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WOMEN'S HEALTH CARE PHYSICIANS

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Committee on Health Care for Underserved Women

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Health Care for Underserved Women in collaboration with committee members Serina Floyd, MD, MPH, and Joy Anderson, MD.

Sexual Assault

ABSTRACT: Sexual violence continues to be a major public health problem affecting millions of adults and children in the United States. Medical consequences of sexual assault include sexually transmitted infections; mental health conditions, including posttraumatic stress disorder; and risk of unintended pregnancy in reproductive-aged survivors of sexual assault. Obstetrician–gynecologists and other women's health care providers play a key role in the evaluation and management of sexual assault survivors and should screen routinely for a history of sexual assault. When sexual violence is identified, individuals should receive appropriate and timely care. A clinician who examines sexual assault survivors in the acute-care setting has a responsibility to comply with state and local statutory or policy requirements for the use of evidence-gathering kits. This document has been updated to include model screening protocols and questions, relevant guidelines from other medical associations, trauma-informed care, and additional guidance regarding acute evaluation of survivors and evidence-gathering kits.

Recommendations

The American College of Obstetricians and Gynecologists makes the following recommendations and conclusions regarding sexual violence:

- Sexual assault and rape are pervasive problems in the United States, creating a major effect on public health.
- Obstetrician–gynecologists and other women's health care providers should screen all women for a history of sexual assault.
- Clinicians who evaluate survivors of sexual assault in the acute phase must comply with certain medical and legal requirements.
- Clinicians should recognize the short-term and long-term health consequences of sexual assault, such as infection, pregnancy, and mental health conditions and manage them appropriately.
- Clinicians should incorporate a trauma-informed care framework when assessing the needs of sexual assault survivors.

Definitions

The terms "rape" and "sexual assault" are sometimes used interchangeably, and the legal definitions of both terms vary from state to state. Specifically, sexual assault is a crime of violence and aggression and encompasses a continuum of sexual activity that ranges from sexual coercion to contact abuse (unwanted kissing, touching, or fondling) to rape (1). *Rape*, as re-defined by the Federal Bureau of Investigation in 2013, is the penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim. This definition notably excludes any gender of victim and perpetrator and any reference to force. The definition acknowledges that rape and sexual assault occur in situations in which consent is not given, such as situations of intoxication or when individuals are otherwise mentally or physically incapable of demonstrating consent (2). Sexual assault and rape often further are 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 the relationship to the abuser.

Acquaintance rape and date rape refer to sexual assaults committed by someone the victim knows. When the perpetrator is a family member of the victim, the assault is defined as *incest*. Statutory rape refers to consensual sexual intercourse with an individual younger

than a specific age. The age at which an adolescent may consent to sexual intercourse varies by state and generally is 16–18 years. Some states allow for consent at ages younger than 16 years when the partner is close in age. Sexual assault that occurs in childhood, defined by most states as younger than 14 years, is considered child abuse. *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 forms of sexual exploitation of children, or incest with children" (3). The scope of this Committee Opinion does not include childhood sexual assault. Please refer to guidelines from the American Academy of Pediatrics, *The Evaluation of Children in the Primary Care Setting When Sexual Abuse Is Suspected* (http://pediatrics.aappublications.org/content/132/2/e558.long) (4); North American Society for Pediatric and Adolescent Gynecology's *Updated Guidelines for the Medical Assessment and Care of Children Who May Have Been Sexually Abused* (https://www.sciencedirect.com/science/article/pii/S1083318815000303); and the American College of Obstetricians and Gynecologists' Committee Opinion No. 498, Adult Manifestations of Childhood Sexual Abuse, for more information (4–6).

Incidence and Prevalence

Sexual assault and rape are pervasive problems in the United States, creating a major effect on public health. An estimated 1.47 million rape-related physical assaults occur against women annually (7). Approximately one in five U.S. women (19%, or an estimated 23 million women) surveyed reported that they had been victims of a completed or attempted rape during their lifetime (7). Nearly 80% reported that they were first raped before age 25 years, and 41% reported that they were raped before age 18 years (7). Adolescents are more likely to be assaulted repeatedly and victimized in incestuous relationships (6). Minority women experience a higher prevalence of estimates of rape. A total of 32% of multiracial women, 29% of American Indian/Alaska Native women, 21% of non-Hispanic black women, 20% of non-Hispanic white women, 15% of Hispanic women, and 10% of Asian/Pacific Islander women have experienced rape at some point during their lifetime. Among female sexual assault survivors, 47% reported that at least one perpetrator was a current or former intimate partner, 45% reported an acquaintance, 13% reported a family member, and 13% reported a stranger (7). Female veterans experience increased rates of sexual assault during their time in the military, as well as during civilian life, compared with their civilian counterparts. They are eligible to receive lifetime care at any Veterans Health Administration facility for health problems related to military sexual assault (8).

Medical Consequences of Sexual Assault

Negative health consequences from sexual victimization can be short-term and long-term. Acute traumatic injuries of sexual assault include scratches, bruises, and welts. Some women sustain more extensive injuries such as fractures, head and facial trauma, lacerations, bullet wounds, or even death. Survivors of sexual assault may sustain traumatic injuries to the vulva or vagina severe enough to require surgical intervention. The risk of injury increases for adult female rape survivors 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; the perpetrator threatens harm to the victim or another; 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 (9).

Sexual assault may lead to pregnancy. The national rape-related pregnancy rate is approximately 5% per rape among women aged 12–45 years, or approximately 32,000 pregnancies resulting from rape each year (10). Pregnancy rates are especially high among adolescent sexual assault survivors because of their relatively low use of contraception and higher baseline fertility. When rape results in pregnancy, women are more likely to choose pregnancy termination than continuation (10).

Various long-term health effects are associated with female sexual assault. Increases in patient-reported physical symptoms, diminished levels of social function, alterations in health perceptions, and decreased quality of life are sequelae of childhood and adult sexual abuse (11–12). Many women do not discuss a history of sexual assault spontaneously but may present with chronic pelvic pain, dysmenorrhea, and sexual dysfunction more often than those without such a history (13). Additional information on adult manifestations of childhood sexual abuse is available elsewhere (6). Clinicians should recognize the short-term and long-term health consequences of sexual assault, such as infection, pregnancy, and mental health conditions and manage them appropriately.

Psychological and Mental Health Consequences of Sexual Assault

An individual 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, or disorganization phase (the first phase), may last for days to weeks and is characterized by physical reactions such as generalized pain throughout the body, eating and sleeping disturbances, and emotional reactions such as anger, fear, anxiety, guilt, humiliation, embarrassment, self-blame, and mood swings (1, 14). The delayed, or organization, phase (the next 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, 14).

Posttraumatic stress disorder is a long-term consequence of sexual assault. Posttraumatic stress disorder is characterized by a symptom cluster involving re-experiencing the trauma, avoidance, and a state of hyperarousal (15). 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 long-term associations with sexual assault. In a survey of women seeking substance use disorder treatment, prevalence rates of completed rape or other types of sexual assault were 64.2% and 44.8%, respectively (16).

Incorporation of Trauma-Informed Care

Traumatic life events are widespread and encompass exposure to a variety of interpersonal violence scenarios, including sexual assault. The trauma experienced by individuals can have lasting adverse effects on their functioning and mental, physical, social, and emotional well-being (17). The trauma-informed approach to care uses a framework that acknowledges the effect of trauma, recognizes signs and symptoms of trauma, responds by integrating knowledge about trauma into practices, and seeks to resist retraumatization. The key principles of trauma-informed care include ensuring physical and emotional safety, maximizing trustworthiness, prioritizing individual choice and control, empowering individuals, and encouraging peer support (17). This framework is particularly relevant to provision of care to sexual assault survivors and can help optimize the patient−provider relationship, improve health outcomes, and reduce long lasting burdens of trauma. Clinicians should incorporate a trauma-informed care framework when assessing the needs of sexual assault survivors.

Roles and Responsibilities of Clinicians

The American College of Obstetricians and Gynecologists recommends that obstetrician–gynecologists and other women's health care providers screen all women for a history of sexual assault, paying particular attention to those who report pelvic pain, dysmenorrhea, or sexual dysfunction (18). Model screening protocols and questions have been developed to assist clinics (see Box 1 and Box 2).

Early identification of survivors of sexual assault can lead to prevention of long-term and persistent physical and mental health consequences of abuse. When a history of sexual abuse is disclosed, the clinician can expect that various health care procedures, such as pelvic, rectal, breast, and endovaginal ultrasonographic examinations, may trigger panic and anxiety. Such reactions may stem from posttraumatic stress disorder and may have a connection with more remote events. Clinicians should screen women with a history of sexual assault for substance use disorder and, conversely, also should screen women with a history of substance use disorder for a history of sexual assault. Counseling can help sexual assault survivors understand their psychologic and physical responses, thereby diminishing the associated symptoms (14).

Many hospitals have implemented programs to provide acute medical and evidentiary examinations for sexual assault victims by Sexual Assault Nurse Examiners (SANEs) or Sexual Assault Forensic Examiners (SAFEs). These individuals receive specialized education and clinical preparation in the care of survivors of sexual assault and can perform medical forensic examinations that meet standard criteria of assessment. When there is no designated hospital program, a specialized examiner can be located through the International Association of Forensic Nurses at https://www.forensicnurses.org/search/custom.asp?id=2093 (19).

In some settings obstetrician–gynecologists remain the first point of contact for the evaluation and care of sexual assault survivors. Clinicians who evaluate survivors of sexual assault in the acute phase must comply with certain medical and legal requirements (see Box 3). When called on to perform a sexual assault examination,

Box 1. SAVE Model Protocol

SCREEN all patients for sexual violence
ASK direct questions in a nonjudgmental way
VALIDATE the patient
EVALUATE, educate, and refer

Modified from Florida Council Against Sexual Violence. How to screen your patients for sexual assault: a guide for health care professionals. Tallahassee (FL): FCASV; 2012.

Box 2. Sample Sexual Assault Screening Questions

- Has anyone ever touched you against your will or without your consent?
- Have you ever been forced or pressured to engage in sexual activities when you did not want to?
- Have you ever had unwanted sex while under the influence of alcohol or drugs?
- Do you feel that you have control over your sexual relationships and will be listened to if you say "no" to sexual activities?
- Is your visit today because of a sexual experience you did not want to happen?

the clinician who has no experience or limited experience should request assistance from trained hospital personnel to ensure appropriate evidence collection. If trained personnel are unavailable, a detailed protocol from the U.S. Department of Justice's Office of Violence Against Women titled "A National Protocol for Sexual Assault Medical Forensic Examinations of Adults/Adolescents" may be consulted at https://www.forensicnurses.org/search/custom.asp?id=2093 (20). Technical assistance and clinical guidance also are available for clinicians serving assault victims through the SAFE Technical Assistance program at https://www.safeta.org (21). Innovative alternatives, such as the use of video conferencing technology, also are being developed to assist clinicians in remote areas or with limited resources. Improper evidence collection, including a break in the chain of custody and incorrect handling of samples, virtually eliminates the option to prosecute the case, so care must be taken.

The clinician conducting an evidentiary evaluation of a sexual assault victim must comply with state and local statutory or policy requirements involving the use of evidence gathering collection kits. These requirements can be found by contacting local law enforcement agencies. In the event such regulations cannot be found, national best practices for sexual assault kits have been developed by the U.S. Department of Justice (22). Sexual assault survivors who communicate with a physician's office, emergency department, or clinic before evaluation should be encouraged to go to a medical facility immediately and told not to bathe, change clothes, douche, urinate, defecate, wash out the mouth, clean fingernails, smoke, eat, or drink. Many jurisdictions use a 72-hour cutoff time for collection of evidence in a sexual assault case, whereas some have extended the time to 1 week. When collecting evidentiary materials, clinicians should comply with the required timeframe within their jurisdiction (20); however, if an assault is reported outside of the time limit of a particular jurisdiction, clinicians still should perform an examination and provide subsequent clinical management, as appropriate.

Before initiating a medical forensic examination, consent for the medical evaluation and for evidence collection and release must be obtained from the sexual assault victim. A complete history of pertinent information is imperative. Details of the assault, including time between the assault and the evaluation and specifics of any injuries, should be documented. Relevant medical history, including obstetric and gynecologic conditions and current pregnancy or risk of pregnancy, should be recorded (1). A detailed examination of the entire body should be performed, and injuries should be photographed or drawn.

The clinician should document the emotional condition of the survivor as assessed by direct observation and examination (1). If the individual is a minor or a vulnerable adult (those unable to care for their daily needs because of mental or physical disabilities), the clinician should report the incident to the appropriate authorities as required by state law. Efforts should be made to encourage involvement of a trusted adult.

When the survivor's physical, medical, and legal needs have been addressed, the clinician should discuss with her the degree of injury and the probability of infection or pregnancy. Emergency contraception should be provided, requiring its immediate availability in hospitals and facilities where sexual assault survivors are treated. The most common sexually transmitted infections reported in sexual assault victims include trichomoniasis, gonorrhea, and *Chlamydia trachomatis* (23–24). The Centers for Disease Control and Prevention (CDC) recommends testing and empiric antimicrobial treatment

Box 3. Evaluation and Management of Sexual Assault Survivors

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 STI testing
- Provide appropriate infectious disease prophylaxis as indicated
- If the assailant's HIV status is unknown, evaluate the risks and benefits of postexposure prophylaxis
- 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*

- Document events
- Document injuries with drawings or photographs
- Collect samples as indicated by local protocol or regulation
- Identify the presence or absence of sperm in 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 sexual assault survivor 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 https://www.rainn.org/articles/rape-kit for more information on rape kits.

Abbreviations: HIV, human immunodeficiency virus; STI, sexually transmitted infection.

for these sexually transmitted infections as well as testing for additional relevant infections such as human immunodeficiency virus (HIV), hepatitis B, and syphilis. Vaccination for hepatitis B and human papillomavirus also are recommended, as indicated (25).

Cases of HIV transmission after sexual assault have been described, although infrequently (26). Multiple characteristics of sexual assault increase the risk of HIV transmission, including genital or rectal trauma leading to bleeding, multiple traumatic sites involving lacerations or deep abrasions, and the presence of preexisting genital infection or ulcers in the victim (27). Postexposure prophylaxis (PEP) is a 28-day course of highly active antiretroviral therapy that, when initiated soon after high-risk exposure, can reduce risk of HIV infection significantly. If the assailant's HIV status is unknown, clinicians should evaluate the risks and benefits of PEP on a case-by-case basis. If indicated, PEP should be initiated as soon as possible but no later than 72 hours after potential exposure to HIV. The CDC provides guidance on factors to consider in decision making around PEP, information to be shared with individuals about PEP usage, and appropriate management plans (24).

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. Clinicians are urged to assemble and maintain a list of individuals and other resources for patient referral. The CDC maintains a list of national resources to assist clinicians in their efforts that can be found at https://www.cdc.gov/violenceprevention/sexualviolence/resources.html (28).

Because of the emotional intensity of the experience, a sexual assault survivor may not recall all the information provided during an 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 with additional encounters scheduled thereafter as indicated by results and assessments.

Evidence Collection Kits

Sexual assault evidence collection kits, also known as rape kits, are packages used to collect evidence from a survivor during a medical forensic examination. These containers usually include checklists, materials used for specimen collection, documents, and instructions. Many jurisdictions develop their own kits, but premade kits can be purchased through commercial vendors (22).

To maintain evidence integrity, jurisdictional policies must be followed (20). These policies include details on packaging, labeling, and sealing evidence and specifics on transfer, storage, management, and distribution of evidence (20). In addition, the U.S. Department of Justice recommends that the time between the collection of a kit and its transfer and storage be minimized, the transfer of evidence be done only by law enforcement officials or authorized agents, storage only occur at a crime laboratory or other law enforcement facility, and chain-of-custody information be documented to ensure no loss or alteration of evidence before a trial (20).

Currently, in many parts of the United States there is a significant backlog of unanalyzed rape kits, which presents a major obstacle to prosecution of perpetrators. In multiple states, this backlog includes thousands of untested kits. A national campaign to address this problem has resulted in passage of laws in several states, increased availability of funding for processing evidence, and technical assistance and support to cities and states. Obstetrician–gynecologists and other health care providers should support efforts to address rape kit backlogs.

Conclusion

Sexual violence affects millions of individuals in the United States and has a major effect on public health. For sexual assault survivors, the physical, psychological, and emotional effects can be devastating and have long-term consequences. Obstetrician–gynecologists and other women's health care providers have a unique opportunity, and a responsibility, to screen all patients for sexual violence and, when identified, to provide competent, compassionate, and appropriate care.

For More Information

ACOG has identified additional resources on topics related to this document that may be helpful for obgyns, other health care providers, and patients. You may view these resources at www.acog.org/More-Info/SexualAssault.

These resources are for information only and are not meant to be comprehensive. Referral to these resources does not imply the American College of Obstetricians and Gynecologists' endorsement of the organization, the organization website, or the content of the resource. The resources may change without notice.

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