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Women's Health Care Physicians

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This information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Sexual Assault

ABSTRACT: Victims of sexual assault who are of reproductive age are at risk of unintended pregnancy as well as sexually transmitted diseases. Therefore, emergency contraception and prophylaxis for sexually transmitted diseases should be available and provided to these women. Sexual assault victims are also at risk of mental health conditions such as posttraumatic stress disorder. Health care providers should screen routinely for a history of sexual assault. The physician who examines victims of sexual assault has a responsibility to be aware of state and local statutory or policy requirements that may involve the use of assessment kits for gathering evidence.

Definitions

Sexual assault is a crime of violence and aggression, not passion, and encompasses a continuum of sexual activity that ranges from sexual coercion to contact abuse (unwanted kissing, touching, or fondling) to forcible rape (1). Because definitions vary among states, sexual assault is sometimes used interchangeably with rape. *Rape* is defined as forced sexual intercourse, including vaginal, anal, or oral penetration by a body part or object (2). Sexual assault, or rape, often is further characterized to include acquaintance rape, date rape, statutory rape, child sexual abuse, and incest. These terms generally relate to the age of the victim and her relationship to the abuser.

Acquaintance and date rape refer to sexual assaults committed by someone known to the victim. Instances in which the perpetrator has a close familial relationship to the victim generally are defined as *incest*. Statutory rape refers to consensual sexual intercourse with a female younger than a specified age. The age at which an adolescent may consent to sexual intercourse varies by state and ranges from 14 years to 18 years. Sexual assault occurring in childhood also is defined by most states as child abuse. Childhood sexual abuse is further defined by the Child Abuse and Prevention Act as “the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or the rape, and in cases of caretaker or interfamilial relationships, statutory rape, molestation,

prostitution, or other form of sexual exploitation of children, or incest with children” (3).

Incidence and Prevalence

The method of obtaining data influences the estimates of the incidence and prevalence of rape and sexual assault. Data compiled from reports to law enforcement officials will always underestimate the incidence of sexual assault. Key findings of the National Violence Against Women survey reveal that there are more than 300,000 rape-related physical assaults against women annually (4). Approximately 18% of women surveyed reported that they had been the victim of a completed or attempted rape during their lifetime. Of these women, 54% were younger than 18 years. Among children and adolescents, most cases of sexual assault are in the form of acquaintance rape. Of the children and adolescents who reported rape, 14.3% of women younger than 18 years reported that they were assaulted by a stranger.

Medical Consequences of Sexual Assault

Acute traumatic injuries reported can be relatively minor, including scratches, bruises, and welts; but some women will sustain fractures, head and facial trauma, lacerations, bullet wounds, or even death. The risk of injury increases for adult female rape victims in the following situations: the perpetrator is a current or former intimate partner; the rape occurs in the victim's or perpetrator's home; the rape is completed; harm to the victim or another is threat-

ened by the perpetrator; a gun, knife, or other weapon is used during the assault; or the perpetrator is using drugs or alcohol at the time of the assault (4).

Sexual assault is associated with a risk of pregnancy and contributes to unintended pregnancy in the United States. The national rape-related pregnancy rate is calculated to be 5% per rape among females aged 12–45 years (5). This would be equivalent to approximately 32,000 pregnancies as a result of rape each year. This is especially true among adolescent assault victims because they are more likely to be repeatedly assaulted because of the predominance of incestuous relationships with perpetrators in this age group and their relatively low use of ongoing contraception. Rape-related sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV), are a major concern. Additional conditions that are diagnostic or suspicious for childhood sexual abuse include syphilis, human papillomavirus, and herpes simplex infection (6). Additional information on sexual assault in this population is available elsewhere (7).

Various long-term health effects have been associated with female sexual assault. Increases in patient-reported symptoms, diminished levels of functional capacity, alterations in health perceptions, and decreased positivity of overall quality of life have all been reported as sequelae of childhood and adult sexual abuse (8, 9). Many women will not be forthcoming with a history of sexual assault but are more likely to present with chronic pelvic pain, dysmenorrhea, and sexual dysfunction than those without such a history (10). Additional information on adult manifestations of childhood sexual abuse is available elsewhere (11).

Psychologic and Mental Health Consequences of Sexual Assault

A woman who is sexually assaulted loses control over her life during the period of the assault. After the assault, a rape-trauma syndrome often occurs. The acute phase, or disorganization phase, may last for days to weeks and is characterized by physical reactions such as generalized pain throughout the body, eating and sleep disturbances, and emotional reactions such as anger, fear, anxiety, guilt, humiliation, embarrassment, self-blame, and mood swings (1, 12). The next phase, the delayed (or organization) phase, is characterized by flashbacks, nightmares, and phobias as well as somatic and gynecologic symptoms. This phase often occurs in the weeks and months after the event and may involve major life adjustments (1, 12).

Posttraumatic stress disorder may be a long-term consequence of sexual assault. Posttraumatic stress disorder is characterized by a cluster of symptoms involving re-experiencing the trauma, avoidance, and being in a state of hyperarousal (13). These symptoms may not appear for months or even years after a traumatic experience.

Alcohol abuse, including binge drinking, and illicit drug use and dependence have a long-term association

with sexual assault. A survey of women seeking substance abuse treatment found that prevalence rates of completed rape or other type of sexual assault were 64.2% and 44.8%, respectively (14).

Roles and Responsibilities of Health Care Providers

Physicians can encourage primary prevention of sexual assault by being involved in advocacy in professional, community, and educational arenas. In addition, the American College of Obstetricians and Gynecologists recommends that health care providers routinely screen all patients for a history of sexual assault, paying particular attention to those who report pelvic pain, dysmenorrhea, or sexual dysfunction (15). Health care providers who routinely screen for a history of sexual assault are better able to identify victims of sexual assault and thereby provide tertiary prevention of long-term and persistent physical and mental health consequences of sexual assault. If a history of sexual abuse has been obtained, the clinician needs to be aware that various health care procedures can be triggers for panic and anxiety reactions such as pelvic, rectal, breast, and endovaginal ultrasound examinations. When these reactions are seen in clinical practice, it is important to consider that they may be caused by post-traumatic stress disorder and may have a connection with more remote events rather than the immediate practice situation. Clinicians should screen for substance abuse in patients with a history of sexual assault. Conversely, clinicians should screen for a history of sexual assault in patients with a history of substance abuse. Counseling can help the patient to understand her psychologic and physical responses, thereby diminishing the associated symptoms (12).

In recent years, there has been a trend toward the implementation of hospital-based programs to provide acute medical and evidentiary examinations by sexual assault nurse examiners or sexual assault forensic examiners. In some parts of the country, however, obstetrician–gynecologists will still be the first point of contact for the evaluation and care of patients after a sexual assault. Often obstetrician–gynecologists will be called on to perform evaluations and, if conducting screening for a history of sexual assault, will realize the importance of this information in providing comprehensive health care. Therefore, all physicians should be familiar with the forensic examination procedure. If a physician is called to perform this examination and he or she has no experience or limited experience, it may be judicious to request assistance because any break in the technique in collecting evidence, or break in the chain of custody of evidence, including improper handling of samples or mislabeling, will virtually eliminate any effort to prosecute a case in the future.

The health care provider conducting an evidentiary evaluation of a victim of sexual assault has a number of responsibilities, both medical and legal, and should be

aware of state and local statutory or policy requirements that may involve the use of assessment kits for gathering evidence. The health care provider's role in the evaluation of sexual assault victims is summarized in Box 1. If a sexual assault victim communicates with the health care provider's office, emergency department, or clinic before evaluation, she should be encouraged to come immediately to a medical facility and be advised not to bathe, change her clothes, douche, urinate, defecate, wash out her mouth, clean her fingernails, smoke, eat, or drink.

A history of previous obstetric and gynecologic conditions should be recorded, and it is necessary to determine whether the patient may have a preexisting pregnancy or be at risk of pregnancy (1). A detailed examination of the entire body should be performed and the injuries should be photographed or drawn. Rape and sexual assault are legal terms that should not be used in medical records. Rather, the health care provider should report findings

as being consistent with whatever aspect of the reported assault is being evaluated.

The health care provider should document the emotional condition of the patient as judged by direct observation and examination (1). If the patient is a minor, the health care provider should report the incident to the appropriate authorities as required by state law. An effort should be made to involve a parent or parental figure unless such an individual represents a security threat to the patient.

When the physical and medical-legal needs of the patient have been addressed, the health care provider should discuss with the patient the degree of injury and the probability of infection or pregnancy. Emergency contraception should be provided. Emergency contraception should be available in hospitals and facilities where victims of sexual assault at risk of pregnancy are treated. The most common STDs reported in sexual assault victims are those most common in the general community and include trichomoniasis, gonorrhea, and *Chlamydia trachomatis* infection (16). Prophylaxis for these STDs is recommended. The Centers for Disease Control and Prevention recommendations for prophylaxis for these STDs can be found at <http://www.cdc.gov/std/treatment> (17).

An STD of particular concern among victims of sexual assault is HIV. The HIV status of the assailant in a sexual assault is often unknown or unavailable. There are multiple characteristics that increase the risk of HIV transmission if the perpetrator is infected, including genital or rectal trauma leading to bleeding, multiple traumatic sites involving lacerations or deep abrasions, and the presence of pre-existing genital infection in the victim (18). The U.S. Department of Health and Human Services recommends that an individual seeking care within 72 hours after nonoccupational exposure to blood, genital secretions, or other potentially infective body fluids of an individual known to have HIV receive a 28-day course of highly active antiretroviral therapy, initiated as soon as possible after exposure. If the assailant's HIV status is unknown, clinicians should evaluate the risks and benefits of nonoccupational postexposure prophylaxis on a case-by-case basis. For individuals initiating care more than 72 hours after exposure, clinicians might consider prescribing nonoccupational postexposure prophylaxis for exposures conferring a serious risk of transmission if, in their judgment, the diminished potential benefit of treatment outweighs the potential risk of adverse events from antiretroviral medications (19).

Other health personnel, particularly those trained to respond to rape-trauma victims, should be consulted to provide immediate intervention if necessary and to facilitate counseling and follow-up. Health care providers are urged to assemble and maintain a list of these individuals and other resources for patient referral.

Because of the emotional intensity of the experience, a woman may not recall all of what is said during an

Box 1. Health Care Provider's Role in the Evaluation of Sexual Assault Victims

Medical Issues

- Obtain informed consent
- Assess and treat physical injuries
- Obtain past gynecologic history
- Perform physical examination, including pelvic examination with appropriate chaperone
- Obtain appropriate specimens and serologic tests for sexually transmitted disease testing
- Provide appropriate infectious disease prophylaxis as indicated
- Provide or arrange for provision of emergency contraception as indicated
- Provide counseling regarding findings, recommendations, and prognosis
- Arrange follow-up medical care and referrals for psychosocial needs

Legal Issues*

- Provide accurate recording of events
- Document injuries
- Collect samples as indicated by local protocol or regulation
- Identify the presence or absence of sperm in the vaginal fluids and make appropriate slides
- Report to authorities as required
- Ensure security of chain of evidence

*Many jurisdictions have prepackaged kits for the initial forensic examination of a rape that provide specific containers and instructions for the collection of physical evidence and for written and pictorial documentation of the victim's subjective and objective findings. See www.rainn.org/get-information/sexual-assault-recovery/rape-kit for more information on rape kits.

office visit. Therefore, it is helpful to provide all instructions and plans in writing. Generally, a visit for clinical and psychologic follow-up should take place within 1–2 weeks and be scheduled thereafter as indicated by results and assessments at that time.

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