In recent years, the problem of rape and sexual abuse of young persons has received increasing medical and societal attention. Nearly 50% of reported rape victims are adolescents.¹⁻³ Whereas the vast majority of offenses involve girls, the incidence of sexual assaults on young men also seems to be increasing.

Although community resources may vary considerably, most metropolitan areas now have special programs or facilities to assist the victims of sexual assault. Such assistance usually includes advice regarding the management of the acute crisis as well as guidelines for the collection of evidence and preparation for trial should legal action follow. Because so many of the victims are adolescents, they are being seen with increasing frequency in pediatric emergency rooms.

The adolescent who is forcibly assaulted may display a wide range of behaviors, such as hysterical crying, giggling, or agitation, and may have feelings of degradation, anger, rage, helplessness, and nervousness and rapid mood swings. The victim is often angry, confused, and filled with self-blame. Alternatively, the adolescent may appear calm and controlled, masking internal turmoil. In cases of forcible assault, long-term sequelae such as fears, nightmares and sleep disturbances, disturbed peer and sexual relationships, and psychosomatic complaints may develop. Some victims fear retaliation from their attacker and develop ritualistic behavior as a defense. Some believe their bodies to be permanently damaged and may even fear death as a consequence of the violent act they have experienced.

For the victim, the circumstances of the initial medical evaluation may be frightening and stressful. Police interrogation, repeated questioning by health professionals, and the physical examination itself all have the potential to add to the trauma of the sexual assault. When the victim of an assault is a child or an adolescent, it is frequently the pediatrician who must intervene at this time of crisis as health care provider, patient advocate, and trusted professional. In addition, the attending pediatrician in these cases may become a liaison between the police, the victim, and his or her family.

**EVALUATION**

Pediatricians should be equipped to look after the special needs of young victims of sexual assault. Sexual violence toward a teenager is abhorrent to the physician and can be emotionally devastating to the family. Most pediatricians have had little prior experience or training in managing such problems. Residency and continuing medical education programs should assist the pediatrician in developing the necessary skills and techniques for treating these patients in a sensitive and supportive manner. It is imperative that the pediatrician be able to perform the appropriate physical examination, collect the necessary specimens, and provide sensitive and reassuring assistance to victims and their families.

The initial contact should be supportive. Although it is important to obtain a clear account of the circumstances of an alleged rape, it is equally essential to minimize further psychologic trauma that might occur if the patient is immediately forced to relive a painful experience. Under such circumstances, detailed history taking may have to be deferred. At all times, the wel-
fear of the adolescent must be a primary consideration. The patient should not become further victimized through insensitive care and unnecessary trauma. The patient should always be told in understandable terms what to expect in the way of tests or procedures, and strong emotional support should be provided. "True" informed consent gives victims the opportunity to formally gain control of their lives after the terrible loss of control associated with the attack.

Established protocols and procedures are available in most emergency room settings and in rape crisis centers as an aid in the evaluation and care of the patient who has been raped. Such protocols provide guidance in the collection of evidence, the obtaining of microbiologic cultures, the prophylaxis of venereal disease, and the prevention of pregnancy. In institutions that have not yet developed such protocols, it is recommended that the pediatrician, in collaboration with other health professionals, establish appropriate procedures prior to a crisis situation. Moreover, most states have statutes mandating the reporting of assault to law enforcement officials.

COUNSELING

In addition to looking after the needs of the victim, the physician must be sensitive to the reactions of the parents. Some will become angry and blame the adolescent; others will be guilt-ridden. Parents and other family members may exhibit reactions ranging from helpless despair to extreme agitation. Often they require as much support and reassurance as the victim; a private interview with the parents will provide them with an opportunity for open expression of their feelings. With assistance and attention to their needs, most parents will be able to support their teenager at this time of crisis.

Following the resolution of the immediate crisis, most adolescents and their families will require counseling, often separately and individually, in an effort to minimize the long-term effects of the rape and to assist in an early return to a normal living pattern. These families may wish to obtain professional guidance from an established rape crisis center, but often they will feel more comfortable with their pediatrician rather than seeking direction from an unfamiliar resource. The pediatrician needs to remain alert for those instances in which the degree of disruption requires psychiatric consultation or referral.

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APPENDIX

Sample Sexual Assault Data Sheet

I. History
   A. Presentation in emergency room
      1. Date seen __________________________
      2. Time seen __ AM __ PM
      3. Mode of entry: police __ friend __
         family __ self-referral __ other __
   B. Date of assault __________________________
   C. Time of assault __ AM __ PM
   D. Circumstances of assault (including postas-
      sault activity, changes of clothing, bathing, douching. Record evidence of torn clothing,
      bruises, blood, and semen stains):
         __________________________
         __________________________
   E. Menarche __
   F. Last menstrual period _________________
   G. Method of birth control ___________________
   H. Current medications: yes __ no __
      Specify _________________

II. Physical examination
   A. General appearance (include the emotional
      state, behavior of patient. Document areas of
      obvious trauma by photograph or diagram):
         __________________________
   B. T _____ P _____ BP _____ Wt _____ Pubertal
      stage (Tanner)
   C. Evidence of trauma: __________________________
      __________________________
      __________________________
   D. Description of clothing: torn ___________
      blood-stained ___
      semen-stained ___
      normal ______
   E. Description of perineum: normal ______
      laceration ______
      ecchymosis ______
      bleeding ______
F. Pelvic examination:  

done not results  
vagina ________  cervix ________  uterus ________  adnexa ________  rectum ________  

III. Laboratory evaluation  

A. Wet preparation of vaginal fluid for motile sperm and Trichomonas vaginalis  
B. Vaginal washing for  
   1. Acid phosphatase  
   2. ABH agglutinogen  
C. Culture of vagina for Neisseria gonorrhoeae (GC)  
D. Culture of anus for GC  
E. Culture of oropharynx for GC  
F. Culture of urethra for GC  
G. Serologic test for syphilis  
H. Pregnancy test (pubertal females)  
I. Wood’s lamp for semen  
J. Hair combing of pubis  
K. Fingernail scrapings  
L. Serum sample frozen and saved for future testing  
M. Chlamydia (where available)  

IV. Therapy (if indicated)  

A. Antibiotic prophylaxis (in accordance with current Centers for Disease Control recommendations for areas of antimicrobial resistant gonococcal strains):  
   Ceftriaxone, 250 mg, IM, PLUS  
   Doxycycline, 100 mg, by mouth, twice a day for 7 days.  
   OR  
   Tetracycline HCl, 500 mg, by mouth, 4 times a day for 7 days. Tetracycline should not be given to patients who are pregnant or to those allergic to tetracycline. In areas where resistant strains of N gonorrhoeae are nonendemic, regimens known to be less effective against antibiotic-resistant strains may be used.  

B. Tetanus toxoid as indicated according to Public Health Service recommendations.  
C. Pregnancy prevention for girls*.  
   Ethinyl estradiol 5 mg/d × 5 days, or Ovral, 2 mg (1 tablet) q 3 hours × 4, or 2 tablets in 2 divided doses 6 hours apart.  

V. Reported to police: date ___ time ___  
VI. Disposition and follow-up:  

* Note: The use of pregnancy prevention drugs in girls who have been raped is controversial. First, nausea and vomiting secondary to estrogens are common and warrant vigorous counseling at the time of prescription. Such symptoms can be especially unpleasant given the circumstances and can lead to noncompliance. Second, such drugs are associated with a small failure rate. Third, their teratogenic potential is not entirely clear. Finally, the incidence of pregnancy after rape is extremely low, lower than predicted from random single acts of intercourse, so the wisdom of using these drugs is questionable. The practitioner who chooses to use those drugs should be fully informed about these factors and should share these facts with the patient.

REFERENCES  


ADDITIONAL RESOURCE MATERIAL  

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Rape and the Adolescent

**Pediatrics** 1988;81:595

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