

FEATURE ARTICLE

Issues and dynamics of sexually assaulted adolescents and their families

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ABSTRACT: *Interpersonal violence such as sexual assault creates a variety of traumatic responses. Adolescents encounter a significantly high rate of exposure to sexual assault. In the aftermath of sexual assault, issues and dynamics related to traumatic responses include ongoing fear and threats to personal safety, stability, and structure of the family and environment. Each issue is of concern for community and health care practitioners. Sexual assault has a detrimental effect on adolescent intrapsychic development and interpersonal relationships. Symptoms are disturbing and disruptive to daily routines, negatively affect adolescent normal growth and development, and can result in post-traumatic stress disorder. Issues and dynamics regarding sexual assault are explored, with suggestions on how to help adolescents avoid developing a negative world view and long-term negative health consequences.*

KEY WORDS: *adolescents, adolescent development, post-traumatic stress disorder, sexual assault.*

INTRODUCTION

Adolescents reflect the highest rate of exposure to sexual assault. A total of 75% of adolescents know their assailant. In the aftermath of sexual assault, adolescents have significant responses related to fears of ongoing threat to personal safety, as well as the stability and structure of their family and environment (Burgess *et al.* 1995; Greenfeld 1997). Interpersonal violence, such as sexual assault, creates some of the most severe emotional and traumatic reactions. Sexual assault occurs in a variety of situations and as a result of various motives, and can be an impulsive act or a skilfully calculated attack (Clements 1996; Douglas *et al.* 1992; Speck 1999). Sexual assault has a detrimental effect on adolescent intrapsychic development and interpersonal relationships. Post-assault symptoms are disturbing and disruptive to daily routines and can negatively

affect normal growth and development and lead to development of post-traumatic stress disorder (Burgess *et al.* 1995; Garbarino *et al.* 1992). The consequences of adolescent sexual victimization include significant mental health sequelae, such as a poorly-developed sense of self, difficulty with regulation of reactions to disturbing events, poor academic performance, pregnancy, drug addiction, prostitution, repetition of assaults against others, and suicide (Snyder 2000; Wordes & Nunez 2002). Perhaps most important, is that previous victimization is the most highly correlated predictor of subsequent victimization (Marx *et al.* 2001; Nisith *et al.* 2000).

CASE STUDY 1

Susan, 14 years old, was with friends at a party. They had spent all day picking out their clothes, fixing their hair, and getting ready for their dates. She wasn't particularly excited about her date because she had known him since they were in elementary school but he was bringing a friend, Mark, who was 18 years old, from the neighbouring town and she was undeniably attracted to him. Susan and Mark 'hit it off'. In fact, they had such a good time at the party, Susan decided to go with Mark to pick up music CDs from his home.

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While there, Mark invited Susan into his home, Susan agreed. Once in Mark's house, he became belligerent, threatened Susan, and told her she was a 'slut' to have gone with him because she should have known better. He held her down on the couch and raped her. Following the sexual assault, Mark cooled down and offered Susan a soda. She said 'no' and that she wanted to go straight back to the party. Mark said this was okay but told Susan that he still wanted to see her again. Susan was confused and upset.

When Susan shared the violent events with her friend, his response was: 'Mark wouldn't do that!' The next morning, she told her older sister because she began to think she could get pregnant. Her sister told her mother who then called the police. The police interviewed Susan at her home. They determined that a crime may have been committed and based on reporting, the Sexual Assault Response Team (SART) was activated for assessment and intervention.

Susan was taken by the police to the SART program where she was met by a sexual assault advocate and a Sexual Assault Nurse Examiner (SANE). The SANE triaged Susan's injuries and the advocate provided the initial support and instructions about what Susan could expect in the next few hours. In addition, Susan identified her support person as her 'big sister', who would accompany Susan during the evaluation.

After the intake, the SANE interviewed Susan about the details of the violent event and her general health history. Susan reported that she had 'never had that kind of sex before' and that she was still spotting from her period. Susan expressed that her pain was mostly gone but that she was worried that she might get pregnant. She also said she was embarrassed because she went with Mark and she should have known better because her mother told her not to leave the party with anyone.

CASE STUDY 2

Lucy, 17 years old, was being evaluated for medications because, 2 weeks earlier, she had threatened to choke herself and her 2-year-old daughter. She stated:

I first remember being depressed after I was raped by my boyfriend when I was 15. It is rape when you say 'No', isn't it? My shorts were torn, they had a zipper down the back, and I thought I was going to faint, and I couldn't walk because, you know, I was a virgin, and it really hurt to walk. I went to my friend's house, and I told her. My friend told me that if I told him 'No' and he had sex with me against my will that it was rape. She took me down to the emergency room, and they did a thing called a rape kit, and I pressed charges.

Lucy continued:

Since then, I'm not the girl I used to be. I saw a teacher of mine that knew me when I was in middle school, and she told me I used to make all the kids crack up in class. I can't believe I was ever like that! Last year, when they showed us a movie in class about rape, I couldn't watch it; I had to leave the room. Sometimes, I just can't stop thinking about it. Now I want to sleep all the time, sleep, sleep, sleep. I mean, I lock my door every night because I am afraid someone will try to rape me again and I have nightmares about it still, you know being raped by someone. I don't like, no I don't trust them (men) anymore.

CASE STUDY 3

Tabitha, 18 years old, had dropped out of school in the ninth grade. She had lived on the streets when she wasn't in juvenile detention for petty theft or prostitution. This day, she was in the hospital in labour with her fourth pregnancy, actively impaired from using crack cocaine. Her last three children had different fathers and were taken from her at birth to be placed with the infant's maternal grandmother. The first one was removed when her boyfriend fractured the infant's leg while 'whipping' him. Tabitha had been released from the juvenile detention centre when she reached the state's legal age of adulthood and, in her words, 'When I got out, it made it easier for me to get the drugs'. While living on the street, she had been arrested twice on prostitution charges and was awaiting trial. She joked to the nurse that she 'wouldn't be showing up for that!' implying that she would have to do jail time if they could catch her.

When asked by the nurse about the past violence in her life, she flippantly said, 'When has my life *not* had someone kickin' my ass!?' On further questioning, it was discovered that her neighbour started raping her when she was 8. To gain her compliance, he fed her alcohol and drugs so she wouldn't say 'No' to him. He reportedly also gave Tabitha's mother money to help at the end of the month when there wasn't any money to buy food. When Tabitha was 12 years old, she finally told her mother what was happening. Tabitha reported that her mother accused her of being 'fast and seducing him (their neighbour)'. Her mother yelled, 'You lying bitch! All you do is lie! You could get him into big trouble if you tell this lie to anybody!' Tabitha sighed and told the nurse that the rapes continued until she ran away from home at age 14. 'I hate my mum and I hate him ... and the courts are givin' my babies to her (her mother) and it'll happen to them too.'

BACKGROUND AND SIGNIFICANCE

Adolescent development

The years of adolescent development are viewed as a period when intrapsychic and psychosocial developmental processes are ongoing and evolving. The overarching tasks include attainment of independence, which is not necessarily complete at a specific age or end point, it is a process through which adolescents advance. An adolescent developmental trajectory typically corresponds to physical, physiological, and intellectual growth, and is accompanied by a need for parental sponsorship, which ultimately enables self-confidence (Bloch 1995). During this time, maintaining parental relationships and pleasing parents are important. However, while evolving developmentally, adolescents must adapt to their increasing capacities as they adjust to the facts of daily life as an adult. This new identity requires that adolescents experiment, assess ways to maintain a sense of security, integrate their sexuality, aggression, and new cognitive abilities, and deal with parental conflicts (Bloch 1995).

As adolescents grow and develop, interpersonal violence confounds the issues of an expanding moral reasoning, an understanding of the consequences of one's actions, and the need for safety and belonging. Pynoos and Nader (1993) emphasize that exposure to traumatic events, such as interpersonal violence, is particularly challenging for youths as they try to integrate the unanticipated experience into a new inner model of a world that is rapidly changing as a normal facet of adolescent intrapsychic development. As a result, sexual assault is a threatening event and a painful burden because it violates the very basic beliefs of social appropriateness, fairness, and the sanctity of life.

Scope of the problem

The Commonwealth Fund (1997) 'Survey of the Health of Adolescent Girls' was conducted between December 1996 and June 1997 through in-class questionnaires of 6748 boys and girls in grades 5 through 12. The 265 schools included in the survey were public, private, and church-associated schools. A separate sample of 218 high school dropouts was included in the study. Sexual abuse was one component of the study.

A total of 18% of older girls (grades 9 through 12) and 7% of younger girls (grades 5 through 8) said they had suffered some form of sexual abuse. A total of 3% of boys in grades 5 through 8 and 5% of boys in grades 9 through 12 said they had been sexually abused. Of all physically or sexually abused girls, 53% said the abuse had occurred at home, 65% said it had occurred more than once, and 57% said the abuser was a family member.

Boys were considerably less likely than girls to tell someone about the abuse. Of all the boys surveyed who experienced either physical or sexual abuse, 48% told no one, compared with 29% of girls. Of the girls who confided their abuse, 41% had told their best friends, 38% had confided in their mothers, and 7% had told a doctor.

Physical and sexual abuse spanned geographical boundaries, and there was little variation among urban, suburban, or rural areas or by region. Rates of sexual abuse were fairly consistent across racial and ethnic groups, with the exception of Asian Americans; rates of sexual abuse among White, Black, and Hispanic girls were 9%, 10%, and 11%, respectively, yet only 5% of Asian American girls reported sexual abuse (RAINN 1998). These data are similar to the racial prevalence cited in other studies (Ackard & Neumark-Sztainer 2002). In addition, rates in other countries were comparable with the United States in population-based studies from 19 countries (7–36% for females, 3–29% for males). In a further analysis of the 'Survey of the Health of Adolescent Girls', Schoen *et al.* (1997) reported that, for younger adolescents, most abuse occurs at home, is chronic, and the abuser is known to them. Additionally, girls who had been physically or sexually abused said the abuse typically occurred at home (53%), it took place more than once (65%), and the abuser was a family member (57%) or family friend (13%; Schoen *et al.* 1997). For older adolescents, the offender is usually a date or acquaintance. Nearly one in 10 older adolescents report abuse by a date or boyfriend. A total of 8% of high school-aged girls convey that they experienced forced sex against their will. One in four high school girls (26%) said they had been physically or sexually abused by a date or boyfriend. Other studies report repeated dating violence for 48% of females and 34% of males; for both, over 50% experience repeated rape. More than 65% of adolescents experience repeated acts of multiple abuses (Ackard & Neumark-Sztainer 2002).

TYPES OF ASSAULTS

Ludwig (1992) offered definitions for the complexity of legal, institutional, and personal categories of sexual abuse and assault. These included 'statutory rape' (sexual intercourse with a child who is younger than 14 years of age by a person aged 18 years or older), 'involuntary' or 'voluntary deviate sexual intercourse' (intercourse by mouth, by rectum, or with an animal), 'sexual assault' (sexual involvement, including the touching or exposing of sexual or other intimate parts, for the purpose of arousing or gratifying sexual desire in either the perpetrator or child), 'incest' (sexual intercourse with an ancestor

or descendent by blood or adoption), 'promoting prostitution' (inducing or encouraging a child to engage in prostitution), 'rape' (sexual intercourse by force or compulsion), and 'pornography' (the obscene photographing, filming, or depiction of children for commercial purposes or for arousal of self, subject child, or viewing audience).

Generally, however, adolescent and adult sexual assault refers to sexual activities resulting from threats, force, or coercion; the definition often differs from study to study as to whether this includes penetration or not. Furthermore, in Arata's (2002) review of the literature related to the concept of revictimization, adolescent sexual assault is often referred to as abuse, whereas sexual assault refers to an adolescent over the age of 13 or 14 years. However, the majority of research shows that a childhood history of victimization is one of the greatest risks for revictimization in adolescence. Just as important a finding, adolescents who experience rape are at higher risk for adult intrapsychic or physical revictimization.

RISK FACTORS

Awareness of who may be at highest risk for negative outcomes related to sexual assault directs the focus for early intervention efforts. Related factors that influence sexual abuse, summarized from an extensive literature review, include: 'age' (children 12 years of age and older account for one-third of child sexual abuse cases); 'gender' (higher risk starts earlier for girls and lasts longer); 'disability' (impairments that increase vulnerability, such as dependency, institutionalized care, and communication difficulties, increase risk); 'socioeconomic status' (low socioeconomic status is a powerful risk factor for physical abuse and neglect but has less impact on sexual abuse); 'race, ethnicity, and culture' (race and ethnicity influence symptom expression and reporting but do not increase the likelihood of being raped); 'family system impairment' (absence of one or both parents, presence of a stepfather in the home, maternal illness, parental alcoholism, parental absences, marital conflict, substance abuse, social isolation, and punitive parenting all increase the risk of sexual abuse); and a history of 'intergenerational abuse' (sexual abuse is often simultaneous with other forms of abuse. One-third of abused children are thought to become abusive parents (Brady & Matthews 2002; Putnam 2003).

DISCLOSURE

Disclosure of the sexual assault is typically accompanied by multifaceted and complex issues related to adolescent development. These issues are overwhelming and create anxiety and a sense of indecision about additional dis-

closure. Issues typical of adolescent survivors of sexual assault include an impaired ability to trust, blurred role boundary and role confusion, pseudomaturity, and problems with socialization, coupled with failure to accomplish developmental tasks, self-mastery, and impulse control (Clements & Benasutti 2003; Putnam 2003). These issues vary, depending on whether the child represses the abuse, availability of perceived resources, whether there is immediate intervention and therapy after abuse or an assault, and whether therapy is ongoing in coordination with existing support systems (Asher 2003; Burgess *et al.* 1995).

Disclosure does not necessarily result in an alleviation of turmoil or negate future symptoms. This depends on the nature of the information that is disclosed or concealed and how the information is presented and received by a listener. Results of disclosure are ultimately based on the coping repertoire that is available to the adolescent. Overall, the teen must believe social support is available (Kahn & Hessling 2001).

Individuals have a trait-like tendency to disclose distressing information and, simultaneously, the more they disclose related to all situations the less they conceal (Kahn & Hessling 2001). Those who tend to disclose have a greater sense of well-being, fewer negative moods, and higher self-esteem than those who choose to conceal. Thus, it is thought to be an aspect of personality (Kahn *et al.* 2001). Disclosure may also occur from the altruistic adolescent who uses the knowledge that the sexual assault is a crime to make a conscious decision to remove the perpetrator, who may be committing other crimes against the family, thereby creating a safe environment. In addition, adolescents who disclose under these circumstances may also sacrifice their relationship with the non-offending family member(s) to ensure the safety of the other children. Some adolescents may report intra-familial rape and sexual assault when they suspect that the younger sibling is at risk for abuse. Usually, the adolescent has already been subjected to the abuse and is aware of the abuser's pattern of access and secrecy. The adolescent might say something like, 'When I saw him take her into his den (implying this is a place only invited persons can go), I knew he was going to start up with her like he did with me', or 'He doesn't pay much attention to me anymore, but he has started paying lots of attention to my (younger) sister'. These adolescents often have a pseudomature persona and may even make statements with the risk of going into foster care to protect siblings.

EDUCATION FOR CLINICIANS

It is critical to understand that all adolescent victims of abuse benefit from having a clinician focus on the issue of

abuse during assessment and treatment, although it may be disturbing for the clinician and the adolescent. Directed anticipatory guidance provides an opportunity to create choices for the adolescent that define the clinician–patient relationship in a comprehensive evaluation and to additionally return some semblance of control to the victim. This includes reassuring adolescents that the sexual assault was not their fault and was poor behaviour on the part of the perpetrator. The process is time-consuming, but it is a necessary step that creates a foundation for intrapsychic healing and psychosocial reorganization after the abuse. Additionally, clinicians must protect against the ‘throwaway syndrome’ (Clements & Benasutti 2003), which leads to the belief that some adolescents are so ‘damaged’ that they cannot be helped. Clinicians must be in touch with personal issues and perceptions to provide compassion and understanding regarding the nature of abuse, its antecedents and origins, subsequent risk of victimization, and cultures and communities that tolerate it (Speck 1999). Providing a neutral yet supportive environment initiates the process of undoing self-blame and shame by the adolescents, with an ultimate goal of avoiding the perception that they are ‘damaged goods’ (Clements & Benasutti 2003). All survivors require and deserve comprehensive medical, social, psychological and forensic assessment and intervention and the opportunity to heal emotionally and physically.

IMPLICATIONS FOR FORENSIC NURSING

Of immediate focus, injury assessment and pain management are the first steps in the promotion of healing. Following this, it is important to diminish the adolescent’s anxiety and engender trust as a first step in the treatment process (Burgess *et al.* 1995; Clements *et al.* 2001). Assessment requires clinician understanding of the context of the abuse and the cultural and family environments. The adolescent should clearly sense the clinician’s belief that there is a sense for future orientation and hope for a ‘normal’ life. In addition, the clinician can encourage and guide adolescents to communicate their narrative of the event and their memories and feelings. Without these basic tenets, the therapeutic relationship is immediately in jeopardy and all attempts at assessment and intervention are at risk for failure. The physical healing may be rapid, but the memory of the event is long-lasting.

It is of note that not all adolescents have negative outcomes. Approximately 40% present with no symptoms and may embrace a sense of hopefulness and future orientation (Finkelhor & Berliner 1995). Related factors include age, severity of injury, developmental maturity,

and positive characteristics such as resilience, enhanced coping skills, high positive perception of self, and social support. This information can be used to promote mental health, but should be buffered with caution, as the term ‘sleeper effect’, which refers to 20% of those who are asymptomatic early on, denotes that there are some adolescents who will deteriorate over time (Putnam 2003). Despite evidence of health benefits from disclosure (Burgess *et al.* 1995; Pennebaker 1997) and that certain personality traits may portend disclosure or concealment tendencies, practitioners should explain how sharing distressing information in the clinical and home settings can be beneficial with a knowledgeable and compassionate provider. Every effort should be made to accept, without judgement, the antecedent choices made by the adolescent that created their personal vulnerability to the criminal, such as skipping school, sexual experimentation, drug experimentation, or the desire to be a gang member.

Negative feedback from disclosure is possible from peers, parents, practitioners, or necessarily involved law enforcement officers. Adolescents who tend to conceal distress and who are not likely to verbally express assault-related emotions may find writing or drawing about distressing situations to be beneficial (Clements *et al.* 2001; Smythe 1998). Whether immediate or long-lasting, responses are substantially impacted by psychotherapeutic interventions. Conditions clinically associated with negative outcomes include depression and dysthymia (3–5% increased incidence). Interestingly, the gender differences in symptom expression of depression disappear over time (Putnam 2003), whereas others have found worse outcomes with boys (Gold *et al.* 1999).

Long-term effects

Adolescents of both genders with a history of sexual assault are more likely to be arrested for sex crimes and prostitution, putting them at higher risk for teen pregnancy, more and multiple partners, sexually transmitted diseases, and HIV risk-related behaviours (Wordes & Nunez 2002). Early pregnancy and delivery complications are also more likely with teens who have been sexually assaulted (Stevens-Simons & Reichert 1994). Arata (2002) noted that victimization with physical contact leads to the greatest risk of revictimization. Physical effects associated with adolescent sexual assault include an increased incidence of soft tissue injury, pelvic pain syndromes, dissociative disorders, and an inability to trust that directly impacts the potential for intimate relationships. Moreover, the victimization is reported to increase in severity, leading to a cumulative effect and greater post-traumatic stress symptomatology, dissociation, and other psychiatric symptoms. It is the emotional

and behavioural effects of the victimization that increase vulnerability and result in recurrence (Arata 2002).

Neurobiological, emotional and developmental sequelae

In recent years, community and mental health practitioners have come to realize that there are unseen consequences and deleterious neurobiological sequelae following traumatic events of all types, including witnessing domestic violence or homicide, rape, physical assault or other criminal events. In some cases, the trauma affects the hypothalamic-pituitary-adrenal (HPA) axis, the sympathetic nervous system, and, very likely, the immune system. Anatomically, those with a sexual abuse history have been found to have reduced hippocampus volume, similar to combat veterans with post-traumatic stress disorder. Hence, it is not difficult to comprehend that neuronally-sensitive developmental processes may be interrupted and subsequent behaviours affected beyond the maturation period in adolescent survivors.

Disorders of extreme stress not otherwise specified (DESNOS) account for the effects of childhood and adolescent abuse in numerous studies cited by Putnam (2003). Characterization of DESNOS typically includes: (i) altered affect regulation, such as dysphoria, chronic suicidal thoughts, and anger control; (ii) altered consciousness, such as flashbacks; (iii) altered self-perception, such as helplessness, shame, guilt, and self-blame; (iv) altered relationships with others, such as persistent distrust and withdrawal, and failure to protect self; (v) altered systems of meanings, such as hopelessness and despair; and (vi) somatization. Therapy that focuses on these symptoms is comprehensive and long-term. Thus, it is important for the clinician to create an environment that is therapeutic and confidential to begin to ask about the history of abuse and assault. This should additionally include an exploration of the adolescent's relationship to the assailant and his/her perception of the event, which will also provide guidance for proper referrals.

Developmental factors that influence adolescent reactions to sexual assault include their appraisal of the threat, any intrapsychic meaning they attribute to the event, their emotional and cognitive means of coping, their capacity to tolerate strong affects, and their ability to adjust to other changes in their lives (Burgess *et al.* 1995). Subsequently, sexual assault shakes the confidence adolescents might have relative to this sense of security and create confusion regarding the ongoing development of moral codes and determining right and wrong. It can also confound their ability to understand societal norms of interpersonal boundaries, safety, and respect for the value of life. This disruption manifests in

counterproductive behaviours and attitudes (Burgess *et al.* 1995), with a potential to change normal situational adolescent behaviours into persistent antisocial behaviours that plague the adolescent throughout adulthood.

The sexually assaulted adolescent is often in a position of significant inequity of control. Someone, typically an adult or peers of the same age, has exerted his/her power and control to the disadvantage of the adolescent. Additionally, the offenders may tell the teen they can never 'tell' anyone about what happened or else something more terrible will occur. They may be told it was their fault and that they initiated the assault by something they said, their actions, or their clothing. It is important to use the knowledge of this inequity of control as a guide for clinical assessment. The supportive environment of the history and physical examination or other clinical assessment can provide a conduit for the teen to reveal abuse and to seek an anchor for safety (Burgess *et al.* 1995; Clements & Benasutti 2003).

It is also critical to remember that all information in the medical record gleaned from the assessment may be used to prosecute an offender. The most accurate and objective information is gained using therapeutic and forensic medical-legal interview techniques (e.g. open-ended questions, open-body positions, undivided attention to the patient), and physical assessment techniques that educate and empower the adolescent to participate (Speck 1999) while anticipating and validating normal growth and development. Detailed precise documentation, using direct quotes whenever possible and objective phraseology to describe the facts of the case (Speck 1999), and implementing a collaborative plan that considers a healthy outcome are the most important things that the clinician can do for the adolescent.

EDUCATION FOR FAMILY MEMBERS

Parents may not be the offenders and may have survived their own abuse. Hence, they underestimate the severity of distress, need for support, and the feelings that adolescents internalize after an interpersonal trauma (Clements & Burgess 2002; Stoppelbein & Greening 2000). Family therapy may be beneficial for all involved. Parents may be in denial and subsequently blame themselves or the adolescent for the assault. Adolescents typically do not disclose or describe the trauma because they do not want to further upset their parents. Often, adolescents do not want the parents to know because they are usually doing something that they will get in trouble for like skipping school, doing drugs or involvement with a boyfriend that the parents don't like. Occasionally, true to the adolescent's perception, the parents have overt reactions to disclosure after sexual assault. The adolescents are aware

of the potential significant emotional cost and loss resulting from their disclosure.

Families should be informed that sexual assault can create feelings of intrapsychic conflict regarding the developmental task of independence. This may be manifest in labile behaviours and emotions, and may also be expressed as multidirectional anger. The anger may be directed at the offender who betrayed them, directed at a parent who failed to protect them, or internalized as a manifestation of guilt and shame for not preventing the assault and for not being in control. Clinicians can help the adolescent sort through these feelings by illuminating the crime as described in the history, clarifying the expected chaos in the family, defining the post-assault vulnerabilities that have been identified in the history and physical evaluation, and encouraging family communication.

The adolescent may project anger onto the health care providers. This is especially significant in adolescence, when existing relational conflicts are common in the struggle for independence; it is confounded when the relational conflicts are dysfunctional and based on perceptions of tyrannical discipline. Parents should be involved in the therapy that addresses relational strain. Otherwise, adolescents may express their pain and trauma by becoming withdrawn or depressed or by developing physical symptoms (Burgess *et al.* 1995). Parents can be taught through anticipatory guidance to look for, inquire, and seek help when these symptoms appear in their child.

Finally, adolescents may believe that others can look at them and know what has happened. In the event others know about the assault, for example, when the assailant is a schoolmate and has bragged that he had sex with the victim, a safety plan and recommendations for creating a safe school environment are essential for recovery.

CONCLUSION

Adolescents have significant derailing emotional and traumatic reactions to sexual assault. Sexual assault occurs as a result of various motives and can be an impulsive act or a skilfully calculated attack. Sexual assault has a detrimental effect on adolescent intrapsychic development and interpersonal relationships. Symptoms are disturbing and disruptive to daily routines, negatively affect adolescents' normal growth and development, and can result in an array of psychiatric symptoms, including post-traumatic stress disorder. Practitioners must provide adequate assessment and therapeutic intervention to the most vulnerable to mitigate severe post-traumatic reactions and transmute perceptions into adaptive methods of coping.

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