

# **ADOLESCENT SEXUAL DEVELOPMENT AND SEXUALITY**

## **Assessment and Interventions**

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# Chapter 14

## Adolescents and Nonconsensual Sex

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*"I know my head isn't screwed on straight. I want to confess everything, hand over the guilt and mistake and anger to someone else. There is a beast in my gut, I can hear it scraping away at the inside of my ribs. Even if I dump the memory, it will stay with me, staining me. My closet is a good thing, a quiet place that helps me hold these thoughts inside my head where no one can hear them."*

—From *Speak*, by Laurie Halse Anderson

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### INTRODUCTION

Maybe her mother forbade her to go to the party.  
Maybe she had a beer. Maybe she had two. Either way, if her mother finds out, she's dead.  
Maybe she flirted with him all week at school. Maybe she went to the party just to see him.

Maybe she flirted, went to the party against her mother's wishes, and drank beer.

And now, fuzzy from her drink and confused from her struggle, completely conflicted about her decisions, she has also been forced into a sexual situation, which she never wanted. She just wanted to kiss him. She told him to stop. She did not want to have sex with him. She did not want this to happen, not physically, not emotionally.

She goes to the bathroom and worries about what she sees in her underwear. She does not take birth control; she never wanted to have sex. Condom? She does not remember feeling one, does not remember him stopping to put one on. No condom. Her mind starts going through lists of sexually transmitted diseases. She does not want to have to confront this. Not physically, not emotionally. Who can she talk to about this? Her friends? They might tell her to call the police, but the police will call her parents, won't they? Her mom cannot find out about this. Or maybe her friends will tell her the same thing happened to them. Maybe they will tell her she's lucky she got to have sex. Maybe they will call her a slut. Maybe they will tell her to forget about it. But she cannot forget. She relives that party when she tries to go to sleep. She feels guilty, she feels angry. She feels raped. She thinks. She thinks that's what it was. She thinks it was rape.

A woman has a four times greater chance of being raped by someone she knows than by a stranger.

A woman has a four times greater chance of feeling forced into a sexual situation by someone she knows than by a stranger.

Many would say these sentences state the same facts. Many would say they do not. This is a pivotal discrepancy, a discrepancy that leads to awkward and misleading definitions of the problem. For example, an on-line fact sheet on the relationship between alcohol and acquaintance rape begins as follows:

Researchers have used a variety of definitions of rape, sexual assault, and sexual violence. A common definition of the terms follows: "In this report, rape means forced or coerced penetration—vaginal, anal, or oral; 'sexual assault' means other forced or coerced sexual acts not involving penetration; and 'sexual violence' includes both rape and sexual assault." [Crowell & Burgess, 1996, p. 13] Other authors may define sexual assault more broadly to include rape (penetration) as well as other forced sexual acts. ("Alcohol and rape/sexual assault: Fact sheet," 1998)

Such prefaces completely distract readers from the truths contained in the two statistical sentences; such attempts at definition make it difficult to carry out a productive discussion about acquaintance rape. As a specific act, acquaintance

rape is not definable, which *explains* why the discussion of acquaintance rape, especially acquaintance rape among teenagers, too often dissolves into arguments of definition and semantics that collide head on with statistics. As Edward Laumann (1996) frames the predicament, if 22 percent of women say they were forced to do something sexual that they did not want to do but only 3 percent of men said they forced a sexual act, “doesn’t that mean someone is lying?” (p. xvi). No, no one is lying.

“They are both telling the truth as they understand it,” Laumann writes. What the actual experience was, or which words those not involved choose to describe the experience, does not matter. The experience of rape or forced sex or coerced sexual activity has a profound effect on people’s lives. That is what matters. Regardless of what a court might label the experience, what a girlfriend or boyfriend might call the act, regardless of the words a University Board of Regents or a high school social worker might choose to describe the experience, the unwanted sexual act can affect the rest of the lives of the young women and men involved. A look at statistics reveals that unwanted sexual acts between teenagers affect a profound number of young lives:

- 32 percent of sexual assaults occur among victims between the ages of 11 and 17 (O’Sullivan, 1991).
- Dating violence affects at least 1 in 10 teen couples and is one of the major sources of violence in teen life (Levy, 1991).
- One in five young women in college report being forced to have sexual intercourse (National Center for Chronic Disease Prevention and Health Promotion, 1995).
- In a study of 769 male students, grades 7–12 in rural Wisconsin, 52 percent reported engaging in sexually aggressive behavior. 24 percent engaged in the unwanted sexual touch of another teen; 15 percent engaged in sexual coercion (such as lying) to initiate sexual activity; and 14 percent engaged in assault behavior (use of physical force, threats of physical force, or using alcohol to gain sexual activity) (Kerns, 1994).
- According to a 1995 survey of nearly 2,000 eighth- and ninth-grade boys, more than one in four boys agreed that girls who get drunk at parties to on dates “deserves what happens to them” (American Medical Association, 1997).
- This same survey found that almost half of the boys felt that rape was sometimes the victim’s fault, and more than a third of the boys surveyed thought they would not be arrested if they forced a date to have sex. Moreover, nearly 40 percent of the boys in this survey agreed with the statement that if a girl goes into the bedroom on a date, she wants to have sex; more than 7 percent thought that it was okay

for a boy to force a girl to have sex if the girl got him sexually excited (American Medical Association, 1997).

- In their research on designing peer education to reduce sexual violence among teens, Simon and Golden (1996) found between 12 percent and 35 percent of teenagers have experienced violence within a dating relationship, including pushing, shoving, and hitting.
- In a survey of high school students, 56 percent of the girls and 76 percent of the boys believed forced sex was acceptable under some circumstances (White & Humphrey, 1991).
- In White and Humphrey's 1991 survey of 11- to 14-year-olds, 51 percent of the boys and 41 percent of the girls said forced sex was acceptable if the boy spent a lot of money on the girl.
- This same study found that 65 percent of the boys and 47 percent of the girls said it was acceptable for a boy to rape a girl if the two had been dating for more than six months (White & Humphrey, 1991).

## **THE CAUSES OF THE PROBLEM**

Clearly, adolescent sexual assault exists as a widespread, pervasive, and persistent problem. Whereas finding a solution to this problem proves quite complicated, searching for the causes of this problem poses little challenge. Confronting issues of sex, gender, consent, and coercion is a primary developmental undertaking of adolescence. Dating, winning the attention of a romantic partner, inevitably involves issues of power and control. When one partner in a relationship feels out of control or at risk of becoming disempowered in a relationship, issues of physical and mental abuse enter the picture. Practically all the research on adolescent sexual assault acknowledges that constant barrages of sex from the media coupled with peer pressure inextricably complicate this task. It becomes nearly impossible for a teenager to recognize sexual coercion within a society that constantly normalizes coercive sexual attitudes and behaviors in the popular media (Pacifi, Stoolmiller, & Nelson, 2002). This lack of recognition is problematic. Indeed, much of the criticism of the most indisputable studies on sexual assault hinge on the fact that women who survive acquaintance rape often do not recognize it as such. Following her initial studies and in the wake of such criticism, Mary Koss published follow-up studies that explored the fact that in her initial college campus studies, of the women who had reported surviving acts that qualified legally as rape, 11 percent did not feel victimized, and 49 percent thought what had happened to them was a form of miscommunication (Koss, Dinero, & Seibel, 1988).

Therefore, adolescent sociologists have long recognized the predicament posed by peer pressure as it relates to sexual assault, and researchers have long blamed the media for perpetuating dangerous gender stereotypes. However,

understanding these causative factors has not helped educators, the legal system, or society in general combat the widespread problem of acquaintance rape among adolescents, which has forced researchers to explore the interactions of these elements and search for solutions to this social epidemic on a more individual basis.

## **SEARCHING FOR SOLUTIONS**

Steven Brown, a clinical psychologist and sex educator, studies gender stereotypes in society and the influence of peer groups. He tries to deconstruct how these elements operate at the individual level to fuel sexual coercion among adolescents in the United States. Brown specifically looks at levels of psychological and social factors that fuel adolescent relationship violence (Heise, Moore, & Toubia, 1995). First there is the individual adolescent's past experience that might contribute to the current situation (i.e., a history of childhood abuse or family violence). Second is the immediate context of a specific assault; the presences of drugs or alcohol as a factor or if there were other teens urging on the assault. Third, Brown explores how the immediate context relates to peer pressure on a broader level, including other "informal social structures": popularity, social cliques, and the often delicate choreography adolescents must maneuver to feel accepted by their peers. Fourth, Brown addresses the larger issues: cultural values, beliefs, and power structures, all of which foster sexual coercion through the forces that operate on the first three levels. At this macrolevel, Brown makes powerful observations about deeply ingrained social norms. These norms lie at the heart of the power issues underlying adolescent acquaintance rape, and therefore they serve as a launching point for the rest of his work, which deserves further examination (Heise et al., 1995).

### **Addressing Cultural Norms**

Brown begins with the idea that in the United States, men are expected to be strong, brave, and self-reliant. In addition, men are portrayed as emotionless but aggressive and competitive. He goes on to point out that in a society still riddled with homophobia, breaking this male code of conduct comes at the risk of being labeled gay and being socially rejected at a painful level. Brown specifies an array to sexual attitudes that go along with this code of conduct. From talking directly with teenage boys, Brown found that the boys believed:

- Men are not supposed to be a virgins.
- Sexual conquest is a means to manhood.
- Having sex is easier than talking about it.
- Boys should initiate sex.
- When a girl says "no," she really means "maybe" or "yes." Girls want to be convinced and will even struggle a little.

- If a guy is persistent and persuasive, the girl will eventually fall into his arms and be glad she did.
- Even if a girl doesn't want to have sex, she can't really feel that bad.
- Once aroused, a man can't be controlled (Heise et al., 1995).

Brown's research also looks at cultural norms of acceptable female behavior and its influence on the dynamics of acquaintance rape. He states that boys and girls are not supposed to admit to wanting sex. The American "sexual script" says that girls say "no" even when they mean "yes," which gives boys the perfect excuse to ignore them. Brown goes on to emphasize that although mixed messages do not justify coercion, young women will never be able to say no until they are able to say yes; in other words, Brown argues, when young women are empowered to say yes to sex and mean it, they will find themselves more able to avoid sexually coercive situations. Until then, research will continue to show young women having sex that they do not want have. The 1992 National Health and Social Life Survey (NHSLs) results illustrate this point perfectly. This study found that 25 percent of women they surveyed said that their first sex was not wanted and that they were reluctant to have it. For girls under age 15, fully half said they were reluctant to have sex. Those who were not forced offer various reasons for going along with the sexual act: peer pressure, curiosity, being under the influence of alcohol or drugs (Laumann, Michaels, Gagnon, & Michaels, 1992). Research conducted by Moore and Rosenthal (1992) resonates this sentiment and perhaps frames it in terms even more easy to apply to the current situation in the United States. Moore and Rosenthal found that of young men and women of the same age, girls were three times as likely to report feeling guilty after their last sexual encounter, compared with boys. Girls were four times as likely to feel worried and ten times as likely to feel used.

Brown illustrates how for teenage boys and girls the benefits of approval from peers often far outweigh the hypothetical risk of getting accused of rape. Fearful that one false move with a girl will earn them outcast status; teenage boys do not think about consent in sexual situations; they think about conquering. Moreover, looking at peer pressure among the young women who survive assaults by these boys, Brown suggests that for girls, having boyfriends and being popular with their friends outweighs the risk of putting themselves in situations where date rape is possible. These pervasive traditional sex role attitudes and behaviors are still present, despite all the efforts of the women's movement.

### **The Context of Sexual Assault**

The next level in Brown's model, the immediate context of an assault, specifically with regard to drug and alcohol involvement, does not need much illustration. It is inarguable that drugs and alcohol play a large role in the life of the American adolescent, and research shows that alcohol or drugs are involved



in 66 percent of acquaintance rape cases (Kanin, 1984). In Mary Koss's more recent collaborative work, she has explored alcohol's involvement in acquaintance rape on college campuses further, and her research most likely applies to younger adolescents as well. This work on college-age women shows that the women understand that alcohol use decreases the likelihood a rape complaint will be taken seriously and makes it less likely that they could successfully escape a potential rape (Ullman, Karabatsos, & Koss, 1999). However, these women continue to use alcohol as an effective tool to reduce social tension, allowing them to act sexual in social situations. By doing so, however, they put themselves at risk. Companion studies on college-age men show that they interpret any drinking at all, and especially excessive drinking, as a signal of sexual availability which may override women's verbal statements or as signs of a less desirable reputation that may justify sexual assault, and as a means of facilitating "seduction" (Harrington & Leitenberg, 1994). If these are the beliefs of older, college-educated young men and women, it is easy to see where a girl in her early teens, insecure at a party or in a sexual situation, would use alcohol to feel less inhibited, and in doing so would send a message to her teenage partner that she had done so to allow him free sexual reign.

### **Impact of Personal History**

This, mixed with peer pressure and overwhelming societal gender stereotypes leaves us at the at the primary level of Brown's model where he relates adolescent acquaintance rape to individual adolescents' histories. Brown looks at sexual or physical abuse, and at the lack of positive personal role models in teenager's lives and explains that without practical, "realistic modeling of what it means to be male," teenage boys base their behavior on what they have at their disposal—exaggerated, misogynistic models of maleness. He also cites a complete absence of information on sexuality or healthy male/female relationships in the U.S. school system.

Brown's model succeeds at breaking down the obvious factors contributing to adolescent sexual assault, thereby revealing a more nuanced understanding that should lie at the foundation of any proposed solutions. However, the model leaves adolescents in a quandary. It suggests no easy answers. The young men continue on, largely unaware that their behavior constitutes coercion and rape. And the young women, without an accepted title for their experience, and amid constant broadcasting of conflicting messages about their sexuality, find themselves at the bottom of a heavy, nearly impenetrable pile-up of chaos and insecurity. This in and of itself seems overwhelming.

But extract from this big, sociocultural picture one real-life situation, and the confusion actually worsens. Recall all the strikes against the young woman in the introduction talking to her mother about her assault—she had gone to a party against her mother's wishes, she had been drinking, she had behaved like a teenager. Besides the sociocultural factors complicating their situation, the ado-

lescent survivor often has to factor in other “normal” elements of teenage life that make her feel completely unable to confront, let alone report, her experience. The research confirms that compared to survivors of stranger rape, acquaintance rape victims are less likely to seek crisis services, to tell someone, or to report to police. They are also less likely to seek medical care or counseling:

Acquaintance rape victims feel particularly vulnerable and unsafe, since they have found that even people they trusted may commit an act of violence against them. Family and friends may not be a source of support for acquaintance rape victims, as they may be for victims of stranger rape. If they tell friends or family, the severity of the attack may be minimized, or the victim may be blamed for the rape. (Illinois Coalition Against Sexual Assault, 2003)

Lack of support and reluctance to report sexual assault compounds the problem of acquaintance rape prevention and treatment. Most survivors do tell one other person (Wiehe & Richards, 1995). This person is usually a close friend. In the same study, many fewer victims reported the sexual assault to the police (28 percent). However, when it comes to prosecution, the percentage drops even lower (20 percent). In the 1988 study by Mary Koss, only 2 percent reported the assault to police.

Self-blame and self-doubt form the heart of the large body of serious long-term psychological effects of acquaintance rape, especially for teenagers. There is guilt about being in the wrong place at the wrong time, about being curious about sex, maybe even having had sexual relations in the past with the person who this time became an assailant.

And then there is fear of the law. This fear is multilayered. First of all, most adolescents do not know their rights regarding the law, nor do most people in law enforcement or in medical settings. Therefore, even in states where it is illegal for law enforcement or medical personnel to report the assault of an adolescent to parents, many police and crisis workers will do so thinking they are acting in the best interest of the survivor. While parental support is always desired, and while both health-care providers and law enforcement should always try to explore teenager’s fears of reporting an assault to their parents, ultimately, the adolescent herself is best able to determine what is safe for her. Because historically, law enforcement and health care have not respected adolescent’s wishes regarding involving parents, a young woman’s determination not to let her parents know about an assault often convinces her not to seek further help.

### **Complications of Reporting**

On the next level, when an adolescent considers reporting sexual assault by another adolescent, she confronts more social complications and implications. The young woman may see herself as “turning in” her classmate to the police.

If it was her boyfriend who raped her, she is potentially reporting her closest emotional connection to police. If the young man who raped her is in a gang, or even a tight social group in a socially divided school, the young woman may find herself isolated from her own friends, or with a large group of classmates who have turned against her. As the New York State Coalition Against Sexual Assault (NYSCASA, 1998b) report points out, beyond retaliation, there may be cultural factors such as being afraid to turn in a friend or being ashamed.

Again, as in the case of telling parents, there is also fear that when reporting a sexual assault to police, a young woman will somehow implicate herself as guilty. For example, if the young woman is under the drinking age and alcohol was a factor (as it is in 66 percent of acquaintance rapes), she may fear that the police will not take her report. Or, when reporting, she may leave out important parts of her history—having had sex with her acquaintance in the past, for example—for fear the police will not believe she was assaulted. According to statistics cited in a 1993 U.S. Senate Judiciary Committee staff survey of state criminal justice agencies, “a prior relationship between the victim and the offender is the most common factor which prevents cases from going forward” (p. 32). Police and prosecutors without special training often share stereotypical views about the seductiveness of young women and fail to pursue charges (New York State Coalition Against Sexual Assault, 1998a).

The NYSCASA further explores the issue of young women purposefully deleting parts of their story for fear or how police will judge them. The report concludes that the consequences are sometimes serious:

Incomplete victim statements, frustrated authorities and young women who would rather forget about the whole experience than work with authorities to hold offenders accountable for their behaviors . . . This (leads to) the lingering assumption that her report is a fabrication or full of exaggeration, that she is trying to cover up misbehavior or get back at a boyfriend, that the assault never happened or she consented. (New York State Coalition Against Sexual Assault, 1998b)

Whether assaulted by force or threat of force, whether they were intoxicated or not, few women label their experience rape (Schwartz & Leggett, 1999). When officers of the law are unsympathetic to a young victim’s uncertainty, they communicate an entire system’s unwillingness to take significant action.

## **ISSUES IN THE HEALTH CARE ARENA**

This same climate of fear and apprehension exist for the adolescent sexual assault survivor when she enters the health care arena. Reporting sexual assault to a health provider results in a complicated and potentially retraumatizing situation. Once again, although some states do allow adolescents to consent to their

own health care, many do not, meaning that the adolescent's fear of parent involvement is real. Pursuing medical care becomes even more complicated for adolescents without insurance, or for whom the price of health care has made the system unapproachable in the past. Then we are confronted with the fact that sexual assault or rape, be it stranger or acquaintance, tips off a long, involved chain of events in a medical setting. Rape is a crime, and there are laws governing the medical treatment of a rape survivor. Fortunately, an increasing number of medical facilities require practitioners administering rape examinations to receive proper training and certification as Sexual Assault Forensic Examiners, thus ensuring that health providers working with survivors of sexual assault receive education in the medical, legal, and psychological aspects of rape. However, without a properly trained examiner and an advocate or counselors, the medical system can easily overwhelm a survivor. Rape kits—the medical/forensic examination that has been designed to yield evidence with the potential of identifying a rapist—have agendas of their own. Although patients may choose which parts of the exam they do and do not want conducted, without a properly trained advocate, and without the guidance of a specially trained Sexual Assault Forensic Examiner, sometimes choices become blurred. The post-sexual assault examination raises questions about pregnancy and offers survivors emergency contraception, a complicated idea for an adolescent who may not have a substantial sexual education. The examination also forces survivors to confront the idea that they may have been exposed to several sexually transmitted infections, including HIV, which leads to having to make decisions regarding potentially difficult treatment options for prophylaxis. All this information, all this physical poking and prodding, comes on the heels of an emotionally confusing and potentially devastating experience. And it takes time. For the teenager who does not want her parents to find out, trying to find a way to obtain medical care and counseling and still be home after school becomes a nearly impossible task.

Thus most adolescent acquaintance rape goes unreported to police, hospitals, and/or counselors.

## **PSYCHOLOGICAL CONSEQUENCES AND RISKY HEALTH BEHAVIORS**

From the limited research on women who have reported acquaintance rape, psychologists have found that these young women endure similar levels of depression, anxiety, complications in subsequent relationships, and difficulty attaining prerape levels of sexual satisfaction to those of survivors of stranger rape (Koss & Dinero, 1988). Research has also confirmed links between adolescent acquaintance rape and risky health behaviors, including drinking, smoking, drug use, lack of condom use, and eating disorders. (Brenner, McMahon, & Douglas, 1999). In Koss's study of college women, she noted that whether they had acknowledged their experience as a rape or not, 30 percent of the

women identified as rape victims contemplated suicide after the incident, and 82 percent of the victims said that the experience had permanently changed them.

One of the most serious consequences which can develop as the result of acquaintance rape is posttraumatic stress disorder (PTSD). In fact, some believe sexual assault is the most common cause of PTSD in women (Curtis, 1997). *Diagnostic and Statistical Manual of Mental Disorders-IV-TR* (American Psychiatric Association, 2000) defines PTSD as “the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity” (p. 463). To assign a diagnosis of PTSD, an adolescent’s immediate response to an acquaintance rape would include intense fear and helplessness. She might go through mood swings and experience nightmares or flashbacks, eating or sleeping disturbances, recurrent nausea or pain, self-blame, and suicidal thoughts. Most likely, however, none of these symptoms will be recognized as PTSD, as the young woman will most likely never report her assault.

## **THE FAR-REACHING PROBLEM OF ADOLESCENT AND ACQUAINTANCE RAPE**

Adolescent acquaintance rape is a problem of epidemic proportions that has causal factors embedded on a societal and a personal level. It is a problem that the current judicial system cannot adequately address. It is a problem that often goes ignored by the current medical and mental health care systems. It is a huge problem with long-lasting effects for its survivors. When taking all this in at once, it starts to feel as if the only way to truly help survivors would be to somehow miraculously jump in and intercede before the assault takes place. However, this is not the case. Plenty of research exists that helps explain why adolescent sexual assault has grown, or been revealed, as such a far-reaching problem. This research, when carefully synthesized, lays the groundwork to develop effective preventive interventions. As this happens, ideas of how to better help survivors avoid long-term pain will also emerge. This work has already begun. Mary Koss (1999) states that working together, multidisciplinary teams of medical, legal, media, and education experts will pave the way to prevent adolescent acquaintance rape, better screen and treat survivors, and provide effective long-term care. In doing so, these teams will pave the way for many more adolescents to lead violence free, healthy, fulfilling lives.

## **ASSESSING AND EVALUATING ADOLESCENT SURVIVORS OF SEXUAL ASSAULT**

Before the advent of Sexual Assault Nurse/Forensic Examiner programs, the sexual assault medical examination was an emergency room “hot potato.”

No one wanted to assume responsibility for the young survivor's care. The adolescent sexual assault survivor entered the emergency room, which may not have had a coordinated sexual assault program, and the scene was much as we would imagine it. No one wanted the sexual assault case.

Although it seems that staff are uncaring, that is not generally the case. The sexual assault examination is difficult, time-consuming, and challenging to the clinician who is not educationally prepared. Attending physicians may not want their untrained residents to do the examination, because it will prove frustrating for the physician and traumatizing for the survivor and put the hospital at legal liability if evidence is incorrectly collected. It would typically take at least an hour just to coordinate a doctor and a nurse who were comfortable with the examination and maybe up to another hour by the time a sexual assault advocate could be contacted and the single on-call emergency room social worker could get to the patient. Thus the patient effectively waits several hours even before receiving counseling regarding the details of the examination.

When done correctly and compassionately, the assessment and evaluation for sexual assault require that a practitioner create a workable environment for both the patient and practitioner in the midst of a traumatic event.

The examination involves explaining points of law and requires obtaining consent a number of times: for treatment, for evidence collection, for photographs, and for medication. Now consider this scenario combined with the fact that behind the examination room door sits a 15-year-old girl who is about to have her first pelvic examination, has been drinking for perhaps the first time in her life, and has just had sex for the first time in her life—against her will—and we have a scene that is beyond a “hot potato” for an untrained practitioner. A trained health provider has the opportunity to be a positive and vital force in helping the survivor sort out what has happened to her and to begin recovery.

The purpose of the assessment and evaluation examination for sexual assault is twofold. First and foremost, the purpose of the examination is to stabilize and ensure the best health outcome for the survivor, physically and mentally. Second, in cases in which a survivor decides at the time of examination or sometime after to take legal action against the assailant, the purpose of the examination also includes collecting evidence from the crime scene, which is the survivor's body. Based on the survivor's report of what types of sexual acts were involved, the forensic examination will incorporate collecting samples and swabs of fluids from the survivor's body which can be used to establish that sexual activity occurred, identify who committed the sexual act, and establish whether the sexual act produced physical injuries consistent with forced sex. These assessment and forensic tasks need to be achieved simultaneously.

Adolescents have the highest rates of rape of any age group, accounting for 32 percent of all sexual assault victims (Rennison, 1999). Working with adolescents can be both frustrating and fascinating because they are at a unique stage

in their life. Developmentally, they are struggling to find independence and individualization and experimenting in all aspects of their lives. They may be breaking curfews and drinking and lying to their parents, or they might be acting as a primary caretaker for their younger siblings and working a part-time job. They might have been sexually active since the age of 12 or they may be 16 years old and just beginning to be interested in a sexual relationship. They are wholly unpredictable. Which makes them wholly fascinating, special, and yet potentially difficult to provide quality care to, especially for someone who is not used to taking care of adolescents. Not many health care providers are comfortable taking care of adolescents. In fact, 80 percent of teenagers see a doctor for fifteen minutes or less a year (Brenna, 1999). There are not many providers who can approach a discussion about sexual matters and risk prevention in a fifteen-minute period of time at a yearly health screening, and therefore not many providers are comfortable talking to teenagers about sex. Access to health care for adolescents who have experienced sexual assault is vital. Making it clear to them that there are health providers out there with experience working with young adults who have been sexually assaulted is crucial. Education is the first step. The only way to gain that experience is to attend a sexual assault examiner educational program and then “jump into” the examinations as carefully and respectfully as possible. The next step after gaining adequate experience is to never let the medical examination for a sexual assault become “routine.” Once practitioners learn to deal with the emotional issues involved for adolescents following sexual assault, it is easy to lose sight that these issues are as emotionally charged for each survivor as they were for the examiner the first time. Examiners must stay in tune to the moment and remember that with adolescents, they have to use care not to use leading statements. The examiner may think he or she knows what happened next or why but it is crucial to let adolescents offer their narrative. It is the only validation these adolescents will have in the process.

What makes the assessment and evaluation of a sexually assaulted adolescent unique for a health provider? I will not speak as much to the differences point by point between an adult examination and adolescent examination and a child examination but to the overarching issues that guide intervention with adolescents.

The best way to organize the assessment process with an adolescent survivor of sexual assault is to frame the entire procedure as a balance between the survivor’s questions, priorities, and medical requirements and the examiner’s questions, priorities, and medical knowledge (see Appendix 14.1 at the end of this chapter). At some point we need to recognize that the adolescent who seeks out medical attention wants what is best for him- or herself, and the health care practitioner clearly wants that as well. However, what a provider might think most important at a given time for a given survivor might not be what is most important on the survivor’s mind. Unless the provider can reconcile those concerns, neither patient nor provider will leave the examination satisfied that the best care

has been given or received. In fact, the questions, concerns, and worries of the adolescent sexual assault survivor are often interpreted by the practitioner as barriers to providing good care. We know it is important to listen to survivors' concerns and answer their questions, but as practitioners, we often have our own agenda—a complicated rape examination and evidence collection and the need to get it “right” per forensic protocol. Yet it is paramount to gain insight into the wishes, needs, and desires of the adolescent sexual assault survivor and how to approach the medical examination. It is the wishes, needs, and desires that must lay a foundation for care rather than create a barrier between the examiner and his or her adolescent patient.

## **TWO CASE STUDIES**

### **Sexual Assault and the Risk of HIV**

A 16-year-old presents to the walk-in system at a local adolescent health center on a busy Monday. She is there to get the morning-after pill, and has been waiting to be seen for nearly three hours. On interview, she is upset from the long wait. She just got a new babysitting job and has to be at work in thirty minutes. She reports that she and her boyfriend of several weeks had unprotected sex two nights in a row, Friday night and Saturday night. She says that her last period started twelve days ago. Per protocol, the triage nurse asks her if she wanted to be having sex or if the sex was forced. She states two nights ago, the sex they had was consensual. But yesterday she and her 19-year-old boyfriend had a huge argument while she was at his apartment. She said the fight became physical and the boyfriend pushed her down and put a sock in her mouth and had sex with her. She said they were fighting because her friends at school said he had been sleeping with another woman. She said he has always refused to use condoms and is sure he did not use condoms when he slept with other people. She says this is the first time he had forced her to have sex, and that the couple had only had consensual sex a few times before this.

What are the adolescent's concerns, both expressed and implied?

- From her perspective, her first and foremost worries are getting pregnant and getting to work on time.

What are the provider's concerns?

- The provider's concerns are quite different. Concern for the teen's safety and other injuries—if he shoved a sock in her mouth, it is possible there might be more injuries.
- The clinician is also mindful that time be used efficiently to address the distress she is experiencing, most likely the pregnancy issue.
- The clinician will also clarify that this sexual encounter was not want-



ed, nonconsensual, and, in fact, a sexual assault—what happened to the young woman is a crime and a serious medical issue. She also needs to know that no matter what she tells the clinician, the clinician will not call the police.

- The clinician must reassure her that the only way the law will become involved is if she wants to report her boyfriend.
- The clinician must clarify that when boyfriends rape their girlfriends, it is a difficult issue. Although it might seem difficult to think of it as rape, because they have had consensual sex in the past, it is. He physically forced her this time, and that is a crime.
- The clinician must tell the young woman she does not need to decide right now about pressing charges, but that he or she, as a health care professional, has to inform her of her health care and legal rights.
- The clinician must tell her that if she does decide now or sometime in the future to press charges against her boyfriend, it would be to her advantage to have a medical examination for rape completed.
- The clinician must tell her the best time to do the exam is within seventy-two hours after the assault in order for reliable evidence if the case goes to court. The assault was Saturday night; this adolescent still has another twenty-four hours, but the earlier the examination is done the better for both evidence and for her health.
- Most important, the clinician must tell the young woman what an achievement it is that she brought herself to the clinic; she was courageous, and she did the right thing when she sought out emergency contraception.

Thus, the survivor is worried about getting pregnant and getting to work on time, but the provider has at least five times those concerns. How can we reconcile those differences?

It was fifteen minutes before the young woman needed to leave for work, and she had decided she absolutely could not be late. What are the priorities? The clinician in this situation did a urine pregnancy test and offered her Plan B emergency contraception, regularly stocked at the clinic. The medication and instructions were given to the assault survivor. The clinician got her cell phone number and asked if she could be called the next day. The clinician told her it would be better if she missed work and stayed at the clinic, but she could not. She was informed that if she was worried about exposure to HIV, she should call the rape crisis number that night because there is medicine she could take, but it would require a longer discussion in the clinic. She was offered a card with information about how to contact the clinic and a rape crisis phone number. The clinician also emphasized the importance of her returning if not for a sexual assault examination, at least for a pelvic examination. She was also given a hand-

out on sexually transmitted infections and treatment. She was asked about pelvic pain, vaginal discharge or pain, and any urinary pain. She denied all but said she was due for a checkup. She said she would call back. She said she felt relieved to have gotten the emergency contraception and left for work.

She did come back.

She came back because she had discussed with her mother what had happened and her mother was upset and adamant that she have the complete sexual assault exam. An appointment was made for her to come to the emergency department. The attending physician and the triage nurse were notified in the hopes of avoiding the waiting room. But things may not go as planned if the department does not have an operative sexual assault program. Thus this adolescent had to be interviewed by the triage nurse, who asked the young woman to tell her story again even though she had already exchanged adequate information. Then the young woman had to wait for a physician and a nurse who did not want to get started until the social worker and advocate were there. Then the assessment process began: first gathering a history; then blood work. It was this emergency room's protocol to draw blood for the following purposes: (1) hepatitis B screen, (2) BHCG (pregnancy test), (3) syphilis screen, and (4) a forensic sample (in New York State, as we do not refrigerate the kits, it is protocol to saturate a half-dollar-size spot on the gauze in the kit and then air dry it and seal it in the envelope in the kit). Once blood drawing is initiated, it is routine that HIV testing and, if pertinent, HIV prophylaxis are discussed with the patient. At this juncture let us stop for a moment and visualize this scenario again.

Here is a 16-year-old sexual assault survivor returning to the emergency department for a sexual assault examination for a rape that had occurred nearly seventy-two hours previously. The topic of HIV was briefly addressed the day before. The issue of HIV prophylaxis and sexual assault is complicated, and it is complicated to counsel teens effectively on this issue because although there is so much talk about teenage risk-taking behavior and immortality complexes, within the context of sexual assault, discussion of HIV becomes terrifying and an imminent threat. The discussion about HIV must be clearly thought out in terms of what and how it is said. The "hitch" with HIV prophylaxis is that the medication regimen is difficult for many people, in terms of both compliance and tolerating the medications. There is a lot of nausea and repeat blood work after the first week in order to monitor liver function and blood dyscrasias, and the survivor takes the medication for a month. Moreover, there is no conclusive evidence that the prophylaxis works.

The New York State guidelines say that the risk for transmission following mucosal exposure ranges from 0.0001 to 0.07. Recommendations for HIV prophylaxis issued from the Centers for Disease Control have been challenged because they are based on a retrospective case-control study and other indirect evidence.

Recommendations for HIV prophylaxis are even less evidence based for

sexual assault cases because there are no studies of postexposure prophylaxis following sexual assault. Nor are such studies likely to be conducted or developed given the complexity of assault cases and follow-up. Regardless, New York State decided to recommend postexposure prophylaxis as soon as possible postassault as a best-practice model.

Prophylaxis should not be offered thirty-six hours or more after the exposure. New York State recommends that pretreatment focus on (1) potential benefits of prophylaxis; (2) the possibility of side effects, which are complicated; (3) the nature and duration of the medication and monitoring schedule; and (4) the importance of adherence or compliance to the treatment regimen.

New York State also recommends that follow-up HIV testing is done at four weeks, twelve weeks, and six months. In terms of the PCR RNA test (DNA testing), the state recommends that although PCR offers the potential advantage of identifying rape survivors who have been infected within two weeks of exposure, it will not determine conclusively that a survivor has *not* been infected. The preferred PEP (post exposure prophylaxis) regimen is Combivir and Nelfinavir twice daily. The PEP regimen also states that if a patient does not have insurance, or will not use insurance for PEP, or is not eligible for special payment programs, then the treating institution has the ethical responsibility for ensuring a timely, uninterrupted supply of medications to the patient.

The young woman decided to take the PEP medications, but was overwhelmed by the whole decision-making process. The first time she slept with this boy was two weeks earlier, so in this particular case the clinician decided to do a PCR and a baseline test with her. Her PCR was negative. When she came back to the clinic two weeks later for an appointment with her social worker, she had stopped taking the medications. She also declined the rest of the examination because she had become so preoccupied with the PEP issue. She accepted medication for gonorrhea, chlamydia, and trichomonas prophylaxis and returned to the clinic for a pelvic examination with her regular provider. She did have some bruises on her arms, which, if photographed, would have provided good corroborative evidence, but after her PEP counseling, she did not want to have anything else done. She was tired. It was not a positive experience.

### **Alcohol, Drugs, and Sexual Assault**

The next case study involves a 17-year-old survivor who reported that she “thought” she had been raped sometime between midnight and 5:00 A.M. the night before. She came to the clinic to report the assault. According to her history, she was at a party where she had been drinking with some friends and a 21-year-old man she had met at a bar the week before. She stated that she got really drunk, really fast, but did not have a lot to drink. The survivor admitted she had also smoked a little marijuana earlier that same night. She had started to feel “weird” but then could not remember anything until she woke up in the

bathroom in her apartment around 5:00 A.M. the next morning. Although she could not say with certainty that she was raped, her clothes were disheveled and her genital area and vagina were sore. She urinated but did not take a shower. She said she thought she would want to tell the police but did not want her parents to find out because she told them she was at work that night. She wanted to get a medical examination first so she would know what happened to her. She wanted to know if she had injuries. She requested a female do the examination because she had never had a pelvic examination before. She was met at the emergency room by a nurse practitioner who had experience with sexual assault examinations and the rape crisis advocate had already been contacted.

What are the adolescents' concerns in this situation?

- Was she raped? Did something happen to her?
- Why is she sore?
- Will her parents find out?
- If she was raped, what should she do?
- Will the police believe her?
- If she wants the city to press charges, will the fact that she had been illegally drinking and smoking pot hurt her case in court?
- Will she get in trouble for smoking pot?

What are the clinician's concerns?

- Was she drugged?
- Was she raped?
- What physical evidence is available to indicate physical injury or drug ingestion?
- How can she begin to deal with this event when her ability to provide a history is so compromised?
- Was she drugged? Who knows? It was a definite possibility that her drink could have been spiked with GHB (gamma hydroxybutyrate). Although GHB has lost some of its popularity in the drug scene, it remains a front-running rape drug. GHB is colorless and odorless and has a slightly salty taste. As little as a few drops can render a person unconscious for four hours or more, leaving the person with little or no memory of events.

GHB makes rape much easier. Less than a teaspoon of GHB can render a woman vulnerable to assault within ten to twenty minutes. Not only won't the woman fight back, she won't even remember being attacked. GHB exits the body within twelve hours of ingestion. Therefore, by the time the victim real-

izes what has happened (if she realizes what has happened), there will be no evidence that GHB was involved—not in her urine, not in her blood. Even if the earliest urine is collected from a potentially “drugged survivor,” she has usually urinated by the time she arrives at the emergency department and reports that she may have been assaulted.

Thus if GHB was involved, the medical and law enforcement personnel may never know. This is difficult to tell the client, especially if she is expecting to find out if she was drugged and what happened to her. There is a great deal of emotional trauma surrounding the idea of “not knowing.” Attempts are made to console the survivor with the fact that trained examiners will perform a comprehensive examination and collection of evidence with or without a positive toxicology test. However, the challenge of working with a survivor who cannot remember what happened is that the history is missing—the physical evidence may not be corroborated by her narrative. These cases can prove most frustrating.

Like the vast majority of sexual assaults, an acquaintance, someone known to the survivor, allegedly committed the crime. The lack of an assault history makes it difficult to focus the examination on correlating injury with assault history. However, in this case the examiner carefully swabbed the survivor’s body for saliva and semen. DNA will confirm the person with whom the survivor has had sex, but the defense will probably claim that the sexual activity was consensual.

Was she raped? Neither the health care provider nor the medical examiner can state a person was raped; only a jury can make that decision. It is possible to state that there were injuries consistent with blunt force. Unfortunately, without an assault history, the examiner could not relate her narrative of the assault with any physical findings.

It was the young woman’s first pelvic examination. However, because she was having some vaginal pain and was so determined to find out what happened, she “propelled” herself right through the experience. The nurse practitioner reviewed everything that was going to happen and worked quickly. She used breathing exercises and took time positioning the patient comfortably and correctly so she could easily visualize the cervix and collect cultures and evidence smoothly once she inserted the speculum. The practitioner explained to the young woman before the examination that even if the examination did not show injury, it did not necessarily mean that there had not been penetration. In terms of injury identification, the acronym TEAR (Tears, Ecchymosis, Abrasion, Redness and Swellin) is a useful guide. The most common site of injury related to penile penetration is the posterior fourchette. This area is located between 5 and 7 o’clock using a clock diagram of the genital area. This is called a mounting injury; in other words, the area where the penis first touches the perineum (if the perpetrator is in a superior position). Prior to penetration, other areas of injury are the labia minora, the hymen, and the fossa navicularis.

But with colposcopy, erythema and some ecchymoses were noted at the posterior fourchette. This was consistent with a "mounting injury" and blunt force and also corroborated her history of tenderness in the genital area.

This young woman sought follow-up care at another facility. She did not file a report. However, at the time of examination, the colposcopy findings did bring her some piece of mind; it gave her something to hold on to. She did have injuries consistent with blunt force trauma which was comforting to her; she had a small piece in an otherwise blurry puzzle.

## CONCLUSION

These cases were presented to understand the uniqueness of approaching the medical examination with an adolescent who has been sexually assaulted. It is crucial to be able to anticipate how the wishes, needs, and desires of the adolescent sexual assault survivor can sometimes feel like a barrier to an examiner trying to accomplish an efficient, comprehensive examination. This can assist practitioners in predicting some of the issues faced in examining adolescent survivors, as well as help them to strategize to meet their client's needs while not letting those needs frustrate their own.

It is important that we perform these examinations in the best way we can, not just to address the immediate trauma but to use these experiences to build bridges between these teenagers and medical professionals. Ideally, practitioners will help these assault survivors have a violence-free, healthy, fulfilling future.

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**Appendix 14.1**  
**Working With Adolescent Survivors of Sexual Assault:**  
**Ten Key Questions to Keep in Mind**

1. FIND OUT THE ADOLESCENT'S INDIVIDUAL NEEDS AND CONCERNS FIRST.
2. DON'T SPEAK IN MEDICAL/LEGAL "LINGO" or use terminology that is foreign to an adolescent.
3. At the same time, DON'T CONDESCEND. Treat the teen as a client, as an adolescent, but still your professional client, due all the same respect and privileges as an adult.
4. PUT THE ADOLESCENT'S WELL-BEING AS YOUR FIRST PRIORITY—not necessarily what SHOULD happen in terms of the law and attaining justice, or what SHOULD happen in terms of medical protocol. First and foremost concentrate on what is BEST and MOST IMPORTANT for THAT TEEN at THAT TIME.
5. DON'T CONCENTRATE OR RELY ON HAVING THE TEEN DEFINE WHAT HAPPENED TO HIM OR HER. Adolescents may not have the experience, vocabulary or presence of mind to articulate the details of the event in a comprehensive or sequential manner. Try to ask open-ended questions and conduct an examination during which you will ask questions based on your observations. Details may fall into place during the examination, or afterward when you can review the history and physical findings. The adolescent should not feel cross-examined, or not believed. Your role is to accept the history as presented to you, nothing more, nothing less.
6. Think creatively in terms of ACCESSING A SUPPORT SYSTEM. Family members may not be the first option or the best option in these cases.
7. Remember, FOLLOW-UP with this population is possible but difficult. Assess barriers to care in order to best achieve a return visit. Use time efficiently. Be aware of what needs to be accomplished before a first meeting and try to get it done.
8. MAKE SURE THE ADOLESCENT KNOWS THAT WHAT HAS HAPPENED IS NOT HER FAULT.
9. MAKE SURE THE ADOLESCENT KNOWS THAT WHAT HAS HAPPENED IS NOT HER FAULT.
10. MAKE SURE THE ADOLESCENT KNOWS THAT WHAT HAS HAPPENED IS NOT HER FAULT.