, Michael & Brown, Deirdre & Hershkowitz, Irit & Orbach, Yael & Esplin, Phillip. (2018). Tell Me What Happened: Questioning Children About Abuse. 10.1002/9781118881248.

Law 41/2002, of 14 November, regulating patient autonomy and rights and obligations related to information and clinical documentation. (2002)

Law 35/2015, of 22 September, on the reform of the system for the valuation of damages caused to persons in traffic accidents. (2015)

Liautard, M.; Deguette, C.; Alcaraz, E.; Diot, H.; Vasseur, P.; Gorgiard, C.; Dufayet, L. (2022). Male Victims of Rape: An Observational Study over Four Years in Paris, France. *Int. J. Environ. Res. Public Health*, *19*, 13909

Lowe, SM., Rahman, N., Forster, G. (2009). Chain of evidence in sexual assault cases. *International Journal of STD & AIDS, 20*, 799-800

Maercker, A., Cloitre, M., Bachem, R., Schlumpf, YR., Khoury, B., Hitchcock, C., Bohus, M. (2022). Complex post-traumatic stress disorder. *The lancet*, *400*(10345), 60-72

McEwen, BS. (2017) Neurobiological and systemic effects of chronic stress. *Chronic stress*, *1*, 1-11

McEwen, BS., Akil, H. (2020). Revisiting the stress concept: implications for affective disorders. *Journal of Neuroscience*, *40*(1), 12-21

Ministry of Equality. Wassu-UAB Foundation. (2020). *La mutilación genital femenina en España*

Ministry of Equality and Feminism, Government of Catalonia. (2022). *Model d'abordatge de les violències sexuals. Un model de país*

Ministry of Health. Government of Catalonia. (2010). *Protocol per a l'abordatge de la violència masclista en l'àmbit de la salut a Catalunya. Document operatiu de violència sexual*

Ministry of Health. Government of Catalonia. (2011). *Protocol per a l'abordatge de la violència masclista en l'àmbit de la salut a Catalunya – Dossier 3. Document operatiu de mutilació genital femenina*

Ministry of Justice. (2018). *Actuación en la atención a menores víctimas en los Institutos de Medicina Legal y Ciencias Forenses*

Ministry of Justice. (2022). *Guía de buenas prácticas para la actuación forense ante la víctima de un delito facilitado por sustancias psicoactivas: intervención ante la sospecha de sumisión química*

National Institute of Justice. US Department of Justice. (2017). *National Best Practices for sexual assault kits: a multidisciplinary approach*

Naumann, DN., Morris, L., Bowley, DM., Appleyard, TL., Cumming, J., Wardlee, D. (2023). Anogenital injury following sexual assault and consensual sexual intercourse: a systematic review and meta-analysis. *EclinicalMedicine, 5*(65), 102266. DOI: 10.1016/j.eclinm.2023.102266

Navarro, P. (2001). Valoración de la región anal en el delito sexual en la medicina forense clínica. *Med. leg. Costa Rica, 18*(2), 68-77

Newton, M. (2013) The forensic aspects of sexual violence. *Best Practice & Reserch Clinical Obstetrics and Gynaecology, 27*, 77-90

Office of the High Commissioner. (2022). *Istanbul protocol professional training series No. 8/Rev. 2 Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*

Oram, S., Khalifeh, H., Howard, LM. (2017). Violence against women and mental health. *The Lancet Psychiatry, 4*(2), 159-170

Organic Law 10/2022, of 6 September, on the comprehensive guarantee of sexual freedom.(2022)

Pereda, N. (2023). Sexual victimization in early childhood: A narrative review of clinical aspects. Papeles del Psicólogo, 44(1), 15-21. https://doi.org/10.23923/pap.psicol.3006

Ressler, KJ., Berretta, S., Bolshakov, VY., Rosso, IM., Meloni, EG., Rauch, SL., Carlezon Jr, WA. (2022). Post-traumatic stress disorder: clinical and translational neuroscience from cells to circuits. *Nature Reviews Neurology, 18*(5), 273-288

Roozendaal, B., McEwen, BS., Chattarji, S. (2009). Stress, memory and the amygdala. *Nature Reviews Neuroscience, 10*(6), 423-433

Sarasua, B., Zubizarreta, I., de Corral, P., Echeburúa, E. (2012). Risk and Protective Factors in the Emotional Impact of Adult Female Victims of Sexual Aggression. *Terapia psicológica, 30*(3), 7-18

Schwabe, L. (2017). Memory under stress: from single systems to network changes. *European Journal of Neuroscience, 45*(4), 478-489

Shackelford, T-K., Goetz, A-T. (2004). Men's Sexual Coercion in Intimate Relationships: Development and Initial Validation of the Sexual Coercion in Intimate Relationships Scale. *Violence and Victims. (19)* 541-556

Sherin, JE., Nemeroff, CB. (2011). Post-traumatic stress disorder: the neurobiological impact of psychological trauma. *Dialogues in Clinical Neuroscience, 13*, 263-278. DOI: 10.31887/DCNS.2011.13.2/jsherin

Soberón, C., Crespo, M., Gómez-Gutiérrez, M., & Fernández-Lansac, V. (2016). Dimensions of DSM-5 posttraumatic stress disorder (PTSD) symptoms. *European Psychiatry*, *33*(S1), S514-S514.

Spanish General Council of Official Colleges of Physicians (2011). *Código de Deontología Médica*

Suttipasit, P. (2019). Forensic Spermatozoa Detection. *Am J Forensic Med Pathol, 40*(4), 304-310

Taroli, A. (2009). Medical Examination of Sexually abused children. En: Hazelwood, RR., Burguess, AW. (Ed.). *Practical aspects of rape investigation*, (pp. 311-312). CRC Press

Tarragona City Council. (2021). *Guia jurídica contra les violències sexuals, AADAS*

Toledo P., Pineda, M. Grup de Recerca Antígona & Creación Positiva. (2016). *L'abordatge de les violències sexuals a Catalunya. Marc Conceptual sobre les Violències Sexuals Violències sexuals: un marc conceptual, teòric i ètic*

Thomas, JC., Kopel, J. (2023). Male victims of sexual assault: a review of the literature. *Behavioral Sciences, 13*(4), 304

Vega C., Navarro E., Edo, JC. (2014). Protocol for sexual assault medical forensic examinations *Rev Esp Med Leg., 40*(3), 120-128

Vega C., Navarro E. (2021). Protocol for sexual assault medical forensic examinations: review and update. *Gac. Int. Cienc. Forense, 41*, 43-54

Waldner, L. K., Vaden-Goad, L., Sikka, A. (1999). Sexual coercions in India: An exploratory analysis using demographic variables. *Archives of Sexual Behavior*, *28,* 523-538.

Walker, L-E.(2018). Assessment of Battered Women. Nova Southeastern University.

Widanaralalage, BK., Hine, BA., Murphy, AD., Murji, K. (2022). "I didn't feel i was a victim": a phenomenological analysis of the experiences of male-on-male survivors of rape and sexual abuse. *Victims & Offenders, 17*(8), 1147-1172

World Health Organisation. (2003). *Guidelines for medico-legal care for victims of sexual violence*

World Health Organisation. (2013). *Understanding and addressing violence against women: female genital mutilation*

World Health Organisation. (2018). *Care of girls and women living with female genital mutilation: a clinical handbook*

World Health Organisation (WHO) (2020). ICD-11 for Mortality and Morbidity Statistics. https://icd.who.int/browse/2024-01/mms/en

Annexe I

GUIDE FOR DATA COLLECTION IN CASES OF SEXUAL ASSAULT

GENERAL INFORMATION

IDENTIFICATION

- Name
- Resident / tourist / student status.
- Gender: male, female, male/female transgender (specify, if necessary, transition status).
- Special circumstances

ANAMNESIS

- Relevant background information of organic pathology
- Surgical interventions
- Psychopathological background information
- Usual treatment

- Gynaecological background information
  - Menarche
  - LMP
  - Menstrual cycle
  - Gestations Births Abortions
  - Previous sexual relations
  - Last sexual relation
    Known person ☐yes ☐no Use of protection ☐yes ☐no
  - STI

Data in relation to the facts.

- Date and time of events
- Place of occurrence
- Number of people/offenders Are they known?
- Type of aggression
  - Penetration ☐yes ☐no
    ☐Vaginal ☐Anal ☐Oral
  - Use of Protective Methods
  - Ejaculation
  - Others
- Physical violence
- Threats

- Toxic consumption
    - Type of substance and doses
    - Intake period

- Characteristics of the memory of the sequence of events

- Presence of memory alterations. (Time in which memory is affected)

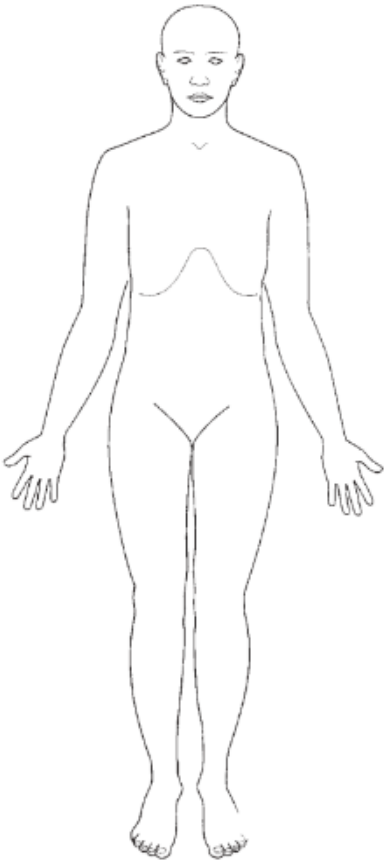
Subsequent conduct between the facts and the moment of taking the sample.

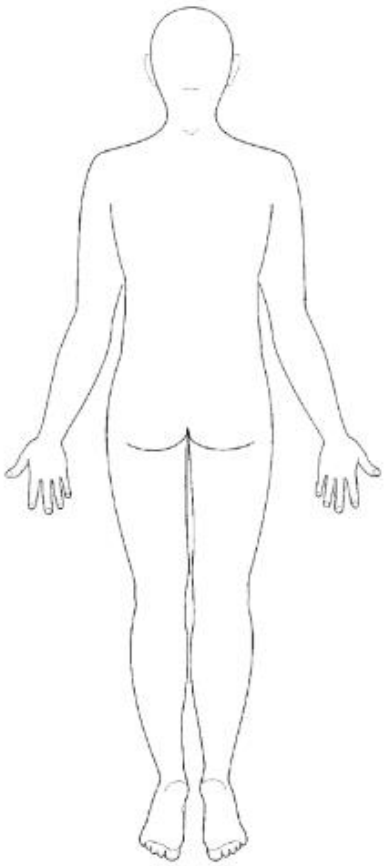
- Post-treatment administration
- Other subsequent consumptions
- Other subsequent sexual relations
- Change of clothes
- Post-event hygiene
- Possible urination, deposition, vomiting after the event.

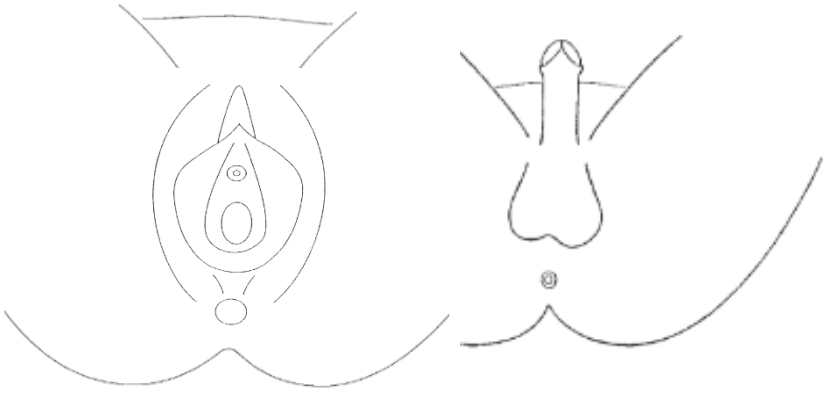
Psychopathological assessment

- Consciousness
- Orientation
- Attention
- Appearance: groomed or not
- Signs of intoxication
- Attitude: approach, collaboration
- Speech: spontaneity, fluency, structure, etc.
- Psychotic clinic
- Affective sphere: state of mind (*example: calm, contained, emotionally stable or blocked, with signs of psychophysical anxiety, etc.)* possible autolithic ideation.
- Critical judgement
- Others

Physical exploration







- Vulva
- Hymen
- Vagina
- Perineum
- Anus

Observations

COLLECTION OF SAMPLES

Toxicological analysis

☐ Blood ☐ Urine ☐ Hair

Biological analysis

☐ Introitus and vulva fluid ☐ Swab No.:

☐ Intravaginal fluids ☐ Wash No.: ☐ Swab no.:

☐ Liquids from the anal margins or the skin ☐ Swab No.:

☐ Rectal samples: ☐ Wash No.: ☐ Swab no.:

☐ Oral samples ☐ Wash No.: ☐ Swab no.:

☐ Body surface ☐ Swab no.:

☐ Nails ☐ Body hair ☐ Others

☐ Clothing ☐ Knickers ☐ Skirt/trousers ☐ Others:

Undoubted samples

☐ Undoubted sample ☐ Other undoubted sample

Annexe II

SAMPLING SUMMARY

Samples for biological analysis

Deadlines for taking biology samples

- Vaginal: up to 7-10 days later
- Anal: up to 72 hours
- Oral: up to 48 hours
- Body surface: up to 7 days later, if there has been no cleaning of the surface
- Prepubertal children (body surface): optimally before 72 hours

Recommended sequence for taking biological samples

1. Oral samples
2. Anorectal samples: the most external first
3. External genitalia samples: in order from outside to inside
4. Vaginal samples: the most external samples first
5. The rest of the samples (clothing, objects, etc.), at the time it is considered

Samples for toxicological analysis

Types of samples

- *Venous blood:* two 5 ml tubes, one of them with EDTA (purple cap), and the other with sodium fluoride and potassium oxalate (grey cap).
  They allow the determination of substances up to 48 hours after consumption.

- *Urine:* everything possible in a plastic container of up to 50 ml. They allow the determination of substances up to 5 days after consumption.

- *Hair:* if the exploration takes place more than 5 days later.

  Taking the sample must take 4-6 weeks.

Annexe III

Coercion scale proposal

10.5 Proposta d'escala de coerció, versió en català

Escala per a l'exploració medicoforense de la coerció sexual

Instruccions: La sexualitat es un aspecte important de les relacions entre les persones i a vegades és motiu de conflicte. A continuació li farem una sèrie de preguntes relacionades amb la seva experiència i conducta sexual viscuda al llarg de tota la relació de parella denunciada. Aquesta informació formarà part de la nostra valoració forense.

Està d'acord en contestar les següents qüestions que se li plantegen?

☐ Si ☐ No

Si ha marcat SI i per tant està d'acord, li demanem que contesti de la forma més sincera possible.

Si us plau, indiqui AMB QUINA FREQUENCIA durant la relació amb la parella denunciada han succeït les següents situacions. Marqui la opció que millor representi la seva resposta.

M) Mai A) A vegades F) Freqüentment S) Sempre

Nom i cognoms:

Data administració: Localitat:

Nº	ÍTEM	Mai	A vegades	Freqüentment	Sempre
1	La meva parella em va pressionar per tenir sexe amb ell en contra de la meva voluntat	M	A	F	S
2	La meva parella va tenir sexe amb mi quan jo estava inconscient o sota els efectes de l'alcohol o drogues	M	A	F	S
3	La meva parella em va amenaçar de quedar-se o no donar-me els recursos materials (diners, objectes, documents) dels quals depenia si no tenia sexe amb ell	M	A	F	S
4	La meva parella em va animar a beure alcohol o consumir drogues per tenir sexe amb mi, encara que sabia que jo no volia	M	A	F	S
5	La meva parella em va dir que tindria sexe amb una altra dona si no tenia sexe amb ell	M	A	F	S
6	La meva parella em va forçar físicament per fer sexe amb ell	M	A	F	S
7	La meva parella em va fotografiar o gravar sense el meu consentiment en actitud intima (roba interior, despullada, practicant sexe)	M	A	F	S
8	La meva parella es va quedar amb els recursos materials (diners, objectes, documents) si no tenia sexe amb ell	M	A	F	S
9	La meva parella em va amenaçar de forçar-me físicament a tenir sexe amb ell	M	A	F	S
10	La meva parella em va acusar de infidelitat o engany per a tenir sexe amb ell	M	A	F	S
11	La meva parella em va obligar a realitzar actes sexuals que no gaudia o no m'agradaven	M	A	F	S
12	La meva parella va insistir en que em quedés embarassada.	M	A	F	S
13	La meva parella em va amenaçar en utilitzar la violència contra mi si no tenia sexe amb ell	M	A	F	S
14	La meva parella va insinuar de divulgar aspectes de la nostra vida sexual (a familiars, coneguts, xarxes socials)	M	A	F	S
15	La meva parella em va obligar a tenir relacions sexuals sense preservatiu o altres mètodes anticonceptius	M	A	F	S
16	La meva parella em va amenaçar de fer mal a alguna persona o cosa estimada si no tenia sexe amb ell	M	A	F	S
17	La meva parella va insistir en que avortés	M	A	F	S
18	La meva parella em va acusar de ser incapaç de satisfer-lo sexualment	M	A	F	S
19	La meva parella em va dir que tenir sexe amb ell era una obligació o deure	M	A	F	S
20	La meva parella em va amenaçar de divulgar aspectes de la nostra vida sexual (familiars, coneguts, xarxes socials)	M	A	F	S
21	La meva parella va retirar el preservatiu durant la relació sexual sense el meu consentiment	M	A	F	S