Prevention: Sexual Violence Against Adolescent and Young Adult Women

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Chapter 20

PREVENTION: SEXUAL VIOLENCE AGAINST ADOLESCENT AND YOUNG ADULT WOMEN

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INTRODUCTION

Sexual violence is a “profound social and public health problem in the United States,” according to the Centers for Disease Control and Prevention, and it has been found that adolescent females aged 16-24 years are four times more likely to be victims of sexual violence than women in all other age groups, with a lifetime prevalence of rape or attempted rape as high as 42% (1). Sexual assault has historically been viewed as a stranger in the bushes phenomenon, where an unknown perpetrator attacks the victim after which the victim reports the assault to the police and evidence is collected immediately (1,2). However, evidence-based research shows that sexual assault by a known perpetrator is much more
prevalent than sexual assault by a stranger (3) and is often either an acquaintance or dating partner (1). Rates of sexual assault by known perpetrators range between 50 to 88% of total identified assaults (3).

Rape is the most common violent crime on American college campuses today, and ninety percent of college women who are victims of rape know the perpetrator (2). Studies of college-aged populations suggest that a significant portion of young adult victims do not report acquaintance rape, specifically because of the relationship (4). In fact, fewer than five percent of college women who are victims of rape report it to the police (2). It has been postulated that adolescent victims may be even more reluctant to report acquaintance rape due to past sexual intimacy with the perpetrator or due to date-specific behaviors such as the use of alcohol or drugs (4). Table 1 shows a list of the most frequent reasons female college students choose not to report sexual assault experiences to the authorities.

Table 1. Reasons for not reporting acquaintance rape (2)

<table>
<thead>
<tr>
<th>Reason</th>
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<tr>
<td>Embarrassment and shame</td>
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<tr>
<td>Fear of publicity</td>
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<tr>
<td>Fear of reprisal from perpetrator</td>
</tr>
<tr>
<td>Fear of social isolation from the perpetrator’s friends</td>
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<tr>
<td>Fear that the police will not believe victim</td>
</tr>
<tr>
<td>Fear that the prosecutor will not believe victim or will not bring charges</td>
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**Risk Factors for Sexual Assault against Adolescent and Young Adult Females**

Many factors have been associated with increased risk for sexual assault against adolescent and young adult females. One risk consistently cited is that of a history of sexual victimization as either a child younger than 12 years or an adolescent younger than 18 years (1). Some research has shown that young adult females with sexual abuse histories may have difficulty in accurately perceiving risk in potentially harmful sexual situations and may, therefore, be more vulnerable to repeated victimizations (5). Other identified risk factors include number of dating and sexual partners, earlier age at menarche and/or first date, history of dating violence, and a sexually active peer group (1). The context in which the date occurs may also impact the probability of sexual assault. If the male initiates the date, pays for the date, and drives, the possibility of sexual assault increases. Additionally, the use of alcohol and/or drugs by the victim, perpetrator, or both also increases the likelihood of a sexual assault (1).

**Sequelae of Sexual Assault**

Females who experience sexual assault also often experience a dramatic negative impact on their functioning. As many of 50% of rape victims will develop Posttraumatic Stress Disorder and many will develop other psychological disorders (6). Victims also often have more somatic complaints and more chronic pain than nonvictims. Rape victims have been shown to
utilize health care services twice as often and report engaging in twice as many negative health behaviors, such as smoking or drinking excessively, when compared to nonvictims (6). Regardless of the ill effects, many victims of sexual assault do not inform their healthcare providers nor do they seek mental health treatment, even though disclosure has been identified as an important step in recovery and improved health (4).

SCREENING AND REFERRAL FOR SEXUAL ASSAULT IN ADOLESCENT AND YOUNG ADULT FEMALES

The American Academy of Pediatrics, the American College of Obstetricians and Gynecologists and the American Medical Association all endorse universal screening for intimate partner violence (IPV), one form of which is sexual assault (4) and it has been recommended that all female patients over age 14 years be screened regardless of symptoms or signs of abuse, and regardless of whether the provider suspects abuse has occurred (7). Further, a number of practice organizations have practice guidelines that recommend screening for IPV (8). Nonetheless, actual screening rates remain low (9).

In recent research asking whether young women between the ages of 15 and 24 years supported universal screening for IPV in a healthcare setting, the majority surveyed indicated overwhelming support. However, underage females (15-18 years), were 2.9 times more likely to voice many concerns regarding violence screening by a provider than those young women aged 19-21 years (10). It was speculated that females under the age of majority may have greater concerns of confidentiality, since there might be a greater likelihood that adults would be given information that the younger teens might not want revealed. A study (6) with regard to violence screening specific to sexual violence, showed that 52% of women reported that they had never been screened for sexual violence nor provided any type of information about sexual violence by their healthcare professional. Table 2 includes some tips for physicians when they see a victim of acquaintance rape.

Table 2. Tips for physicians

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<tr>
<td><strong>1</strong></td>
<td>Listen to the victim without expressing shock or judgment</td>
</tr>
<tr>
<td><strong>2</strong></td>
<td>Determine the nature of the relationship with the perpetrator and whether or not the sexual victimization occurred in the past, present, and/or is ongoing</td>
</tr>
<tr>
<td><strong>3</strong></td>
<td>Explain the rights and options the victim has with regard to reporting, prosecution, and treatment</td>
</tr>
<tr>
<td><strong>4</strong></td>
<td>Involve the victim’s parents when possible and appropriate</td>
</tr>
<tr>
<td><strong>5</strong></td>
<td>Provide resources and referrals for support and treatment</td>
</tr>
<tr>
<td><strong>6</strong></td>
<td>Perform a physical examination, if appropriate, including tests for sexually transmitted infections and pregnancy</td>
</tr>
<tr>
<td><strong>7</strong></td>
<td>Explain the necessity for reporting the assault to the authorities, i.e., the law determines what is reportable, and make the report in a timely manner</td>
</tr>
<tr>
<td><strong>8</strong></td>
<td>Schedule a follow-up appointment for the discussion of test results, information obtained regarding the legal report, and assessment of victim’s emotional status and progress toward obtaining support and treatment</td>
</tr>
<tr>
<td><strong>9</strong></td>
<td>Continue medical treatment for the victim as determined by need and desire on the part of the victim</td>
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Healthcare providers have been questioned regarding their reasons for not screening their patients for sexual and other types of violence. In one review of 12 studies identifying barriers to IPV screening, respondents reported several concerns, including the lack of effective interventions for IPV once identified, fear of offending patients, lack of provider education about IPV, and limited time. Additionally, providers reported that they were concerned about patient nondisclosure, patient fear of repercussions, and patient noncompliance (9,10).

**PREVENTION**

A publication by the World Health Organization (WHO) together with the London School of Hygiene and Tropical Medicine on preventing intimate partner and sexual violence against women outlined several key strategies (11):

**During infancy, childhood and early adolescence**

- Implement home-visitation and parent-education programmes to prevent child maltreatment
- Improve maternal mental health programs
- Identify and treat conduct and emotional disorders in children
- Improve interventions for children and adolescents subjected to child maltreatment and/or exposed to intimate partner violence
- Improve school-based social and emotional skills development
- Implement school-based training to help children to recognize and avoid potentially sexually abusive situations
- Implement bullying prevention programmes

**During adolescence and early adulthood**

- Implement school-based programmes to prevent dating violence
- School-based multi-component violence prevention programmes
- Sexual violence prevention programmes for school and college populations

**During adulthood**

- Execute empowerment and participatory approaches to reduce gender inequality
- Apply home visitation programs to prevent intimate partner violence
- Execute multi-component programs (like the program to prevent suicide by the US Air force, which with is multi-purpose program managed to reduce the rate of suicide by 33% and the rates of severe and moderate family violence by 54% and 30% respectively)

**All life stages**

- Reduce access to and harmful use of alcohol
Prevention: Sexual violence against adolescent and young adult women

- change social and cultural norms related to gender that support intimate partner and sexual violence

The WHO report (11) found it important to achieve change at the population level and target societal-level factors in the primary prevention of intimate partner and sexual violence. This can be achieved by various strategies, like enactment of legislation and the development of supporting policies that protect women; addressing discrimination against women and helping to move the culture away from violence – thereby acting as a foundation for further prevention work.

CONCLUSION

Sexual assault against adolescent and young adult females is a public health problem of great prevalence. Most sexual assault is committed by a person known to the victim, and the majority of victims do not report the assault even though it has been shown that disclosure is often an important part of the healing process. Universal screening for sexual and other types of violence in personal relationships is recommended by a number of healthcare practice organizations, but many healthcare practitioners do not practice universal screening for a variety of reasons, including lack of knowledge regarding referral or intervention after a disclosure and lack of provider education about IPV. Healthcare providers would benefit from formal education and training regarding sexual and other forms of violence against women. They should also be provided with referral and treatment resources for females who are victims of violence.

REFERENCES