Sexual Assault and the Adolescent

Committee on Adolescence

ABBREVIATION. STD, sexually transmitted disease.

Rape is a significant and serious crime in our society. The Uniform Crime Report for 1991 published by the US Department of Justice listed over 100,000 reported statutory rapes nationwide, but this report excluded rape against men, and unreported sexual assaults. The National Victim Center estimates that almost 700,000 women are raped each year, and that 61% of the rape victims are under the age of 18.

The American Academy of Pediatrics last published a policy statement on rape and the adolescent in 1988, and in 1991 the Committee on Child Abuse and Neglect addressed the evaluation of the sexually abused child. Current definitions of rape, new data on date rape and acquaintance rape, and new suggested protocols for rape management mandate an updated knowledge base for the pediatrician who may need to care for the patient who has been sexually assaulted.

Sexual assault in childhood and adolescence includes incest, acquaintance rape, and stranger rape. As incest has been discussed in the statement on childhood sexual abuse, this statement will focus on a discussion of stranger and acquaintance rape.

DEFINITIONS

There is often confusion among legal definitions, medical terminology, and lay usage of terms related to sexual assault. Rape has historically been defined under standard common law as “the unlawful carnal knowledge of a woman by a man, forcible and against her will, or without her consent.” In general, the ability to consent to an act is an essential concept in defining sexual assault. Current legal and medical definitions are included in Tables 1 and 2. When legal definitions are reviewed, it is important to note that, in first-degree sexual assault, lack of consent does not necessarily require physical resistance or verbal refusal. For example, someone who is intoxicated may be unable to give consent. Age alone defines third-degree sexual assault (formerly called statutory rape) — lack of consent and the elements of force and resistance are not required. The age of consent in the United States varies from state to state from 14 to 18 years of age.

DATE AND ACQUAINTANCE RAPE

There is the common perception that rape is perpetrated by strangers, although about half of adolescent sexual assaults are committed by acquaintances. “Date rape” in the context of the assailant and the victim knowing another has received attention in the literature only recently. In a survey of middle school and high school students, 12% of the males and 18% of the females reported a history of unwanted sexual activity, with the majority of these episodes occurring between 13 and 16 years of age. Female adolescents overwhelmingly reported being forced into sexual situations against their will, and male adolescents reported being socially pressured into sexual situations before they were ready for them. In addition, large surveys of college students in both the United States and New Zealand have documented that over 50% of women in college had experienced unwanted sexual activity in the past, and up to 25% of all college women and 6% of college men reported having been the victims of assaults that met the legal definition of rape. Virtually none of these episodes had been reported to the authorities. Several studies show that there is confusion among youth about what constitutes sexual consent, and educational programs for adolescents are now being developed to clarify these issues. The law is currently unclear on issues of male rape by a female.

Of those women surveyed and described in the studies, the highest incidence of acquaintance rape appeared to occur in grade 12 and the freshman year of college. These data were collected from college students and did not include those women who had dropped out of high school. Of the 25% of college women surveyed who reported having had unwanted sexual intercourse, 84% knew their assailant, 57% of the episodes occurred on dates, and 41% of the women stated they were virgins at the time of the assault. Between 25% and 47% of date rape occurred on the first date, with an increased risk of rape if the male had initiated the date, driven the car, and paid for the date. Several studies have also documented that both males and females believe that forced sex may be legitimate and acceptable in certain circumstances.

Male victims represent about 5% of the total number of sexual assault cases reported. The actual number of males assaulted is probably much higher than statistics indicate because of the low incidence...
TABLE 1. Legal Definitions of Sexual Assault

Every state has statutory definitions of sexual assault. This example from Rhode Island is representative of current statutes:

First-degree sexual assault—sexual penetration by a part of a person’s body or by any object into the genital, oral, or anal openings which occurs when there is a) force or coercion or b) mental or physical inability to communicate unwillingness to engage in an act.

Second-degree sexual assault—sexual contact without penetration that could include intentional touching of a person’s sexual or intimate parts or the intentional touching of the victim’s clothing covering these intimate parts when there is a) force or coercion or b) mental or physical unwillingness to engage in such an act.

Third-degree sexual assault—sexual penetration by a person 18 years or older of a person under the age of consent.

of reporting by men. A majority of male victims knew their attackers, and the use of weapons and multiple assailants were more common in male rape than in female rape.14,15

Victims of rape have a difficult adjustment to the assault, as they tend to blame themselves, may suffer diminished self-esteem, and may have difficulty establishing trust in future relationships.16 Date rape usually occurs in the context of a relationship between two people in a social setting before the assault, with subsequent betrayal of trust.17 The date rapist tends to be sexually promiscuous, to have a hostile attitude toward women, and to use verbal coercion and alcohol to facilitate the sexual assault.8 In contrast, rapes by strangers usually involve more violence, trauma, and the display or use of a weapon.18 Little is known about men who rape men, although there is some information about men who are victims of rape.13,14

An association exists between the high incidence of alcohol and other drug abuse on college campuses and date rape.6,10 Up to 20% of college students are considered problem drinkers,19 and many surveys have shown a link between impairment of judgment in sexual relationships and the use of alcohol. In a large college study, 73% of the assailants and 55% of the victims had used drugs, alcohol, or both immediately before a sexual assault.20 College officials are beginning to address the problem of date rape by establishing written policy on date/acquaintance rape, providing educational programs for students on both rape and alcohol, training staff on how to manage sexual assault situations, and providing appropriate counseling and support for the victims.16

Pediatricians need to provide both information and counseling about acquaintance rape and its association with alcohol and other drug abuse as part of an annual adolescent health visit. This preventive counseling is especially important during the precollege physical examination.

MANAGEMENT OF THE RAPE VICTIM

Rape is a serious medical and psychological emergency. The pediatrician has an obligation to the adolescent patient who has been the victim of sexual assault to provide optimal medical care and to sup-

TABLE 2. Medical Terminology of Sexual Assault

Molestation—noncoital sexual activity between a child and an adolescent or an adult, which may include viewing, genital or breast fondling, or oral-genital contact.

Sexual assault—any contact of an offender with the genitalia of a nonconsenting victim.

Rape—a sexual assault in which the penis of an assailant is introduced into the victim’s genitalia, either without consent or by threat of force or compulsion.

Acquaintance or date rape—in which the assailant and the victim know one another.7

port that patient and his or her family. The goals of rape intervention include identification and treatment of injury and infection, pregnancy prevention, evidence collection, and psychological assessment with referral for counseling. Findings need to be carefully and accurately documented in the medical record. State legal mandates may require parental notification of the minor’s sexual assault that may supersede confidentiality issues.

RAPE PROTOCOL

The pediatrician may be the first professional consulted about the sexual assault. Some pediatricians may prefer to perform this type of evaluation themselves, while others may wish to refer the victim to an assessment team.21 Some metropolitan areas have trained rape teams and crisis centers that can respond immediately to the sexual assault victim, but many rapes occur in communities where no such services exist. If a pediatrician is consulted about a possible sexual assault within 72 hours of the event, the best course is for an evaluation by a pediatrician knowledgeable in forensic procedures or referral to a rape crisis center or to the emergency room. State laws and guidelines dictate the content of the legal forensic evaluation and “rape kits” are available for the collection of forensic evidence that may be needed in a criminal investigation. It is essential that a forensic examination include careful documentation and an unbroken chain of evidence of specimens.

If the sexual assault took place greater than 72 hours before the report to the pediatrician, the physical assessment of the patient can appropriately be performed in the pediatrician’s office, as this type of examination would not require forensic legal documentation. An example of a nonforensic protocol is included in the appendix.

New technologies are being applied to sexual assault assessment, including DNA testing and colposcopy. The recent availability in some centers of DNA testing (fingerprinting) on semen specimens may help to aid in the identification of the perpetrator.22 The use of the colposcope is not mandatory in the assessment of a sexual assault victim since almost all findings can be seen without magnification or with a hand-held lens.23,24 The use of these new technologies has not yet become the standard of care.

A major role of pediatricians is to make certain that an adequate rape protocol exists, and each community needs to have written guidelines outlining the
local management of the sexual assault victim. Regardless of which professional conducts the exam, the pediatrician needs to remain available and supportive to the patient.

**MANAGEMENT OF SEXUALLY TRANSMITTED DISEASES**

There is some controversy about appropriate screening and prophylactic treatment of sexually transmitted diseases (STDs) for victims of sexual assault. The risk of acquiring an STD after a rape is indeterminate, as the prevalence of STDs in rape victims is similar to that of the population at large. It is difficult to be certain which infections were already present and which ones were the result of the sexual assault.25-27 The types of STDs that are commonly found in rape victims include gonorrhea, *Trichomonas vaginalis*, genital warts, *Chlamydia trachomatis* infection, herpes simplex virus infection, and pediculosis.28-30 Human immunodeficiency virus (HIV) infection and syphilis, although uncommon, have also been reported in child and adolescent assault victims.31-34 Although there is the theoretical risk of transmission of hepatitis B infection following rape, no cases have yet been reported.

Although the incidence of STD acquisition following sexual assault is not completely known at this time, the American Academy of Pediatrics advises the following evaluation for victims of acute sexual assault.

1. Cultures from appropriate sites for *Neisseria gonorrhoeae* and *C trachomatis*. If vesicles or ulcers exist, a culture for herpes simplex virus can be obtained. A wet mount can be examined for sperm and trichomonads.
2. A baseline urine pregnancy test.
3. A serum specimen drawn and frozen so that serostatus for hepatitis B, syphilis, and HIV at the time of the assault can later be determined, if needed. With appropriate informed consent, the victim can be offered testing for HIV infection with counseling before and after testing. (This testing, however, only indicates baseline status because the incubation period for HIV is 3 to 6 months.)
4. Follow-up examination and blood tests for incubating syphilis, HIV, and hepatitis B (at 6 weeks), and repeat HIV (at 3 to 6 months) should be done when indicated. Even though the medical risk of bloodborne infection is low, the victim may obtain significant psychological relief from negative test results.35

In view of the unknown incidence of STDs acquired following rape and the potential for serious long-term consequences to the adolescent, including sterility, the American Academy of Pediatrics currently recommends that prophylaxis be offered to prevent incubating syphilis, gonorrhea, and chlamydia. Current recommendations from the Centers for Disease Control and Prevention (CDC, 1993) are outlined in Table 3.36

<table>
<thead>
<tr>
<th>TABLE 3. STD Prophylaxis for Acute Sexual Assault* (CDC Guidelines, 1993)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ceftriaxone, 125 mg intramuscularly, in a single dose</td>
</tr>
<tr>
<td>plus</td>
</tr>
<tr>
<td>Metronidazole, 2 g orally, in a single dose</td>
</tr>
<tr>
<td>plus</td>
</tr>
<tr>
<td>Doxycycline, 100 mg orally, two times a day for 7 days</td>
</tr>
</tbody>
</table>

* For patients requiring alternative treatments, see the appropriate sections of the CDC Guidelines.

**PREGNANCY PREVENTION**

Since the overall risk of conception following a rape is approximately 2% to 4%, most experts recommend offering postcoital contraception to the female victims of rape. The possible (but low) failure rate of postcoital contraception and options for pregnancy management in case of failure should be discussed. The current recommended treatment within 72 hours of the rape is Ovral (50 μg of ethinyl estradiol and 0.5 mg of norgestrel per tablet)—two tablets immediately, followed by two tablets 12 hours later or Lo-Ovral (35 μg ethinyl estradiol and 0.5 mg of norgestrel)—four tablets immediately, followed by four tablets 12 hours later. Mild side effects are not uncommon, but if nausea or vomiting occur after the first dose, the patient can be given an antiemetic such as prochlorazine, 5 to 10 mg orally, before the second dose.37 Recently, mifepristone (RU 486) has been shown to be more effective than Ovral treatment for postcoital contraception,38,39 and, if RU 486 becomes available in the United States, it may become a treatment option. Regardless of the prophylaxis given, a urine pregnancy test should be done 2 to 3 weeks later to detect treatment failures.

**PSYCHOLOGICAL REACTIONS**

In addition to managing the physical needs of the adolescent sexual assault victim, the pediatrician should be sensitive to the psychological needs of both the adolescent and the parents. Some parents become angry or feel guilty, and they may blame the adolescent for the sexual assault. Parents can require as much support as the victim, and they need help and counseling to remain supportive to their teenager during this time of crisis.1

The majority of adolescent rape victims report concerns about safety, self-blame and shame, irrational fears of bodily damage (infertility, STDs, and abnormal genital function), and fear of pregnancy.40 During the early stages of the patient's psychological reaction to the rape, referral to a rape crisis team, when available, may be an important adjunct to treatment. Many studies have documented a long-term reaction to rape that has the characteristics of a posttraumatic stress disorder.41-43 This disorder is thought to affect at least 80% of all adolescent rape victims. This syndrome is characterized by the following four symptoms: (1) re-experiencing the traumatic event by intrusive thoughts, dreams, or flashbacks; (2) an avoidance of previously pleasurable
activities; (3) an avoidance of the place or circumstances in which the rape occurred; and (4) an increased state of psychomotor arousal leading to difficulties with sleep and memory. Counseling for the adolescent with posttraumatic stress disorder as a result of rape is usually directed toward helping the victim deal with the trauma as well as encouraging the avoidance of self-blame and guilt that often result from the rape. The pediatrician needs to develop referral sources for this type of counseling in the community.

During the period of recovery after a rape, the adolescent may present to the pediatrician with psychophysilogic symptoms, depression, and multiple phobias. Acting out behaviors including running away, truancy, and promiscuity may also occur during this time.

RAPE PREVENTION

One study on both adolescent and adult female rape victims suggests that strong physical resistance by an adult-sized victim during a sexual assault will decrease the incidence of completed rape while increasing the chance of physical injury. Overall, about 1% of injuries during a rape require hospitalization and about 0.1% of rape injuries are fatal.

Epidemiologic studies of rape include one report of 63 adolescent male rapists, most of whom committed the sexual assault as an unprovoked and unanticipated act of violence that occurred while the rapist was intoxicated. Another study reported on more than 100 adolescent female rape victims and found that most sexual assaults occurred at night with three factors involved: (1) a teenage girl voluntarily agreeing to go to the house, apartment, or car of a young man she had known for less than 24 hours, (2) impairment of the victim by drugs or alcohol, and (3) hitchhiking.

The pediatrician can alert the adolescent patient to this information and can direct the patient to community resources, including police self-protection classes and self-defense courses, that may be available through community centers such as the YWCA/YMCA. School programs for middle school, high school, and college students and programs for out-of-school youth need to offer similar educational and practical advice.

RECOMMENDED COURSE OF ACTION

The American Academy of Pediatrics recommends that pediatricians:

1. be knowledgeable about the incidence of stranger and acquaintance sexual assault;
2. participate in the establishment of rape protocols;
3. understand the legal aspects of the forensic examination; and
4. be prepared to offer preventive counseling, immediate medical referral, and psychological support to the adolescent patients in their practices who may be the victims of a sexual assault.

Anticipatory guidance about sexual assault needs to be given to adolescent patients at annual health visits and in school settings during middle school and high school. The pediatrician also needs to be aware of community resources for both the management of the examination and the counseling of the patient after the rape. The pediatrician should remain a member of the team that provides the ongoing medical and psychological support to the adolescent sexual assault victim.

APPENDIX: SEXUAL ABUSE AND RAPE PROTOCOL

This protocol is adapted from The Children's Hospital Rape Protocol, Boston, MA.

A. General Information
- Name, DOB, race, parent and sibling information
- Alleged perpetrator and relationship to victim

B. Pertinent History
- Chief complaint or description of event in victim's own words
- Description of event from caretaker's report of victim's statement

C. Pertinent Medical History
- If pubertal female-menarche age, last menstrual period, use of tampons, history of vaginitis, previous sexual activity, use of birth control
- Pre-existing physical injuries
- Pertinent medical history of ano-genital injuries, surgeries, diagnostic procedures, or medical treatment
- History of child abuse

D. Summary of Acts Described by Patient and/or Historian
- Genital contact (with penis, finger, foreign object, etc)
- Anal contact (with penis, finger, foreign object, etc)
- Oral copulation of genitats (of victim by assailant, or of assailant by victim)
- Oral copulation of anus (of victim by assailant, or assailant by victim)
- Physical symptoms (ie, pain, urinary retention, enuresis, bleeding, discharge)
- Behavioral symptoms (eg, sleep, aggressiveness, sexual acting out)

E. Physical Examination
- Vital signs, general physical examination, documentation of physical injuries by diagram
- Genital examination, female
  - Document Tanner stage of breasts and genitalia
  - Indicate method used for genital examination—direct visualization, colposcope, hand-held magnifier
  - Examination position used—supine, knee chest, stirrups
  - Describe labia majora, clitoris, labia minora, urethral meatus, periurethral tissue
  - In prepubertal female, careful examination of external genitalia, including hymen
  - In postpubertal female, speculum pelvic examination if traumatic, otherwise external examination with cotton-tipped swab samples
  - Female/male anus
    - Describe buttocks, perianal skin, anal tone, tags, anal spasm, fissures, anal laxity, stool in vault
    - Document method of examination (observation, digital, anoscopy, proctoscope) and position used (supine, prone, lateral recumbent)
  - Genital examination, male
    - Document Tanner/genital or sexual maturation staging
    - Describe method of examination (direct visualization, colposcope, hand-held magnifier)
    - Diagram any lesions on genitalia, anus, perineum, or buttocks

F. Laboratory Collection
- Cultures for N gonorrhoeae and C trachomatis from appropriate sites—vagina, cervix, rectum, urethra, pharynx
- Blood for RPR, HIV, hepatitis B, frozen serum
- Wet mount, pregnancy test, sperm studies

G. Treatment (see text of statement for STD and postcoital contraception discussion)

H. Follow-up Appointments
- Counseling at 2- and 6-week follow-up appointments, with testing then for pregnancy, syphilis, HIV, hepatitis, and other STDS as indicated
REFERENCES


29. Murphy SM. Rape, sexually transmitted diseases and human immunodeficiency virus infection. Int J STD AIDS. 1990;1:79-82


49. Jenny C. Adolescent risk-taking behavior and the occurrence of sexual assault. AJDC. 1988;142:770-772

<table>
<thead>
<tr>
<th>Updated Information &amp; Services</th>
<th>including high resolution figures, can be found at: <a href="http://pediatrics.aappublications.org/content/94/5/761">http://pediatrics.aappublications.org/content/94/5/761</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Permissions &amp; Licensing</td>
<td>Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at: <a href="https://shop.aap.org/licensing-permissions/">https://shop.aap.org/licensing-permissions/</a></td>
</tr>
<tr>
<td>Reprints</td>
<td>Information about ordering reprints can be found online: <a href="http://classic.pediatrics.aappublications.org/content/reprints">http://classic.pediatrics.aappublications.org/content/reprints</a></td>
</tr>
</tbody>
</table>
Sexual Assault and the Adolescent
Committee on Adolescence
*Pediatrics* 1994;94;761

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://pediatrics.aappublications.org/content/94/5/761