Caring for female adolescent acquaintance rape victims

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Acquaintance rape, or rape perpetrated by someone known to the victim—such as a friend, date, or partner—is a growing form of sexual victimization experienced in the adolescent population. The unique needs of female adolescent rape victims must be understood in order to provide the best treatment and promote recovery. Patients are more likely to disclose a prior sexual assault in a confidential and empathetic therapeutic environment. This article focuses on the special needs and management of female adolescent victims of acquaintance rape.

Acquaintance rape is defined as a sexual assault committed by someone familiar to the victim, such as a boyfriend, girlfriend, classmate, or friend.[1] *Sexual assault* is a term describing all forced or inappropriate sexual activity; the term encompasses a victim's inability to consent, physical/psychological coercion, and nonconsensual sexual contact, with or without penetration.[2] In the past 20 years, research has shown that sexual violence against females is perpetrated more often by acquaintances than by strangers.[3] Females are more likely to be victimized by a non-stranger than by a stranger in almost 70% of violent crimes.[4] As many as 75% of relationships *continue* post-assault when the perpetrator is someone known to the victim.[5]

Prevalence and context of adolescent acquaintance rape

One in 10 high school females is a victim of rape, and 1 in 4 young females reports being verbally or physically coerced into sexual acts.[6,7] A national survey of females who suffered one sexual assault showed that most of them knew their assailant: 30.4% of the assailants were intimate partners, 23.7% were family members, and 20% were acquaintances.[8]

According to a survey of students at 159 US high schools, 8.0% reported forced sexual intercourse.[9] Sexual victimization was significantly more common among African-American students versus Caucasian students, and among high school juniors and seniors versus underclassmen. With a survey response rate of only 67%, these statistics may be higher than reported.[9]

Livingston et al[10] interviewed a community sample of 319 women aged 18-30 years regarding their most recent unwanted sexual experience. Incidents were categorized as occurring during adolescence (ages 14-17) or adulthood (after age 18). Qualitative analysis was used to identify the contexts in which adolescent victimization occurred, as well as factors contributing to adolescent vulnerability. Four contexts in which adolescents were sexually victimized emerged: within intimate relationships, at parties/social gatherings, during an encounter with an authority figure, and while alone with a friend. Lack of experience with sex and dating, lack of guardianship, substance use, social and relationship concerns, and powerlessness contributed to adolescent vulnerability within these contexts.

Approaching victims of rape

If nurse practitioners suspect that an adolescent presenting for an office visit may have been the victim of a rape, recently or in the past, they must be able to approach the patient with competence and sensitivity. Each case is different; a continuum exists wherein some patients seek immediate care and others bury their trauma for years. The NP role in a nonacute situation is to support and advocate for the patient, provide appropriate treatment, establish a safe space, and, most important, respect the patient's wishes. NPs need not pry or request details of an assault that took place in the recent or distant past unless medically and legally necessary for documentation.* Instead, NPs need to validate victims' experiences and convey empathy.

> Providing an empathetic therapeutic environment free of prejudice regarding rape is essential.

More than half of female rape victims do not acknowledge the event or its consequences.[11] Victims who do not acknowledge the rape are more likely to have been romantically involved or at least acquainted with their perpetrator and view the experience as a miscommunication rather than rape.[11] This misperception on the victim's part demonstrates the importance of good history taking and of establishing a safe environment for discussion and disclosure.

Adolescents may not interpret acquaintance assault as rape because of a mismatch between the actual experience and their perceived rape script.[12] A *rape script*, or a patient's cognitive structure of rape, often involve strangers, violence, and severe bodily trauma; in reality, though, acquaintance rape may manifest quite differently.[12] Persons who do not initially view their experiences as an assault or rape are more likely to have delayed disclosure or nondisclosure.[13]

Understanding the psychological impact of rape

Providing an empathetic therapeutic environment free of prejudice regarding rape is essential.[14] After all, rape is an assault on the psyche as well as the body, often yielding self-devaluation and self-blame.[14] To gain control of the situation, some victims construe that they are responsible for the rape and are thus capable of preventing another rape from occurring.[15] Victims are more likely to continue a relationship with their perpetrator if they do not disclose their assault, which may yield further psychological distress.[5] When counseling females who remain in abusive relationships, NPs need to consider relationship characteristics such as commitment, satisfaction, investment, and quality of alternatives; however, first and foremost, they must consider the safety of the victim.[16] NPs need to explain to victims that

*Care of acute rape victims is usually undertaken by forensic or sexual assault nurse examiners and is beyond the scope of this article.

the rape is not their fault, that they did not encourage the assault, and that the only person responsible is the assailant.

A study of 265 women who reported unwanted sexual intercourse indicated that the traumatic impact of the experience was greatest for forcible rape victims, intermediate for incapacitated rape victims (ie, those who could not act or respond, often because of alcohol- or drug-related intoxication), and least for victims of verbal coercion.[17] Post-traumatic symptoms included stress, self-criticism, self-blame, hopelessness, helplessness, and preoccupation with danger. Even though many rape victims experience similar emotional reactions, there is no classic rape victim reaction, regardless of whether or not force, drugs/alcohol, and/or other forms of coercion are used.

Koss and Figueredo[18] assessed the psychological effects of rape in 59 female survivors over a 2-year period. Results demonstrated that self-blame was associated with psychosocial distress, and that a decrease in self-blame facilitated recovery. NPs must help patients build self-esteem and restructure their feelings of self-blame through education and validation.[18] Campbell[19] described rape victims who experienced a *secondary rape*—that is, a sense of being victimized a second time—while seeking medical, legal, and/or mental health assistance, leaving them feeling blamed and doubted and with unmet needs. In emergency departments (EDs), many rape victims report feeling bad about themselves, depressed, violated, distrustful, and reluctant to seek further help.[20]

Many rape victims do not receive comprehensive post-assault health services or have sufficient access to mental health practitioners. When NPs see these patients in their practice, they need to look for manifestations of sexual victimization and routinely assess their sense of safety and well-being. In many cases, referral to a mental health specialist is needed.

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Screening and physical examination

Nurse practitioners need to screen all adolescent patients for unacknowledged or unwanted sexual experiences, including those involving acquaintances. Patients may be more likely to disclose this information if NPs avoid terms such as *rape* and *sexual assault* and use the term *unwanted sexual experience* instead. A detailed violence and assault assessment is incorporated into every adolescent health encounter and reported in the record. Some patients may have greater ease in disclosing their assault if they are informed that other adolescents have had similar experiences.[21] Victims who delay disclosure are less likely to inform or seek help from healthcare practitioners. Nondisclosure is linked to depression, post-traumatic stress, and physical health complications.[13]

If a physical examination related to a very recent rape is needed, NPs must have the victim's consent before performing the examination and must know where to refer if police or forensic involvement is requested or required.[22] NPs must be aware of their state's regulations regarding forensic evidence, reporting to the police, and confidentiality requirements. In some states, patients can have a sexual assault forensic examination (SAFE) performed without police involvement; other states have a dual process. More information about the SAFE protocol is available at **www.ncjrs.gov/pdffiles1/ovw/241903.pdf**.[23] The forensic exam is completed by a person certified to perform it within 120 hours post-assault, although evidence may be found up to 7 days later.[2,24] Even if not certified as sexual assault nurse examiners, NPs must be familiar with physical findings and clinical manifestations suggesting that a sexual assault has occurred—especially when a patient has experienced such an assault but has not disclosed it despite the screening questions.

Swelling, erythema, abrasions, and bruising may be present after an acute genital trauma, although healing often occurs

within 48-72 hours.[22] In a retrospective review of 234 women aged 14-29 years who were examined within 72 hours of rape, genital injury occurred in 62.8% of cases.[25] Sixty-six percent of these injuries occurred in adolescents, with younger age associated with increased number of injuries, especially to the thighs, labia minora, periurethral area, fossa navicularis, and vagina. A substantial proportion of female rape victims have no signs of genital trauma, further supporting the necessity of assault screening.

Compared with older rape victims, adolescents have an increased risk of experiencing genital injuries. In this younger group, genital injury is most commonly seen at the cervix (26.6%), labia minora (15.7%), and posterior fourchette (15%) (*Table 1*).[25] Adolescents with deep vaginal lacerations can present with severe vaginal pain, prolonged or excessive bleeding, and hypovolemic shock. Hymenal injuries caused by forced penetration are usually seen in the posterior hymen between five and seven o'clock. If a patient suffers an acute event, a hymenal injury will likely heal quickly. However, if a patient is a victim of chronic abuse, the hymen will not fully heal, the tissue will be deficient, and the orifice to the vagina will likely be enlarged.[22] The acronym TRACS, often used by sexual assault forensic examiners, defines genital injuries caused by blunt force and stands for tears/tenderness, redness, abrasions, contusions, and swelling.[26]

Primary strategies for assessing genital trauma include direct visualization, staining techniques, and colposcopy. Staining with toluidine blue is helpful in forensic examinations because it adheres to lacerated skin and identifies more injuries than does direct visualization alone.[27] Colposcopy, which uses magnifying lenses and a light source to enhance digital or film images, is the gold standard for SAFEs.[23] Colposcopy is beneficial in magnifying genital and/or rectal injuries related to sexual assaults. To avoid false-positive results, the speculum is not inserted into the vagina until the toluidine blue staining and external genital examination have been completed.[24]

Table 1. Common areas of genital injury in adolescents post-sexual assault[25]

External genitalia	Internal genitalia
Labia majora	Cervix
Mons pubis	Fossa navicularis
Perineum	Hymen
Thigh	Labia minora
	Periurethral area
	Posterior fourchette
	Vagina
	Anus

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Sexual assault victims who have been orally, vaginally, or anally penetrated are offered prophylactic treatment for chlamydia, gonorrhea, trichomonas, bacterial vaginosis, and hepatitis B if they report the assault within 72 hours. Emergency contraception (EC) is offered to all victims of rape in which ejaculate came in contact with female genitalia. ECs can be taken within 120 hours of the assault, although they are most effective if taken within 72 hours.[28] *Table 2* lists recommended regimens for sexually transmitted infection (STI) prophylaxis and EC.[28-30]

Although HIV is rarely transmitted from a single sexual assault, HIV prophylaxis may be offered if a patient is identified as being at risk and if the mucosa of the oral, vaginal, and/or anal orifices were exposed.[2] Immunizations against other infectious diseases are assessed; assault victims are at risk for hepatitis B and human papillomavirus infections. Vaccines are offered to individuals who have not begun or completed their immunization schedules. The advantages of STI prophylaxis

Table 2. STI prophylaxis and emergency contraception regimens[28-30]

STI	Recommended regimen
Chlamydia trachomatis	Azithromycin 1 g orally (single dose) OR Doxycycline 100 mg orally twice daily x 7 days (if ≥8 years old and not pregnant)
Gonorrhea	Ceftriaxone 250 mg IM (single dose) PLUS Azithromycin 1 g orally (single dose) OR Doxycycline 100 mg orally twice daily for 7 days
Trichomonas spp and bacterial vaginosis	Metronidazole 2 g orally (single dose)
Hepatitis B	Immunize if patient is not fully immunized. Follow-up doses of hepatitis B vaccine 1-2 and 4-6 months after the initial dose.
Human papillomavirus	Immunize if patient is not fully immunized.
HIV	Assess risk for HIV infection. Consult specialist in HIV post-exposure prophylaxis. If patient is at risk, give antiretroviral prophylaxis for 3-7 days until follow-up appointment. Antibody testing at presentation, then 6, 12, and 24 weeks later.
Emergency contraception	**Recommended regimen**
Plan B	Levonorgestrel 0.75 mg orally, 2 tablets at the same time. Add antiemetic.
Oral contraceptive pills	OCs containing ethinyl estradiol 20 or 30 mcg plus levonorgestrel 0.1 or 0.15 mg or norgestrel 0.3 mg; 2 doses must be given 12 hours apart. Each dose should contain ≥100-120 mcg of ethinyl estradiol and 0.5-0.6 mg of levonorgestrel or 1 mg of norgestrel. Add antiemetic.
Antiemetic	Meclizine 25-50 mg, one dose by mouth prior to the first dose of OC

IM, intramuscularly; OC, oral contraceptive; STI, sexually transmitted infection.

are both reduction of transmission of infection and promotion of psychological comfort to the victim.[31] Once the severity of physical trauma is determined and STI screening performed, NPs can initiate appropriate treatment.

Treatment

Acute care for adolescent rape victims depends on the type of assault, injury severity, and time span between assault and treatment. Treatment of minor wounds, suturing of lacerations, administration of antibiotics for infection prophylaxis, and administration of analgesics for pain secondary to genital injury may be necessary. Severe injury requires referral to a gynecology specialist. To help patients deal with emotional trauma, referral to a counselor or sexual assault center is beneficial. Victims may have difficulty coping if they see their perpetrator every day in school or at work. Support groups can help in recovery by fostering a sense of belonging.[21]

Follow-up care consists of a visit 1 week following the initial presentation.[2] NPs ascertain whether physical injuries are healing, discuss the patient's psychological status, and determine whether counseling has been initiated. A pregnancy test can be performed 2 weeks post-assault. Mental health status and coping strategies are assessed at subsequent follow-up visits. Follow-up STI testing, along with completion of vaccinations, is provided as needed.[2]

Straight and Heaton[31] reviewed ED care of sexual assault victims to determine whether screening, treatment, and follow-up care complied with national treatment guidelines. The study analyzed 251,762 ED visits for sexual assault or sexual molestation of children and adults. Nearly 80% of the victims received insufficient care. Only 6.7% received appropriate antibiotic prophylaxis according to Centers for Disease Control and Prevention recommendations, 50.2% of victims had cultures performed, and 36.7% of victims aged ≥12 years underwent pregnancy testing. Thirteen percent of victims received HIV serology testing and 8.9% of females aged

≥12 years were provided with EC. These results suggested that national guidelines are not being followed and that further teaching to practitioners caring for adolescents is critical.

Anticipatory guidance and prevention

Nurse practitioners play an essential role in rape prevention and education. Adolescents must be taught about the prevalence of sexual assault and how to seek healthcare if they are hurt. NPs need to help adolescents identify unsafe situations, including attending parties with guests they do not know, having in-person contact with people they meet on the Internet, and using drugs and alcohol.[2] Adolescents are advised to abstain from drinking or at least manage their alcohol intake, not to drink from an unattended cup, never to accept drinks from strangers, and to *buddy up*.[2] However, buddying up is not always safe; a buddy can become a perpetrator.

Additional high-risk situations include use of recreational drugs that impair judgment, a prior history of sexual victimization, and certain sexual role beliefs (eg, persons who pay for dates have the right to expect sex).[1] These situations do not place blame on victims of rape—the perpetrator is the only person at fault—but they teach adolescents to be aware. NPs need to convey the idea that rape occurs not only in high-risk situations; adolescents can be raped in their own home, a friend's home, school, or another place where they feel safe. NPs need to heighten adolescents' awareness of the signs of physical, sexual, and psychological violence in a relationship, and the rights that individuals always have within intimate experiences.[32]

Table 3. Sample sexual violence assessment questions and discussion topics[32]

- Do you feel safe at home?
- Tell me about a time when you felt unsafe in your relationship(s).
- Do you feel safe with your friends?
- Do you feel safe at school?
- Do you feel safe at your job?
- Do you feel safe at parties?
- In the past year, did your boyfriend or girlfriend do anything physically to you that made you feel uneasy or uncomfortable?
- Have you ever been threatened with violence?
- Have you ever been forced to have sex?

> NPs need to dispel myths about acquaintance rape, including that it is the victim's fault.

At all adolescent well visits, a complete sexual history is obtained *without* a parent or guardian in the room. NPs explain to patients that disclosure of information remains confidential. NPs ask about patients' age at first sexual encounter, their sense of gender roles, whether they have had any unwanted or forced sexual experiences, and whether they have used the Internet to search for sexual or romantic partners.[2] NPs may ask directive questions such as "In the past year, has your boyfriend done anything to you physically that made you feel uncomfortable or uneasy?" or "Did you ever feel unsafe in your relationship?" (*Table 3*).[32] These questions are likely to provoke discussion and prevention efforts. NPs need to dispel myths about acquaintance rape, including that it is the victim's fault. If NPs replace myths about rape with facts, patients may be more likely to discuss their experiences.

Research has shown that adolescents benefit from dating violence prevention programs that address sexual harassment, abusive behavior, and bullying, and that teach skills regarding problem solving, anger/conflict management, assertiveness, relationship building, and listening and communication.[32] In addition, these programs teach adolescents about their rights regarding their body and behavior. They must never feel pressured or forced to engage in activities that seem inappropriate or that

Table 4. National advocacy organizations[32]

Organization	Website
National Center for Victims of Crime	www.ncvc.org
National Organization for the Prevention of Rape and Assault, Inc.	www.nopra.org
Rape, Abuse & Incest National Network	www.rainn.org
The National Teen Dating Abuse Hotline	www.loveisrespect.org
American Academy of Experts in Traumatic Stress	www.aaets.org
The National Child Traumatic Stress Network	www.nctsnet.org
National Sexual Violence Resource Center	www.nsvrc.org
Network of Victim Assistance	www.novabucks.org
National Center on Domestic and Sexual Violence	www.ncdsv.org

would make them feel uncomfortable. Many adolescents have difficulty saying no if another person is intimidating them because of his or her physical size or verbal or physical coercion, which is why assertiveness, communication, and listening skills are important to strengthen. Furthermore, NPs need to discuss *healthy* relationships so that adolescents can recognize *red flags* or unsafe situations. Education regarding sexual scripts is provided so that adolescents understand what constitutes acceptable sexual behavior versus forced sex or sexual coercion. NPs need to educate adolescents at an early stage in order to prevent sexually coercive behavior.[33]

Parents, oftentimes the first to recognize signs of dating violence, must be educated on where to seek help if needed. Patients who know that their practitioner is trustworthy are more likely to seek help. NPs need to be aware of their community resources and refer patients to reliable Internet sources (*Table 4*), educational materials, hotlines, shelters, and legal assistance regarding adolescent acquaintance rape.[32]

Conclusion

Nurse practitioners must keep up to date regarding current national guidelines for the care of adolescent rape victims, including methods of forensic testing, STI treatments, and EC options. NPs need to be cognizant of community resources and make appropriate referrals.[24] NPs must know how to approach rape victims, the psychological impact of acquaintance rape, and how to provide acute and follow-up care and anticipatory and preventive guidance. The NP visit can provide a safe, confidential space for victims to disclose information, seek treatment, and learn about the prevention of sexual violence. It is through relationships with empathetic, supportive, and devoted practitioners that teenage survivors of rape can receive appropriate health services and initiate their journey toward recovery.

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