

Gender Differences in Extrafamilial Sexual Abuse Experiences Among Young Teens

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ABSTRACT: Extrafamilial sexual abuse experiences of young adolescents (ages 10–14), particularly young teen boys, are not well studied. This retrospective chart review study compared psychosocial correlates and victimization experiences between young adolescent girls ($n = 226$) and boys ($n = 64$) referred to a hospital child advocacy center. Several differences in risk behaviors and abuse experiences were found: Girls were more likely to have run away, to be truant from school, to report substance use, to have multiple perpetrators, and to have physical findings from the abuse. Boys were more likely to have a diagnosis of attention deficit disorder and to report anal penetration, and rarely disclosed abuse at the time of the incident. Peers were girls' most common choice for disclosing abuse, whereas boys confided most often in their mothers or other adults. These findings suggest sexually abused young adolescent girls and boys need distinct, developmentally appropriate screening and care in school and health care settings.

KEY WORDS: adolescent, gender differences, risk factors, sexual abuse, victimization

INTRODUCTION

Extrafamilial sexual abuse is more common than incest for both adolescent boys and girls (Saewyc, Pettingell, & Magee, 2003). Sexually abused adolescents are at risk for an array of negative health consequences, including substance abuse, depression and self-harm, sexually transmitted infections (STIs), unintended pregnancy, and further sexual and physical violence (DeBellis, 2001; Holmes & Slap, 1998; Saewyc, Magee, & Pettingell, 2004). Health care professionals need to be aware of the abuse experiences of these boys and girls in order to respond to their immediate needs when sexual abuse is disclosed, to understand the association of risk behaviors and abuse, and to have awareness of future health consequences. How-

ever, little is known about the extrafamilial abuse experiences of young adolescent boys and girls (Fargason, Zorn, Ashworth, & Fountain, 1997; Finkelhor, Ormrod, Turner, & Hamby, 2005). These young teens' experiences may indicate that they have health care needs distinct from those of older adolescents and that young adolescent boys have needs different from those of girls.

Although studies have documented gender differences in the prevalence of sexual abuse among teens, few studies have focused on early adolescence or extrafamilial abuse or have compared abuse experiences and legal outcomes for these 10- to 14-year-old girls and boys. The purpose of this study was to describe the sexual abuse experience and associated risk behaviors associated with young adolescent boys and girls who were interviewed and examined at a hospital-based child advocacy center.

LITERATURE REVIEW

Past research on childhood sexual abuse has focused overwhelmingly on girls and young children or older teens (Finkelhor, 1994; Holmes & Slap, 1998). Research on male victims of sexual abuse indicates that male victimization is more pervasive than re-

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ported in crime statistics (Finkelhor et al., 2005; Saewyc, Pettingell, & Magee, 2003). In school-based population surveys of older adolescents, nearly one in six students reported a history of sexual abuse; girls were more likely to report abuse than were boys (Holmes & Slap; Saewyc, Pettingell, & Magee). The prevalence of male and female victimization varies greatly depending on the definition of abuse, the population surveyed, and the method of data collection (Finkelhor et al.).

Studies including sexual abuse experiences of young teen boys and girls are minimally represented in the literature (Finkelhor et al., 2005; Holmes & Slap, 1998; Saewyc, Magee, & Pettingell, 2004). The literature tends to focus on intrafamilial abuse of younger children or reports of older adolescents in school-based surveys (Edinburgh, Saewyc, Thao, & Levitt, 2006). Sexual abuse appears to be underrecognized and undertreated for both boys and girls (Holmes & Slap). Further, there are gender differences in the risk behaviors associated with teens who report forced or pressured sex (Shrier, Pierce, Emans, & DuRant, 1998). This may be, in part, because of how sexual abuse is disclosed (Sorenson & Snow, 1991). There are also wide differences among communities in how the disclosure of sexual abuse is handled and in the help available to girls and boys disclosing abuse (Berliner & Conte, 1995). Although the literature supports that children disclose abuse in layers and first disclose abuse to those they trust, who young adolescents first talk to about their abuse is not well documented (Palusci, Cox, Shatz, & Schultze, 2006).

Research finds that the majority of perpetrators for both girls and boys are males (Banyard, Williams, & Siegel, 2004; Edinburgh, Saewyc, Thao, & Levitt, 2006). When females have been identified as abusers, more than 40% were friends and acquaintances, and another 30% gained access to the victim through babysitting (Rubenstein, Yeager, Goodstein, & Lewis, 1998; Holmes & Slap, 1998). Although most of the perpetrators of sexual abuse tend to be from outside the family, very few of those extrafamilial perpetrators are strangers (Lenderking & Mayer, 1997). Ninety percent or more of perpetrators identify as heterosexual (Jenny, Roesler, & Poyer, 1994).

Sexual abuse during childhood or adolescence has been associated with a great number of negative outcomes, including increased risk for pregnancy, sexually transmitted diseases (STDs), substance use and abuse, mental health problems, school and family problems, and higher risk of subsequent sexual assault and intimate partner violence (Saewyc, Magee, & Pettingell, 2004). Mental health problems for abused boys and girls include greater rates of posttraumatic stress disorder, major depression, anxiety disorder, borderline personality disorder, antisocial personality disorder, paranoia, dissociation, somatization, bulimia, anger and aggressive behavior, and poor self-image

(Holmes & Slap, 1998; Nagy, Adcock, & Nagy, 1994). Abused teens are also more likely to report poor school performance, running away from home, and legal trouble compared with those who have not been abused (Rotheram-Borus, Mahler, Koopman, & Langabeer, 1996). Sexually abused boys and girls are both more likely than their nonabused peers to be involved in pregnancy, often due to higher involvement in unprotected sexual behaviors and multiple partners. However, in one study, abused boys had higher odds of pregnancy involvement than similarly abused girls did, when compared with their nonabused peers (Saewyc, Magee, & Pettingell).

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The health care required once a boy or girl has been identified as being a victim of sexual abuse is well described (Kellogg, 2005). The diagnosis of sexual abuse is made almost entirely from the history provided by the child or teen (Adams, 2001; DeJong & Rose, 1988; Levitt, 1993), so how teens are questioned about abuse becomes paramount, not only for how victims are treated within the health system, but also for the criminal investigation. After the history is obtained, a complete physical assessment is necessary (Kellogg; Levitt, 1992). Physical evidence may need to be gathered immediately, but can still be present months after an assault for girls in the form of healed hymeneal transections or pregnancy (Adams), as well as anogenital scarring and untreated STIs for both boys and girls (Adams; Berenson et al., 2000). However, the lack of physical evidence does not mean abuse did not occur; sexual abuse often does not produce physical anogenital trauma that leaves scars (Adams, Harper, Knudson, & Revilla, 1994).

METHODS

A retrospective chart review was completed for all girls and boys ($N = 290$) ages 10.0–14.99 years who were diagnosed with extrafamilial sexual abuse at a Midwestern hospital-based child advocacy center between 1998 and 2003. The clinic is located in a Midwestern city. The center uses a multidisciplinary model of care, with both nurses and physicians highly experienced in evaluating children and adolescents for suspected physical and sexual abuse. Sexual abuse–related health care assessments were conducted by a health care practitioner who was expert in abuse assessment; these evaluations consisted of a solo interview with the patient, an interview with a parent or

caretaker (if available), a physical exam, a video-colposcopic genital exam, tests for sexually transmitted disease, and appropriate collection of forensic evidence. Interviews with adolescents were semistructured and were videotaped as per the clinic protocol. If there were questions about the teen's abuse after the chart review, the videotaped interview was reviewed. Also, SCAN Trak (Midwest Children's Resource Center, St. Paul, MN), a computer program that is used to prospectively track information on all sexual abuse cases evaluated in the clinic, was used to determine legal outcomes of the reviewed cases.

Demographic characteristics, risk behaviors, abuse experiences, physical findings, and legal outcomes were compared for girls and boys using cross-tabulations with chi-square and *t* tests. A *p* value of $<.05$ was considered statistically significant. Youths were excluded from the study if they lived with the perpetrator, the perpetrator performed caretaking responsibilities, or they did not disclose sexual abuse. Because cases were limited to medically diagnosed cases of extrafamilial sexual abuse, results may not be generalizable to cases of suspected sexual abuse or cases of incest. This project was approved by the Institutional Review Board of the hospital.

RESULTS

Demographically, the sample consisted of 22% boys ($n = 64$) and 78% girls ($n = 226$). The boys were slightly younger than the girls, with mean ages of 11.83 and 12.58 years, respectively. The largest group of teens lived in one-parent homes (41.5%), but significant numbers lived in two-parent homes (24.6%), out-of-home placements (15%), or blended families (13.8%). A smaller percentage (5.2%) lived with other relatives. There were no differences in living arrangements between the boys and the girls. The girls were more likely to come from larger families with a mean number of 2.49 siblings (*SD* 2.02) compared with the boys, who had a mean of 1.59 siblings (*SD* 1.23). The majority of teens lived in urban or suburban settings.

Many psychosocial correlates differed markedly between boys and girls (Table 1). Boys were truant significantly less often (measured by missing 15 or more days of school in one school year) and had run away from home less. Boys were also less likely to have a history of cutting or burning themselves. There were no statistically significant differences between the groups regarding a history of suicidal ideation or prior psychiatric hospitalization. Boys were more likely to have a prior diagnosis of attention deficit/hyperactivity disorder (ADHD). There were no statistically significant differences between the groups concerning other previously diagnosed chronic medical conditions. Boys reported alcohol and drug use less often than did girls.

There were no differences between the two groups in prior exposure to domestic violence or the likeli-

hood of a personal history of physical or sexual abuse. In cases where prior abuse had occurred, boys reported that it occurred at a younger age than girls reported (boys, 5.78 vs. girls, 7.51 years; $t = 2.50$; $df = 16.57$; $p = .023$).

The abuse experiences of boys were strikingly different from those of girls. Boys were more likely than girls to have a sexual abuse experience with a single extrafamilial perpetrator. Thus, boys were less likely than girls to report gang rape, multiple extrafamilial assaults, or involvement in prostitution. Among boys, none had five or more perpetrators, whereas 11.6% of the girls had at least five perpetrators. Boys were more likely to report anal penetration. Overall, boys experienced fewer acts of sexual abuse, but were more likely to describe unusual sexual abuse experiences and to have been exposed to pornography. Perpetrators for both groups were overwhelmingly male, but boys were more likely to experience an abuse event with a single older juvenile (boys, 44.4% vs. girls, 24.7%; $\chi^2 = 13.65$). Boys never or rarely reported alcohol or drug involvement during the assault.

Once abuse occurred, boys were most likely to talk to their mothers or other adults, whereas girls talked to their peers first about the abuse incident.

Once abuse occurred, boys were most likely to talk to their mothers or other adults, whereas girls talked to their peers first about the abuse incident (Table 2). However, boys were more likely than girls to state that there was no one whom they could talk to about the incident. Boys were significantly less likely than girls to report the abuse within 72 hours. When the incident was reported less than 30 days after it occurred, boys reported it an average of 4.76 days later than girls (boys, 12.17 vs. girls, 7.14; $t = 2.49$; $df = 143$; $p < .05$). When the incident was reported more than a month later, boys were also significantly more likely to delay reporting at least 3 months longer (boys, 8.08 months vs. girls, 5.06 months; $t = 1.79$; $df = 48$; $p < .05$).

Boys were unlikely to have anogenital injury exam findings that were consistent with abuse (2%), but such findings occurred in 27% of girls' examinations (Table 1). There were no significant differences regarding whether or not an evidence collection kit or testing for STDs was completed when controlling for a history of penetration. DNA evidence was seldom available (5.9% of cases overall had DNA found), due to several reasons: few cases were reported within 72 hours, a small number of victims refused exams, evidence kits were sometimes not collected with types of assault unlikely to produce forensic evidence, and evidence kits were sometimes not processed at the lab even when collected (e.g., when a perpetrator confessed). However, among those victims where evi-

dence collection kits were used and results were charted (36 cases), 16 cases, or 47.2%, had DNA findings, and all of them were girls. Nearly one in five of those had DNA found on clothes (18.8%); also, some of those with positive DNA had evidence collected even when the case was reported slightly later than 72 hours after the assault.

Overall, STDs occurred infrequently (<7% of the overall sample). When considering only those who had vaginal or anal penetration and were tested for STDs, this percentage is more accurately 12.7%. It should be noted that all those with positive chlamydia, gonorrhea, and syphilis cultures were girls, but due to the low rates of infection, there were no statistically

significant differences between boys and girls in any STD test results.

The majority of sexual abuse cases were prosecuted (60.9%), but there were no significant differences by gender. Males were overwhelmingly the most likely perpetrators of sexual abuse for both girls and boys. Female adult or juvenile perpetrators were rare.

DISCUSSION

This study demonstrates that there were numerous marked differences in psychosocial correlates and abuse experiences of the young adolescent boys and girls in this sample. The most marked gender-related psychosocial differences were in the number of girls

Table 1. Comparisons of Sexual Abuse Experiences Between Boys and Girls

Variable	Boys (%)	Girls (%)	χ^2	df	p Value
Risk Factors					
1. Running away	1.6	19.9	11.01	1	.001
2. Truant	3.2	25.2	13.39	1	<.001
3. Domestic violence	34.0	35.3	0.034	1	NS
4. Prior physical abuse	14.5	9.8	1.11	1	NS
5. Prior sexual abuse	14.5	23.1	2.15	1	NS
6. History of alcohol use	5.0	25.1	10.27	1	.001
7. History of drug use	1.6	14.0	6.03	1	.007
8. ADHD	33.9	9.9	19.99	1	<.001
9. All other prior medical/psych conditions	27.4	19.7	2.05	3	NS
Assault Variables					
1. Time from assault to exam >72 hours	93.5	75.2	8.8	1	.003
2. Perpetrators' ages:					
Adult only	55.6	65.3			
Juvenile only	44.4	24.7			
Adult & juvenile	0.0	10.0	13.65	2	<.001
3. Perpetrator's gender:					
Single female	1.6	1.3			
Single male	93.7	78.2			
Multiple males	3.2	17.3			
Males & females	1.6	3.1	8.8	3	.032
4. No./type of perpetrators					
Single	95.2	68.3			
Multiple perpetrators (gang rape, prostitution)	4.8	24.4			
Stranger rape	0.0	7.2	18.42	2	<.001
5. Number of sexual acts					
1	34.9	50.7			
2 to 4	33.3	17.8			
5 or more	31.7	31.6	8.21	2	.017
6. Use of pornography	25.8	3.6	28.57	1	<.001
7. Weapon use during abuse	6.5	5.9	0.028	1	NS
8. Drug use during abuse	3.2	9.9	2.77	1	NS
9. Perpetrator used penis in vagina and/or anus	37.5	67.7	17.88	1	<.001
10. Penile-anal assault only	38.7	12.6	20.53	1	<.001
11. Kissing as part of assault	6.5	20.6	5.8	1	.009
Physical Findings of Abuse Exam					
1. Anogenital injury indicative of abuse	1.6	27.4	18.50	2	<.001
2. DNA found (exams with evidence kit only)	0.0	48.6	(x ² not stable due to small expected counts in cells)		
3. Positive chlamydia culture (among penetrated only)	0.0	10.9	2.30	1	NS
4. Positive gonorrhea culture (among penetrated only)	0.0	2.3	.447	1	NS
Legal Outcomes					
1. Case was prosecuted	64.7	60.2	0.24	1	NS

Note. NS = not significant.

who were truant from school, ran away from home, and had a history of cutting or burning themselves. The abuse experiences were also different. Boys were more likely to have only one perpetrator, whereas the girls experienced more abuse events and more perpetrators per abuse event.

Although there were no differences between the sexes in the type of fondling acts, boys reported penile-anal penetration more often than girls did. Physical findings from penetration were rare in boys and more common in girls, consistent with other research (Heppenstall-Heger et al., 2003). Boys were more likely to be exposed to pornography and to report unusual sexual acts that are far removed from mainstream sexual activity.

Boys were more likely to have a juvenile perpetrator, whereas girls had older perpetrators. The boys' perpetrators' ages may have reduced their access to alcohol or drugs, explaining the lower frequency of alcohol or drugs during the sexual abuse event. Alcohol or drug intoxication can be a risk factor for sexual assault, and more girls than boys reported alcohol and drug involvement occurring along with the assault. Girls were also more likely to report gang rape or to have multiple perpetrators. These sexual abuse experiences of girls were closely linked to a history of running away, which may put them at greater risk for multiple victimization.

On average, the boys were younger than the girls were in this sample. This does not necessarily indicate that perpetrators against boys seek younger victims than do those against girls. As they get older, boys simply may be less likely than girls to report abuse. The boys may fear that sexual contact with a same-gender perpetrator implies homosexuality and may wish to avoid the stigma that a gay or bisexual identity can confer (Saewyc, Magee, & Pettingell, 2004). Other possible reasons include common beliefs, such as "males are able to protect themselves from abuse" or "males want to have sex." These beliefs also may hinder self-reporting of sexual abuse as boys become older and develop increased awareness of societal norms. Such messages also portray the male as the initiator of sex, which may increase boys' shame in disclosing abuse that has been forced on them (Saewyc, Magee, & Pettingell). These complex pressures complicate the process of disclosing abuse for the adolescent boy.

Table 2. Gender Difference in Patterns of Disclosure of Abuse

Whom Teen Talks to About the Abuse	Boys (%)	Girls (%)	χ^2	df	p Value
No one	17.8	11.2			
Perpetrator or gang members	2.2	4.1			
Peer	15.6	42.6			
Other adult	35.6	24.3			
Mother	28.9	17.8	12.49	4	.014

The younger age of boys in this sample may be a contributing factor to their lower level of truancy, run-away events, and alcohol and drug use. The boys were more likely to be in lower grades in school, placing them in a peer cohort that may not be exposed to these behaviors yet. Although psychiatric diagnoses such as depression, anxiety disorders, and bipolar disorder occurred in both groups, boys were significantly more likely to have a diagnosis of ADHD. Boys with ADHD may already be at the fringe of the main peer group because of lower self-esteem or poor performance in school. The ADHD boy may therefore be more susceptible to the perceived friendship of an older male and potential perpetrator.

The patterns of disclosure differed between boys and girls. Girls were more likely to talk to their peers about the abuse incident, whereas boys were most likely to talk to their mothers. However, boys were also more likely to state that there was no one to tell about the sexual abuse incident. This may help explain why the cases of reported sexual abuse among boys are lower than the prevalence of abuse self-reported in population-based student surveys. School-based surveys are anonymous and are a place where boys identify as having been abused. School-based surveys reveal large numbers of boys reporting sexual abuse, but when boys are counted as victims in police reports they are underrepresented as victims. This may be occurring because boys are more likely to report having no one to confide in about their abuse experiences. If a boy does not talk to anyone about the abuse experience, the crime is not going to be reported, and thus the boy will not be counted in national victimization statistics.

Both sexes commonly delayed reporting the abuse. Thus, forensic evidence from the sexual assault rarely was available, and decisions about prosecution of offenders were going to be made primarily on the basis of the victim's statement and through police interviews with alleged offenders.

Both sexes commonly delayed reporting the abuse. Thus, forensic evidence from the sexual assault rarely was available, and decisions about prosecution of offenders were going to be made primarily on the basis of the victim's statement and through police interviews with alleged offenders. There appeared to be no gender bias in patterns of charges brought against the perpetrator of criminal sexual conduct cases. In addition, the gender of the victim did not appear to influence whether the case was prosecuted.

This study includes all the cases from 1998–2003

from a regional child advocacy center, which provides a detailed view of extrafamilial sexual abuse cases among young adolescents who have been referred for examination. Although this includes both rural and urban areas in the upper Midwest region, it should be noted the cases primarily come from one state. Legal outcomes could differ in other states, because charging of criminal sexual cases vary by jurisdiction and state. Likewise, the majority of cases were referred as a result of disclosure; to the extent that young adolescent boys might be less likely than girls to disclose abuse, these findings may reflect differences in willingness to disclose as much as differences in abuse experiences and outcomes.

This is a chart review, with the limitations inherent in the quality of charted data. However, because medical records from child advocacy centers are used often in court proceedings, the clinic employs rigorous, systematic checks to audit the accuracy and completeness of charting. Successful prosecution of abuse relies on the testimony of expert witnesses being able to clearly communicate the victim's health history and physical exam from medical records created at the time the patient was seen. The accuracy and completeness of medical charts from the child advocacy center may be stronger than the usual level in clinics whose records are not regularly held up to scrutiny in a court of law.

IMPLICATIONS FOR SCHOOL NURSING PRACTICE

The findings reported here suggest that sexually abused young adolescent boys and girls have distinct needs, but that both boys and girls should be screened for sexual abuse. It is important to train school staff and health care providers on best practices for screening young adolescents for a history of sexual abuse. This is especially vital if there is a history of truancy or running away. School nurses should be aware that boys and girls within the ADHD spectrum of behavioral disorders also may be at increased risk for abuse, as their impulsivity or behavioral challenges may make them more vulnerable (Ford et al., 2000). However, it is also possible that young adolescents with posttraumatic stress syndrome (PTSD) from sexual abuse may be misdiagnosed as having ADHD, because many of the symptoms of both PTSD and ADHD overlap.

Although disclosure about a sexual assault usually occurs after the time period when forensic evidence is most likely to be found, school nurses can help ascertain the timing of the abuse and can make immediate referrals for examination when the abuse occurred within the last 72 hours. Immediate medical assessment is recommended for young adolescents after sexual abuse to identify physical injuries, to secure forensic evidence, and to provide prophylactic treatment to prevent pregnancy and STIs (Palusci, Cox, Shatz, & Schultze, 2006). Additionally, school nurses need to be aware that phys-

ical evidence is more likely to be present on the victim's clothes than on the body (Christian, Lavelle, DeJong, Loiselle, Brenner, & Joffe, 2000). In abuse cases that occurred more than 72 hours ago, school nurses can help report the abuse as mandated by individual state laws and arrange for the young adolescent to receive a physical exam during a scheduled appointment. This provides an opportunity for education, physical assessment, reassurance, and screening for asymptomatic STIs. This is also another chance to assure victims that they are not at fault and serves as an opportunity for further teaching about reproductive health care choices. This is important, because boys and girls with a history of sexual abuse are at higher risk for risky sexual behaviors and unintended pregnancy than their nonabused peers (Saewyc et al., 2004).

The individual to whom an abused teen chooses to disclose the abuse will most likely be a peer. This should be considered when planning the curriculum for sexual violence education programs in schools. Young teens are at a developmental stage in which talking with peers is becoming increasingly important. A peer, rather than an adult, will most likely be the first to hear and to react to the sexual abuse disclosure if a girl is disclosing. Although boys are more likely to disclose to their mothers, peer disclosure is also a pattern for them. Because young teens attend elementary or middle school, sexual abuse education in these settings needs to teach students what to do if a peer discloses abuse. School nurses can help provide clear messages on the definitions of sexual abuse and address social norms around sexual harassment and healthy relationships, thus helping prevent behaviors that perpetuate sexual harm. Staff responses to students' disclosures should be based on clear policies and knowledge of their responsibility for reporting abuse.

Ideally, school staff and nurses will be able to refer a young teen to a child advocacy center to be interviewed by an expert in sexual abuse. School nurses need to be familiar with their community's child advocacy center or abuse clinic nearest their location. Some jurisdictions have joint child protection and police reporting; some do not require a report to child protection about extrafamilial abuse. School nurses should identify the arrangement in their community. In some areas, sexual abuse services are provided in emergency departments by sexual assault nurse examiners, and youth are not seen in a child advocacy center. However, child advocacy centers can be a resource for nurses in all communities. They can provide education to health care providers about when abuse needs to be reported, as well as how to assess teens for different types of abuse.

School nurses need to be familiar with their community's child advocacy center or abuse clinic nearest their location.

Because young teens still have developmental difficulty with determining the timing of abuse and even describing the assault, the multidisciplinary child advocacy center benefits young teen victims of abuse. The centers' expertise in conducting sexual abuse assessments minimizes further trauma to the abuse victim, while providing legally rigorous evidence for prosecution of perpetrators. Many teens in this study had multiple perpetrators; many had multiple abuse events. The complexity of cases that may involve multiple perpetrators, occurring over different time periods, and even in separate cities, demands a multidisciplinary team approach.

CONCLUSION

There appear to be distinct gender differences in the demographics, abuse experiences, and related risk behaviors of very young adolescents referred to this study's medical setting for assessment of extrafamilial sexual abuse. Awareness of these differences may help researchers and clinicians understand potential differences in sequelae, to design effective treatment plans, and to develop community prevention programs. Additional research is needed to identify protective factors for young adolescents who have been abused and to determine how to promote these factors. School nurses can play a key role in helping prepare young teens for potential disclosure by their peers, in screening children at risk who may have been sexually abused, and in helping young victims and their families connect with appropriate services to address the abuse and help prevent negative sequelae.

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