



CLINICAL REPORT

Care of the Adolescent Sexual Assault Victim

Guidance for the Clinician in Rendering
Pediatric Care

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ABSTRACT

Sexual assault is a broad-based term that encompasses a wide range of sexual victimizations including rape. Since the American Academy of Pediatrics published its last policy statement on sexual assault in 2001, additional information and data have emerged about sexual assault and rape in adolescents and the treatment and management of the adolescent who has been a victim of sexual assault. This report provides new information to update physicians and focuses on assessment and care of sexual assault victims in the adolescent population. *Pediatrics* 2008;122:462–470

INTRODUCTION

Many terms have been used to describe sexual assault, including rape, statutory rape, acquaintance or date rape, sexual abuse, molestation, and incest. There is great overlap and some confusion in the definitions of nonconsensual sex acts. “Sexual assault” is a comprehensive term that includes any forced or inappropriate sexual activity. Sexual assault includes situations in which there is sexual contact with or without penetration that occurs because of physical force or psychological coercion or without consent, including situations in which the victim would be unable to consent because of intoxication, inability to understand the consequences of his or her actions, misperceptions because of age, and/or other incapacities. These situations can include touching of a person’s “sexual or intimate parts” or the intentional touching of the clothing covering those intimate parts.”¹

The age of consent for sex varies from state to state. Reporting requirements to child welfare agencies, parents, or the police are also variable, sometimes governed by local jurisdictions, and in flux. In addition, in some states (eg, Texas and California), there are laws mandating that sexual intercourse and sexual contact must be reported if certain age differences exist between a minor (usually defined as younger than 18 years) and his or her sex partner (whether minor or adult), even if the sexual act was voluntary and consensual. Some adolescents may refuse to seek care or disclose personal risk information because of possible reporting of sexual partners.^{2–5}

This report only addresses acute sexual assault in the adolescent age group and not sexual abuse that might be chronic and identified long after the fact. For more information about sexual abuse, see the American Academy of Pediatrics clinical report “The Evaluation of Sexual Abuse in Children.”⁶

Because of the differences between states and the likelihood of change, physicians need to be familiar with the particular laws in their state and continue to be aware of any changes that may occur. This information is available online through the Child Welfare Information Gateway.⁷

EPIDEMIOLOGY

National data show that teens and young adults have the highest rates of rape and other sexual assaults of any age group. It is widely accepted that statistics on sexual assault reflect substantial underreporting, so the reported rates, in all likelihood, are underestimates. Annual rates of sexual assault per 1000 persons (male and female) were reported in 2004 by the US Department of Justice to be 1.2 for ages 12 through 15 years, 1.3 for ages 16 through 19 years, 1.7 for ages 20 through 24 years, and 1.6 for ages 24 through 29 years.⁸ There are significant gender differences in reports of adolescent rape and sexual assault, with the 2005 National Crime Victimization Survey statistics reporting 176 540 rapes and sexual assaults of females 12 years or older and 15 130 rapes and sexual assaults of males 12 years or older.⁹ This represents a significant decrease from peak rates of rape and sexual assault reported in this group in 1992.^{9,10} These figures may not indicate a true decrease in the rate of rape but may reflect, instead, methodologic differences in reporting rates over time. Studies have demonstrated that two thirds to three quarters

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The guidance in this report does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

Key Words

sexual assault, victim, victimization, adolescent, violence, dating violence

Abbreviations

GHB— γ -hydroxybutyrate

STI—sexually transmitted infection

NAAT—nucleic acid–amplification test

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of all adolescent sexual assaults are perpetrated by an acquaintance or relative of the adolescent.^{10,11} Older adolescents are most commonly the victims during social encounters with the assailants (eg, a date). With younger adolescent victims, the assailant is more likely to be a member of the adolescent's extended family. Adolescents with developmental disabilities, especially those with mild mental retardation, are at particular risk of acquaintance and date rape.¹²

Adolescent rape victims presenting to emergency departments are more likely than adult victims to have used alcohol or drugs and are less likely to be physically injured during a rape, because assailants in adolescent rape tend to use weapons less frequently.^{11,13} Adolescent female victims are also more likely to delay seeking medical care after rape and sexual assault and are less likely to press charges (when given a choice) than are adult women.^{11,13} Male victims are less likely to report a sexual assault than are female victims.¹⁴⁻¹⁶ Studies of sexual assault of males have demonstrated that up to 90% of perpetrators are male. Sexual assault of males by females is more commonly reported by older adolescents or young adults, compared with children or young adolescents.^{14,16} Male perpetrators of male sexual assault more commonly identify themselves as heterosexual than homosexual.¹⁴ The rate of perpetration by an acquaintance of the victim is similar for male and female victims, but multiple assailants, use of a weapon, and forced oral assaults are more common in assault of males than of females.⁴

SUBSTANCES AND SEXUAL ASSAULT

Alcohol or drug use immediately before a sexual assault has been reported by more than 40% of adolescent victims and adolescent assailants.¹⁵ Adults have been shown to significantly underreport voluntary drug use associated with sexual assault, but the same has not been demonstrated in adolescents.¹⁷ Increasing rates of adolescent acquaintance rape have been associated with the availability of illegal so-called date-rape drugs. The most well known of these is flunitrazepam (Rohypnol, manufactured by Roche Pharmaceuticals Inc outside of the United States), which is a benzodiazepine sedative/hypnotic. The effects of flunitrazepam begin 20 to 30 minutes after ingestion, peak within 2 hours, and persist for up to 8 to 12 hours if given without alcohol and up to 36 hours with alcohol. Drug effects include somnolence, decreased anxiety, muscular relaxation, and profound sedation. There may also be amnesia for the time that the drug exerts its action. Flunitrazepam can go undetected by an adolescent if added to any drink, thus increasing the risk of sexual assault, especially in the adolescent population. Hypotension, visual disturbances, dizziness, and urinary retention are all possible medical complications. After ingestion, it can be found in the bloodstream for 24 hours and in urine samples for up to 48 hours.¹⁸⁻²¹ Therefore, urine and blood samples can be sent for toxicology screening, with every effort made to ensure the chain of evidence. Date-rape drugs and many other drugs of abuse are not included in standard drug-screening panels. At the time of evaluation, health

care professionals should inquire how to detect the presence of suspected drugs and collect the proper specimens from the victim.

γ -Hydroxybutyrate (GHB) is also used as a date-rape drug. People who are given GHB in low doses are likely to experience drowsiness, euphoria, increased libido, and passivity.²² In addition, at higher doses, they can experience amnesia, intoxication, dizziness, and visual hallucinations. Medical complications of high doses include hypotension, bradycardia, severe respiratory depression, and coma. GHB acts quickly, usually within 15 minutes of ingestion. The effects last for 3 to 6 hours when taken without alcohol and 36 to 72 hours when mixed with alcohol or other drugs. It is cleared quickly and is undetectable in urine after only 12 hours or even earlier.²³

Ketamine effects include amnesia, delirium, vivid hallucinations, tachycardia and arrhythmias, mild respiratory depression, confusion, irrationality, violent or aggressive behavior, vertigo, ataxia, slurred speech, delayed reaction time, euphoria, altered body image, analgesia, and coma. Ketamine effects occur within 20 minutes. The effects last for less than 3 hours. Opinion varies on clearance, with sources quoting detectability in urine from 24 to 72 hours after ingestion.^{24,25}

Because all of these drugs are detectable for only a short time, if there is suspicion that 1 of them has been used, toxicology screening should be performed as soon as possible, perhaps even before finishing the history and physical examination. The reference concentrations of these drugs are not universally available, and referral to a sexual assault center may be required for drug testing.

In addition to these 3 drugs, common prescription benzodiazepines and over-the-counter antihistamines are also being used to facilitate sexual assault, so testing should be performed for these medications also.²⁶

Alcohol is still the most common date-rape drug, and adolescents should be warned of their increased vulnerability to assaults when drinking. If their friends are also drinking, they cannot count on them to notice that an assault is taking place.

SEXUAL ASSAULT OF YOUNG PEOPLE WITH DISABILITIES

Children and adolescents with disabilities are at significantly increased risk of sexual assault: 1.5 to 2 times higher than the general population.²⁷ Those who have milder cognitive disabilities are at the highest risk.^{28,29} A number of factors probably result in the increased risk, including decreased ability to flee or fight off an attacker; an expectation of increased compliance and tolerance of levels of physical intrusion not expected of people without disabilities; dependence on others for personal care; and, in general, ineffective safeguards.³⁰

A number of factors apply to the reporting of sexual abuse or assault by those with disabilities, including what significance the victim attaches to the incident; whether the victim has a means of communication; whether they perceive there to be a trustworthy, capable person to whom the information may be disclosed; and issues of being believed and feeling safe.^{29,31,32} Some of these factors uniquely affect individuals with disabilities,

but others are shared by individuals without disabilities as well.

Health care professionals should be familiar with counseling agencies, programs that specialize in child abuse, and other services that are physically accessible and that have communication skills that are appropriate for teenagers using augmentative communication devices or who are cognitively impaired. Services should be identified that can provide appropriate genital and pelvic examinations for victims having physical disabilities requiring mobility aids.

ADOLESCENTS' PERCEPTIONS AND ATTITUDES REGARDING SEXUAL ASSAULT

Exploring the perceptions and attitudes of adolescents regarding nonconsensual sexual encounters is important. Because there may have been voluntary participation before the assault occurred, an adolescent might think that he or she will not be believed. Teenagers may be reluctant to report an incident because they feel guilty, are worried that their parents will restrict them from going to social events, or have little memory of the assault because of the use of date-rape drugs. One study demonstrated that male and female adolescents who viewed a vignette of unwanted sexual intercourse accompanied by a photograph of the victim dressed in provocative clothing were more likely to indicate that the victim was responsible for the assailant's behavior, more likely to view the man's behavior as justified, and less likely to judge the act as rape than when the victim was in less-provocative clothing.³³ Also, some aggressive behavior on the part of a male perpetrator may be seen by some adolescents as normative.^{34–37}

ADOLESCENT REACTIONS TO RAPE

Unwanted sexual experiences during adolescence are common, with a large survey of middle- and high-school students indicating that 18% of females and 12% of males have had an unwanted experience.³⁸ Studies of female adolescents have found rape during childhood or adolescence to be associated with increased risky behaviors and mental health problems, including younger age of first voluntary intercourse; higher rates of depression, including suicidal ideation/attempts; and other self-harm behaviors such as self-mutilation and eating disorders.^{34,35,37,39–42} When found in the gender less affected, psychiatric or behavioral problems that are more prevalent in the other gender (such as eating disorders in girls, fighting in boys) may be an indication that sexual assault or abuse has occurred.⁴⁰

Rape trauma syndrome is described as consisting of an initial phase that lasts for days to weeks, during which the victim experiences disbelief, anxiety, fear, emotional lability, and guilt followed by a reorganization phase that lasts for months to years, during which the victim goes through periods of adjustment, integration, and recovery.^{43,44} Part of rape trauma syndrome is post-traumatic stress disorder, which occurs in up to 80% of rape victims.⁴⁵ A 4-question screening tool for posttraumatic stress disorder has been used with some success

with adults by gynecologists.⁴⁶ Counseling designed to specifically address these issues, as well as additional psychological trauma that results from date or acquaintance rape, should be available. Psychotropic medications may be required in some instances. The physician should be knowledgeable about services available in the community to address these issues and should provide initial psychological support.

Other victim reactions to sexual assault can include the feeling that his or her trust has been violated, increased self-blame, less-positive self-concept, anxiety, alcohol abuse, and effects on sexual activity (including younger age at first voluntary sexual activity, poor use of contraception, greater number of abortions and pregnancies, sexually transmitted infections [STIs], victimization by older partners, erectile dysfunction in males, and sexual dissatisfaction).^{41,47–52} Adolescent victims may feel that their actions contributed to the act of rape and have confusion as to whether the incident was forced or consensual.^{53–55} Male victims also report fragility of their gender identity and sense of masculinity and confusion about their sexual orientation.⁵⁰ All victims should be screened for suicidal ideation and self-harm behavior.

INVESTIGATIONS

Adolescents may report a sexual assault to their physician, sometimes because they came to do so and other times because the question has been asked. Depending on the patient's current age, age at time of the event, the identity and presence of the alleged perpetrator (such as an acquaintance, a relative, teacher/coach, or even health care professional), and state law, the assault may have to be reported even if the teenager does not want it to be reported. At the time of examination after acute assault, an adolescent may have a hard time making a decision to press charges and can be encouraged to have a forensic medical examination to assess for injury and infection and to collect forensic evidence. Before any forensic examination, victims should be advised not to wash their clothes, bathe, or shower until they have been examined. These clothes should be stored in a paper, not plastic, bag. In some facilities, adolescents may have the option of freezing forensic evidence if they are uncertain about filing charges for possible use in the future. A forensic medical examination includes a medical forensic history, documentation of biological and physical findings, collection of evidence from the patient, and follow-up for additional evidence gathering.⁵⁶ With DNA-amplification techniques, a forensic examination can be useful for at least 4 days after the assault⁵⁷ and possibly longer.^{58–60} Between 4 and 7 days, local authorities should be contacted to determine if it is useful to collect evidence. After 1 week, examination, counseling, and treatment can take place without need for forensic collection. Unfortunately, not everyone presenting with the same history may get the same forensics and treatment, with homeless females being a group that has been identified as getting less-than-adequate services.⁶¹ Decreased access to care is likely to lead to increased rates of infections with STIs and their sequelae, unwanted pregnancies, increased psychiatric

TABLE 1 Investigations According to Site⁶²

Screening	Throat	Vagina	Cervix/Urethra	Anorectal	Blood (Bodily Fluids, Any Site)
Gonorrhea culture	Yes	No	Yes	Yes	NA
Chlamydia culture	No	No	Yes	Yes	NA
NAAT for chlamydia, gonorrhea	No	Yes	Yes	No	NA
Microscopy for trichomoniasis, bacterial vaginosis, candidiasis	No	Yes	No	No	NA
HIV, hepatitis B, syphilis	No	No	No	No	Yes

NA indicates not applicable.

complications, and poor reporting of sexual assault. The Centers for Disease Control and Prevention's treatment guidelines for STIs⁶² include a recommendation for comprehensive clinical treatment of victims of sexual assault, including emergency contraception and HIV prophylaxis, if indicated. The evaluating health care professional should ensure that specimens are available for timely clinical care and that follow-up plans are communicated and feasible.

Before any examination, the health care professional should address the adolescent's immediate health concerns such as the likelihood of having contracted an STI, the possibility of pregnancy, and worries about acute and permanent physical injury/damage. A referral for examination and treatment should be made to an emergency department or sexual assault treatment center where there are personnel experienced with adolescent assault victims. Physicians involved in the management and forensic examination of adolescent victims of sexual assault should be trained in the forensic procedures required for documentation and collection of evidence. Colposcopic procedures allow examiners to detect and document genital trauma, including microtrauma, with a growing body of literature demonstrating the patterns of genital injury in sexual assault victims.⁶³⁻⁶⁵ Physical examination is unlikely to yield evidence of penetration that, other than the possible presence of seminal fluid, is visible to the naked eye. After the acute period, it is uncommon to find any indication of genital trauma,⁶⁶ although as many as 32% of teenagers who have not previously had intercourse may show physical signs after the acute period.^{67,68} Adolescents have reported that the experience of video colposcopy may be beneficial, with many accepting offers to watch their own examination on screen.⁶⁹

It is essential that the forensic examination be performed by a person such as a physician who specializes in child abuse or a nurse with sexual assault care training, who can ensure an unbroken chain of evidence and accurate documentation of findings.^{43,47,58,70-72} Details of the required examination and documentation are presented in a handbook published by the American College of Emergency Physicians, *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient* (available online).⁷³ Physicians who treat sexually abused or assaulted patients need to be aware of the legal requirements, including completion of appropriate forms and maintaining the legal chain of evidence and

reporting to appropriate authorities specific to their locale.

Documentation of the history and physical examination is important. Value judgments should not be included, nor should interpretations of the meaning of the adolescent's body language or facial expressions. Descriptions should be exact, and terms such as "hymen not intact" should be avoided. The clinical records from both the referring physician and the assault center are likely to be subpoenaed if there is a prosecution. Again, there is more likelihood of the evidence being accepted if the examiner is an expert in handling cases of sexual assault. Any examination or treatment should be performed only with the consent of the adolescent.

For an examination after acute assault, testing for STIs is somewhat controversial. There is a concern that a speculum examination may be traumatic, especially for a teenager who has not had one before, possibly leading to avoidance of pelvic examinations in the future. Finding an STI, particularly *Chlamydia trachomatis*, may give a defense lawyer an opportunity to introduce the victim's previous sexual history. However, many victims of assault have been reported to have positive culture results and/or samples at the time of the acute evaluation.⁷⁴⁻⁷⁶ Obviously, positive results may indicate an existing infection as a result of the victim's history of consensual sexual contact, but some cultures or samples may be positive as a result of the assault even when obtained within 72 hours of the assault. Specimen collection should be discussed with the adolescent, who then can choose whether to have cultures performed. If specimens are to be collected, the decision of which sites should be sampled should be based on possible contact with the perpetrator's bodily fluids (see Table 1). Because some courts will only accept positive culture results for gonorrhea and chlamydia (as opposed to nucleic acid-amplification tests [NAATs] and other indirect tests), cultures are preferable over NAATs for any case in which there is likely to be prosecution. However, there may be an advantage to using an NAAT in addition to a culture to detect chlamydia, because the high sensitivity makes it more likely to detect before the end of the incubation period.⁷⁷ Vaginal secretions can be microscopically examined for *Trichomonas* species and sent for culture where available.

If prophylactic treatment is given, cultures do not need to be performed at follow-up unless requested by the victim. If there is no prophylaxis prescribed, then

TABLE 2 Prophylactic Treatment Recommendations

Condition	Recommended Regimen
Gonorrhea	Ceftriaxone, 125 mg intramuscularly once (for oral and/or anogenital penetration) or may use, if available, cefixime, 400 mg orally once (for anogenital but not oral penetration)
<i>Trichomonas</i> species	Metronidazole, 2 g orally once
Chlamydia	Azithromycin, 1 g orally once, or doxycycline, 100 mg orally twice daily for 7 d
Hepatitis B	Immunize, if not previously completed
Human papillomavirus	Immunize, if not previously completed
Pregnancy prevention or emergency contraception	0.75-mg levonorgestrel tablet: 2 tablets orally, 12 h apart
HIV	See text

cultures are recommended 1 to 2 weeks after the assault.⁷⁷

Serum samples can be obtained for baseline testing for syphilis and HIV in areas or populations in which there is a high incidence of infection or if the victim wishes for these tests to be performed (see below for HIV prophylaxis). Syphilis tests should be repeated after 6 to 12 weeks, and HIV tests should be repeated after 3 to 6 months.^{43,58,72,73}

MANAGEMENT

Acute Care

The examining physician should keep in mind that the young person may have nongenital injuries, the treatment of which may be a priority depending on the severity of the injury.

Pregnancy prevention and emergency contraception should be addressed with every adolescent female rape and sexual assault victim. The discussion should include risks of failure and options for pregnancy management. Progestin-only emergency contraceptive pills have the most favorable mix of safety, with fewer adverse effects and increased efficacy.⁷⁸ A baseline urine pregnancy test should be performed. Emergency contraception should be offered to females who have been (or may have been) vaginally penetrated or who think that ejaculate has come into contact with their genitalia.^{43,47,58,65,70,71} Although package labels suggest a dosage of 0.75 mg of levonorgestrel taken twice, 12 hours apart, taking both tablets at once is an easier regimen and is just as effective without increasing adverse effects.⁷⁹

Prophylactic treatment for chlamydia and gonorrhea should be recommended to adolescent sexual assault victims who have been vaginally or anally penetrated (with or without ejaculation) or orally penetrated (with ejaculation). Current recommendations from the Centers for Disease Control and Prevention are to treat with 125 mg of ceftriaxone intramuscularly, 2 g of metronidazole once orally, and either 1 g of azithromycin once orally or 100 mg of doxycycline twice daily for 1 week.⁶² If available, cefixime at a dose of 400 mg once orally can be used instead of the ceftriaxone if only genital penetration occurred (see Table 2).

Teenagers who have not initiated or completed immunization against hepatitis B virus should be offered the vaccine with completion of the series to be facilitated. There are currently no recommendations regarding immunization against human papillomavirus infections in the context of an acute sexual assault; however, all adolescent female victims are within the recommended age group for receiving this immunization, so depending on insurance coverage, immunization can be discussed at this time.

There are only a handful of cases in the literature of HIV being transmitted from a single episode of sexual assault.^{80–82} HIV prophylaxis is not universally recommended but should be considered when there is mucosal exposure (oral, vaginal, or anal). Factors to consider include the risks and benefits of the medical regimen, including whether there was repeated abuse or multiple perpetrators; if there is oral, vaginal, or anal trauma, including bleeding; if the perpetrator is known to have HIV infection; or if either the victim or perpetrator has a genital lesion or if there is a high prevalence of HIV in the geographic area in which the sexual assault occurred.^{43,58,62,72,73,83,84} If rapid testing of the assailant is available, prophylaxis can be started and then stopped if the test result is negative. In 1 study, only 71 of 258 people who had been sexually assaulted agreed to HIV prophylaxis, 29 continued with the treatment past 5 days, and only 8 completed the full course. Those at higher risk were more likely to complete treatment.⁸⁵ A retrospective study found that uncertainties regarding exposure, high rates of psychiatric comorbidity, and low rates of return for follow-up care were all factors in the low rates of adherence to postexposure prophylaxis.⁸⁶ Centers that specialize in treatment of sexual assault victims often provide care without cost to their clients and can advise about local resources when payment, confidentiality, and safety are concerns. No large studies examining different combinations of treatment have been performed with sexual assault victims, but on the basis of current occupational-exposure guidelines, 2 nucleoside reverse-transcriptase inhibitors and 1 of either a nonnucleoside reverse-transcriptase inhibitor or protease inhibitor for 4 weeks is recommended.⁸⁷ In situations in which significant risk exists, prophylaxis with 3 medications should be offered only if the drugs can be started within 72 hours of exposure.⁸⁸

Follow-Up Care

Follow-up can include a visit within 1 week of presentation to assess injury healing and to ensure that counseling has been arranged. Reassessment for STIs may need to occur depending on medications given at the time of the initial evaluation and the intervening history of consensual sexual activity.⁷⁵ At 2 weeks, pregnancy testing can be performed, along with discussion of test results, assessment of adherence to any medications, and the teenager's emotional status. The Centers for Disease Control and Prevention recommends that syphilis and HIV testing be repeated 6 weeks, 3 months, and 6 months after the assault if initial test results were negative and infection in the assailant could not be ruled out.⁶²

Because responses to rape can vary, it is important for physicians to address both the physical and psychological needs of the adolescent. Physicians should be aware that self-blame, humiliation, lack of information (ignorance), and naiveté might prevent the adolescent from seeking medical care. Effective screening, referral, and follow-up allow for support of the adolescent rape victim and appropriate delivery of health care services. Because patients treated in emergency departments often do not return for follow-up care,⁸⁹ it is important that the emergency treatment team refer the assaulted adolescent back to his or her medical home or a specialty treatment center, if they have one and if the teenager consents to his or her primary health care professional knowing about the assault. Contact with the primary health care professional from the emergency department with the information would relieve the teenager of the burden of introducing the topic and encourage follow-up. The adolescent should be encouraged to share information with a parent or other trusted adult. Although adolescents may want confidentiality and have the right to it, this is a time during which support from an adult is very important, especially when teenagers are being treated in unfamiliar emergency department environments. Involving a support person may help ensure that the adolescent gets supportive help and appropriate counseling, particularly if he or she later becomes depressed and lacks the ability to access help. Parents can be counseled and encouraged to focus on their teenager's needs and not blame themselves or their son or daughter.

Male victims' concerns about their sexuality, in particular their sexual orientation, should be addressed.

Physicians should be prepared to provide follow-up STI testing, completion of the hepatitis B virus and human papillomavirus immunization series, treatment of injuries, screening for mental health problems, and management of substance use issues.

A number of studies have shown that trauma-focused cognitive behavioral therapy is useful for adolescents who have been abused or assaulted,⁹⁰ and a call or referral to a sexual assault care center may yield the names of mental health professionals who are more skilled in the care of victims and their families. Under some circumstances, funding may be available to pay for tests and treatments through the Victims of Crime Act (Pub L No. 98-473 [1984]).

SEXUAL ASSAULT AND RAPE-PREVENTION STRATEGIES

Adolescent rape exists in a sociocultural context, including some religious and ethnic values, in which issues of male dominance, appropriate gender behaviors, victimization, violence, and power imbalances in relationships are highly visible. Prevention messages for adolescents need to be designed for males and females.^{47,70,91-93} Adolescents need to be able to identify high-risk situations (such as attending parties with unknown people, meeting people with whom they have had contact on the Internet, walking alone at night, allowing themselves to be photographed nude or in sexually explicit poses or situations); they also should be advised that if they are ever assaulted, they should seek medical care. Factors

that may increase the likelihood of assaults (eg, use of drugs or alcohol) and strategies to prevent sexual assaults (eg, "buddying up," not drinking from anything that has been left unattended, abstaining from or moderating alcohol intake, not accepting drinks from strangers) should be discussed, and associated educational materials should be available and distributed.^{47,70,91-93}

A survey of more than 600 young women in an urban setting showed that the vast majority thought that young women should be screened and counseled by their health care professional regarding dating violence.⁹⁴ Physicians should be aware that sexual assault is common and need to be prepared to counsel their adolescent patients to avoid high-risk situations. Screening of adolescents for sexual victimization should be part of visits for psychological problems, sexuality issues, contraception or substance abuse, and health supervision. Physicians should include information about ways to prevent sexual assault as part of anticipatory guidance with adolescents with and without disabilities, tailored to cognitive abilities to understand. Adolescents should be asked direct questions without their parents present regarding their past sexual experiences. These questions should include those that explore age of first sexual experience, use of the Internet to find romantic or sexual partners, and unwanted or forced sexual acts. Exploration of gender roles and relationship parameters (eg, exploitative, nonconsensual versus healthy) are critical. Adolescents who have been sexually assaulted need the opportunity to describe the experience at their own pace and in their own words.^{47,63-65,70}

SUMMARY STATEMENTS

1. Physicians are encouraged to routinely discuss with their adolescent patients the potential for sexual and physical violence, including relationship violence. The discussion may help prevent and/or reduce the stigma of revealing such issues if violence occurs.
2. Physicians are encouraged to be aware of the current reporting requirements for sexual assault and laws protecting the confidential rights of adolescents to obtain care at rape crisis care centers in their state.
3. Physicians should be knowledgeable about sexual assault and rape evaluation services available in their communities. This information should include when and where to refer adolescents for a forensic medical examination and sexual assault care as well as for services appropriate for teenagers with disabilities.
4. Physicians are encouraged to routinely screen adolescents, including those with disabilities, for a history of sexual violence, covering the potential of dating violence and sexual assaults.
5. For those adolescents with positive histories, appropriate STI screening, prophylaxis, and treatment should be available on a timely basis, including referrals for care and potential sequelae.
6. Emergency contraception should be offered to female sexual assault victims if reported within 120 hours of

the assault. Given the safety of emergency contraception, it should be offered even if the adolescent is not sure whether penetration occurred. Documentation of pregnancy status should occur at the time of the evaluation with either a blood or urine sample.

7. Because of the potential for long-term psychological consequences, physicians should be prepared to offer psychological support or referral for counseling and should be aware of the services in the community that provide management, examination, and counseling for the adolescent patient who has been sexually assaulted.

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