Mini-Review

Acute Sexual Assault in the Pediatric and Adolescent Population

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A B S T R A C T

Children and adolescents are at high risk for sexual assault. Early medical and mental health evaluation by professionals with advanced training in sexual victimization is imperative to assure appropriate assessment, forensic evidence collection, and follow-up. Moreover, continued research and outreach programs are needed for the development of preventative strategies that focus on this vulnerable population. In this review we highlight key concepts for assessment and include a discussion of risk factors, disclosure, sequelae, follow-up, and prevention.

Key Words: Sexual assault, Anogenital injury, Forensic examination, HIV postexposure prophylaxis, Sexually transmitted infections

Introduction

Children and adolescents are populations known to be vulnerable to acute sexual assault.[1,2] According to the US Department of Justice's National Crime Victimization Survey, there are more than 230,000 victims of sexual assault and rape each year.[3] Female adolescents between the ages of 12 and 17 account for 1 in 5 sexual assault reports, and those aged 16 to 19 are 4 times more likely than any other group to be victims of sexual assault.[4] Fifty percent of all rape victims are younger than the age of 18 years, and 16% are younger than the age of 12 years.[5] In most cases the victims and offenders are not strangers as in 3 out 4 incidents the victims report having known the assailant.[2] Despite these alarming statistics, the true incidence of sexual assault is unknown, because approximately 50% of all sexual assault cases go unreported.[6]

Definition

The terms “sexual abuse” and “sexual assault” have some overlap and are often used interchangeably but have important distinctions.[7] They are also legal terms defined by state statutes, and they can have different meanings depending on the context of the use, which adds another layer of complexity. Sexual abuse is the exposure of a child to sexual experiences that are inappropriate for his or her level of physical and emotional development, are coercive in nature, and are usually initiated for the purpose of adult sexual gratification.[8] Sexual abuse usually occurs over an extended period of time, and disclosure of the abuse might happen immediately, but is delayed in most cases. Sexual assault, on the other hand, is any sexual contact that occurs without consent of the recipient.[9] It encompasses a continuum of sexual activity, including sexual contact with or without penetration. It might involve actual or threatened force or restraint, and situations in which the victim would be unable to consent because of intoxication, an inability to understand the consequences of his or her actions, or misperceptions because of age and/or other incapacities.[10,11] For the purpose of this Mini Review, acute sexual assault will refer to contact sexual activity with a child or nonconsensual sexual activity with an adolescent that has occurred within the past 72 hours (or the time frame dictated by jurisdiction). We will focus on the evaluation immediately after the assault, with brief discussions of risk factors, disclosure, sequelae, follow-up, and prevention.

Risk Factors

Known risk factors for sexual assault in this population include female sex, being unaccompanied by an adult, poverty, and physical or cognitive disabilities and previous sexual victimization. Additionally, teen runways or those who are incarcerated and youth who have a parent with mental illness or with drug or alcohol dependency are at increased risk.[11–16]

Adolescence is a time during which executive functioning skills have not fully developed, and as a result, it is often more difficult to foresee the consequences of potentially harmful behaviors.[12] Increased risk-taking behaviors such as interaction with strangers through the Internet or social media and the use of drugs or alcohol pose additional risks to this population.[5,17] In fact, although children and

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younger adolescents are more likely to have episodes of assault by a member of their extended family, older, adolescents are more likely to be the victim of an assault by an acquaintance during a social encounter and involve the use of drugs or alcohol.[11,18]

Disclosure of the Assault

Studies have shown that many victims of sexual assault never disclose their assault to another person and even fewer report the assault to social services or law enforcement.[19–22] A variety of factors may influence whether a victim immediately discloses a sexual assault. In children, fear of or threats by the perpetrator are leading causes of delayed disclosure.[21,23,24] Additional factors include embarrassment, lack of opportunity to tell, and the nature of the relationship with the perpetrator.[21,22,24,25] It is also an unfortunate reality that some parents might not allow a child to report their assault. Among adolescents, fear of retribution, feelings of guilt, not self-identifying as a victim, lack of knowledge regarding victims' rights, and effects from drugs and alcohol might also lead to a lack of or delay in disclosure.[11,12,19,23]

There is also a wide variability in the timing and context of disclosure, and many children wait weeks, months, or years before they tell someone. Whether, when, and to whom sexual assault victims choose to disclose might have important implications for recovery after the assault.[19] A delay in reporting can lead to missed opportunities for medical and mental health evaluations and serve as a potential barrier to the appropriate prosecution of assailants.

Assessment

Every child or adolescent who discloses an acute sexual assault should have a medical evaluation as soon as possible. The American Academy of Pediatrics (AAP) recommends that an examination be performed and a forensic kit collection be considered if an assault occurred within the previous 72 hours.[26] More recent guidelines suggest that forensic evidence collection should be performed if sexual contact that may have resulted in the exchange of biologic material occurred within 24 hours in prepubertal children and within 72 hours for adolescents.[27] The assessment in cases of acute sexual assault can be very challenging; therefore, anyone involved in the management of these cases should have advanced formal education and training in the evaluation of sexual assault, including documentation and collection of evidence, and expert review of images.[11,23,28,29]

Typically, a victim presents to the local emergency department or a pediatrician's office for care. A report should be made to law enforcement and child protection authorities when a sexual assault is suspected in accordance with state reporting requirements. Mandated protocols often dictate the care of the patient from that point. Often jurisdictions have an agreement with a local health care facility or a child advocacy center that serves as the preferred site for sexual assault evaluations. Many such facilities have personnel on call such as pediatric sexual assault nurse examiners (SANE-P), child abuse pediatricians, or physicians and midlevel providers with advanced training who will perform the history, physical examination, and forensic evidence collection.[27–29]

Initial Evaluation

The first step in assessing a victim of sexual assault is to identify and manage any life-threatening injuries, such as hemorrhage resulting from trauma to the genital tract. If a drug-facilitated sexual assault (DFSA) is suspected, blood and urine samples should be obtained under chain of custody procedures as soon as possible. Additionally, if indicated, human immunodeficiency virus (HIV) postexposure prophylaxis (PEP) should be administered on presentation, as discussed in detail in the section on HIV PEP. When immediate medical concerns have been addressed, details of the assault and a complete medical history must be obtained.

Taking a History

Sexual assaults are usually unwitnessed, are denied by the perpetrator, and in a large percentage of cases, do not result in physical injury. Thus, the history of the assault provided by the patient is often the single most important piece of information in a case. Obtaining a history from children and adolescents requires knowledge of child development and appropriate interviewing techniques.[30] This knowledge allows the medical provider to obtain the most accurate information to inform medical diagnosis and guide treatment.

A private, quiet room must be provided for the patient. Issues surrounding confidentiality should always be addressed, including legal obligations to report cases to authorities if necessary.[11,23] Ideally, the victim should be interviewed alone about the assault. Younger children might be influenced if they see their caretaker become upset when they begin to reveal details of their assault. Adolescents also tend to speak more freely when the interview is confidential.[23] Describing the assault can be retraumatizing for the patient, so the number of times that a patient describes an assault should be kept to a minimum, and clinicians should closely monitor the patient's reaction when taking the history. Whenever possible, nonleading questions should be used. In younger children, more directed questions such as “What area of your body was touched or hurt?” might be necessary.[26,30] In Table 1 strategies for obtaining a history are highlighted. The exact wording that a patient uses to answer questions should be documented. The medical history complements, but does not replace, a videotaped forensic interview by a professionally trained interviewer that often occurs later during an investigation at a child advocacy center.[27] In a forensic interview, representatives of the various agencies such as law enforcement, child protective services, and prosecutors can remotely observe the interview and thereby reduce the number of times a child is interviewed.

Physical Examination

The forensic medical examination is critical and includes a medical history, documentation of biological and physical