

Module 4: Impact of Sexual Assault

Purpose

This module explores the physical and emotional impact of sexual assault.

Lessons

1. Physical Impact of Sexual Assault
2. Psychological Impact of Sexual Assault
3. Impact on Partners, Family, and Close Friends
4. Individual Factors Affecting Reactions to Rape

Learning Objectives

By the end of this module, you will be able to:

- Assess the physical and psychological impact of sexual assault.
- Describe the potential impact of rape on people with a range of particular characteristics.

Participant Worksheets

- Worksheet 4.1, STI Scenario
- Worksheet 4.2, Psychological Impact Scenario
- Worksheet 4.3, Participant Presentations

1. Physical Impact of Sexual Assault

In order to best meet the needs of rape victims, advocates must first understand the far-reaching impact of rape. The activity will offer the opportunity to explore the potential physical impact of rape.

Nongenital Physical Injury

The typical assumption is that rape victims experience physical injury during a rape. It also is assumed they will fight back and be injured as a result. In reality, that is not commonly the case. The literature indicates that physical injury resulting from sexual assault is relatively rare, and even minor injury occurs in only about one-third of reported rapes.

As discussed earlier, injury is more common in stranger rapes than in rapes by someone the victim knows intimately (Ledray 2010). Injury is often related to age. Victims under 20 and over 49 years of age are more likely to be injured (Read 2005).

Male victims appear to be injured more often than female victims. In one study of 351 rape victims, the rate of physical injury for male rape victims was found to be 40 percent, compared with 26 percent for female victims (Petrak and Claydon 1995). The SANE program in Minneapolis, between June 2006 and June 2007, found that 27 male rape victims were seen, representing 5 percent of all victims during that period. This is higher than the 2006 National Crime Victim Survey that found 2.8 percent of men reported sexual assault (Tjaden and Thoennes 2009).

The male victims at the Minneapolis program were physically injured 53 percent of the time, compared to 27 percent of the female victims (Ledray, unpublished data). It is important to consider that the injury may have motivated males, hesitant to disclose to law enforcement, to come to a medical facility for treatment.

Far less data exist on lesbian, gay, bisexual and transgender, and bisexual victimization; however, available literature suggests similar rates of injuries for lesbian, gay, bisexual, and transgender adolescents and adults.

Genital Trauma

Few rape victims sustain significant genital trauma as a result of the sexual assault. Colposcopic (magnified) examination has been helpful to visualize vaginal abrasions, bruises, and tears that may be too minute to see with the naked eye (Frank 1996; Slaughter and Brown 1992).

These minor injuries, the result of tightened pelvic muscles and the lack of pelvic tilt and lubrication during forced penetration, usually heal completely within 48 to 72 hours. With colposcopic examination, genital trauma has been identified in up to 87 percent of cases (Slaughter and Brown 1992).

The colposcope is used less today, however, as the pictures of the tears taken with the colposcope are very rarely used in court, and the minute injuries they help identify can also be the result of consenting sexual contact (Slaughter and Brown 1992). Photographic documentation of major injury, visible with the naked eye, is still important and may be used in court; however, SANEs today will more likely document this trauma with a digital camera. Since rape victims often fear vaginal trauma, it is important that they seek a medical examination and that the extent of the trauma, or lack thereof, is documented and explained to them for reassurance (Ledray 2006).

Sexually Transmitted Infections (STIs)

While one study found that 36 percent of the rape victims coming to the emergency department stated that their primary reason for coming was concern about having contracted an STI (Ledray 1991), the actual risk is rather low. It is still important that victims get medical treatment to prevent the STIs that can be easily prevented. In addition to the serious psychological implications, such as fear of contracting an STI, this can prevent medical complications (i.e., the victim actually does contract an STI) as well (Simpson 2011).

The U.S. Centers for Disease Control and Prevention (CDC) estimates that the risk of rape victims contracting gonorrhea is 6 to 12 percent, chlamydia 4 to 17 percent, syphilis 0.5 to 3 percent, and HIV less than 1 percent. The specific STI risk varies from community to community. Since the National Protocol for Sexual Assault Medical Forensic Examinations (OVW 2004) recommends that all medical facilities offer sexual assault victims medications to prevent them from contracting STIs, the rates can be expected to be very low today (Ledray 2006).

Since the early 1980s, HIV has been a concern for rape survivors, even though the actual risk appears very low. The first case in which seroconversion—the process of going from HIV-negative to HIV-positive—was suspected as the result of a rape occurred in 1989 (Murphy, Harris, and Forester 1989). Claydon, Murphy, Osborne, Kitchen, Smith, and Harris (1991) reported four more cases in which the researchers believe a rape resulted in a subsequent HIV seroconversion. While these numbers are extremely low considering the number of rapes that occur, the effect on the individual victim is, of course, significant.

Post exposure prophylaxis (PEP) should be considered for victims at high risk, such as male-on-male assaults. When used, it should be started within 72 hours of exposure. It is not widely used today, however, because of the high cost and the serious side effects that result in few of the patients completing the treatment when started (Simpson 2011).

Even if the survivor did not inquire about HIV in the emergency department, studies have shown that HIV exposure became a concern of the survivor or sexual partner within 2 weeks. Based on the rape survivors' recommendations, the researchers propose that, even if the survivor does not ask questions about HIV during the initial exam, the SANE or medical professional should, in a matter-of-fact manner, provide information about their risk, testing, prevention (PEP), and safe-sex options, which allows the victim to make decisions based on facts, not fear (Ledray 1999).

The best way to deal with the issue of HIV is complicated and controversial. Rates of infection vary from state to state and community to community, as does the actual risk of infection. The decision to offer prophylactic treatment should be based on the risk of the rape combined with HIV prevalence in the specific geographic area. A rape is considered high-risk if it involves rectal contact or vaginal contact with tearing, or existing vaginal STIs that have caused ulcerations or open sores disrupting the integrity of the vaginal mucosa. It also is considered high-risk if the victim knows or suspects that the assailant is an IV-drug user, HIV-positive, or bisexual (Ledray 2006).

The risk of HIV exposure after sexual contact is, overall, reported to be less than other routes of exposure, such as needle sticks, needle sharing, mother to infant, or blood transfusions. While the actual risk varies from study to study, if the assailant is known to be HIV-positive, the risk of HIV from sexual contact may be similar to that with a needle stick (Royce, Sena, Cates, and Cohen 1997).

Nine out of ten SANE programs interviewed across the U.S. recognized the importance of meeting the health needs of rape victims and identified providing high-quality medical care as their number one priority (Patterson, Campbell, and Townsend 2006). This includes addressing the issues of physical injury; STI risk evaluation and prevention, including HIV; and pregnancy risk evaluation and prevention (Ledray 2006).

Pregnancy

Rape victims of reproductive age often fear becoming pregnant as a result of a rape. The actual risk is the same as that from any one-time sexual encounter: an estimated 2 to 4 percent (Yuzpe, Smith, and Rademaker 1982). Most SANE programs and medical facilities offer emergency contraception to women at risk of becoming pregnant, provided they are seen within 5 days of the rape and have a negative pregnancy test in the emergency department.

Oral contraceptives such as Ovral are still used in some areas; however, the drug of choice today is Plan B (levonorgestrel) for emergency contraception. This treatment is not 100 percent effective in preventing pregnancy. A review of 10 studies found an overall effectiveness rate of at least 75 percent, which does not mean that 25 percent will become pregnant; rather, if 100 women have intercourse in the middle 2 weeks of their cycle, approximately eight would become pregnant without post-coital interception. With interception, only two (a reduction of 75 percent) of the 100 would become pregnant (American College of Obstetricians and Gynecologists 2002).

Plan B (levonorgestrel) was developed specifically to prevent pregnancy after unprotected intercourse. It is believed to act as emergency contraception by preventing ovulation or fertilization by altering tubal transport of sperm and/or ova. It also may inhibit implantation by altering the lining of the uterus.

General Health Risk

Sexual assault not only affects victims' health directly and immediately; there is convincing evidence that it also can have a significant and chronic impact on their general health for years to come (Frazier and Ledray 2011). Stress appears to suppress the immune system and increase susceptibility to disease (Cohen and Williamson 1991). Stress such as a sexual assault also may result in injurious behaviors, such as substance abuse or eating disorders (Felitti 1991; Golding 1994).

Increased sexual activity with multiple partners sometimes follows rape which, in a formerly inactive adolescent for example, may result in increased exposure to disease (Ledray 1994). In addition, interpreting a sexual assault as a threat to one's body may lead to increased attention to subtle symptoms and heightened concern about health integrity (Cohen and Williamson 1991). Another possibility is interpreting emotional reactions to the assault as physical disease symptoms (Koss, Woodruff, and Koss 1990).

Psychological Symptoms Perceived as Physical

Rape victims may seek physical versus mental health care following a sexual assault because it is less stigmatizing. Physical symptoms are perceived as more salient than psychological distress (Kimerling and Calhoun 1994). In their sample of 115 sexual assault victims, Kimerling and Calhoun found that 73 percent sought out medical services during the first year after a sexual assault, while only 19 percent pursued mental health services of any kind.

Low levels of social support were associated with higher use of medical services, and higher levels of social support resulted in better actual physical health and health perception. The victims reporting physical symptoms most often identified gynecological problems and sexual dysfunctions. The victims of more severe or multiple crimes were the most likely to seek medical care. The researchers, too, suggest that disease resistance may be compromised by the stress of victimization.

Walker, Katon, Hansom, Harrop-Griffith, Holm, Jones, Hickok, and Russo (1995) found that women with chronic pelvic pain were significantly more likely than women without it to be survivors of sexual abuse. The chronic pain groups also were more likely to be depressed and have substance abuse problems, phobias, and sexual dysfunction.

Koss, Koss, and Woodruff (1991) found that the single most powerful predictor of total annual visits to a physician and outpatient costs was severity of victimization, exceeding the predictive power of age, ethnicity, self-reported symptoms, and actual injury. They also found that rape victims were twice as likely to seek the help of a physician than nonvictims, with visits increasing 56 percent in victim groups compared to 2 percent in nonvictim groups.

Sexual Dysfunction

Not surprisingly, studies have found that sexual dysfunction is a common reaction and often a chronic problem after a sexual assault. This may include a periodic or constant loss of sexual desire, inability to become sexually aroused, slow arousal, pelvic pain associated with sexual activity, a lack of sexual enjoyment, inability to achieve orgasm, fear of sex, avoidance of sex, intrusive thoughts of the assault during sex, vaginismus, or abstinence. Mentioned repeatedly in the literature are avoidance, loss of interest in sex, loss of pleasure from sex, painful intercourse, and fear of sex (Abel and Rouleau 1995; Frazier and Borgida 1997; Ledray 1998).

It is also well documented that sexual assault victims engage in risky sexual behaviors, such as more sexual partners and more current sexual partners as a result of the rape (Upchurch and Kusunoki 2004). This has been found to be true in large national samples of adolescent who were victims of a sexual assault (Upchurch and Kusunoki 2004), college women who were victimized (Brenner, McMahon, Warren, and Douglas 1999), Native American victims (Evans-Campbell, Lindhorst, Huang, and Walters 2006), and military women who were sexually assaulted (Lang, Rodgers, Loffaye, Satz, Dresselhaus, and Stein 2003).

This area still has not received the attention it deserves, considering the extent of the problem and the opportunity to prevent significant long-term health problems that may result.

In one of the earliest reports on the impact of rape, Burgess and Holmstrom (1979) found that 71 percent of the rape victims they interviewed 6 years after the assault still avoided sexual contact and were less sexually active. In a study of 100 women, 61 percent of the women who were sexually abused, compared to 31 percent of a control group, experienced some form of sexual dysfunction 2 to 4 years after the assault (Chapman 1989).

The researchers stress that while rape victims may become sexually active again within months of the assault, they may still not enjoy sex years later. Celibacy or acting out sexually, including more frequent sexual activity with more partners, less condom use, and more alcohol use, are a common response and may be coping strategies (Campbell, Self, and Ahrens 2004). Counselors run the risk of delegitimizing assault-related sexual problems by not recognizing both the sexual and aggressive components of rape.

Substance Abuse

Professionals working with sexual assault victims indicate that from 20 percent to more than 50 percent of rape victims across studies were under the influence of alcohol at the time of the assault (OVC 2005). Individuals are clearly more vulnerable to assault when intoxicated.

In a study conducted at the Sexual Assault Resource Service (SARS) in Minneapolis, 55 percent of rape victims (N=130) self-reported using alcohol at the time of the rape. Sixty percent of these reported the alcohol use was voluntary (Ledray, Frazier, and Peters 2007). While drug-facilitated sexual assault (DFSA) has received considerable attention because of the use of “designer” memory-erasing drugs, it is important to remember that the most-used drug to facilitate a sexual assault continues to be alcohol (OVC 2005).

It also is important to remember that rape can be facilitated by the use of drugs or alcohol, and it also can result in substance abuse in an attempt to dull the memory and avoid thinking about the rape (Ledray 2006).

In a national sample of 3,006 female survivors, both alcohol and drug use significantly increased after a sexual assault, even for women with no prior drug or alcohol use or abuse history (Kilpatrick, Acierno, Resnick, Saunders, and Best 1997). This study also found that women who were already using drugs and alcohol to cope at the first measurement point were more likely to have a history of prior sexual abuse.

The researchers concluded that sexual abuse plays a significant role in initiating and maintaining substance abuse in women, with younger women being even more at risk. In a more recent study, these same researchers reported that victims of rape are 13.4 times more likely to develop two or more alcohol-related problems and 26 times more likely to have two or more serious drug-related problems (Kilpatrick 2003).

Risk behavior is a factor in the lesbian, gay, bisexual, and transgender community as well. According to a 2009 study of LGBT high school students by the CDC, adolescent lesbian, gay, and bisexual students are significantly more likely to engage in health-risk behaviors than heterosexual individuals of the same age.

There is the opportunity to intervene during this crisis period to prevent future substance abuse and emotional disturbance among victims of sexual assault. There is considerable support for the implementation of brief intervention models in similar populations that could readily be adapted to sexual assault victims (Resnick, Acinero, Kilpatrick, and Holmes 2005; Ledray 2009).

2. Psychological Impact of Sexual Assault

Researchers agree that rape victims experience more psychological distress than do victims of other crimes. Compared to nonvictim control groups, rape victims consistently report more symptoms of anxiety, fear, depression, and posttraumatic stress disorder (PTSD) (Frazier and Borgida 1997).

The activity will offer the opportunity to explore the potential psychological impact of rape.

Anxiety

Rape victims are consistently found to be more anxious than nonvictims during the first year after a rape (Frazier, Harlow, Schauben, and Byrne 1993). In one study, 82 percent of rape victims met the DSM criteria for generalized anxiety disorder (GAD), compared with 32 percent of nonvictims (Frank and Anderson 1987).

Fear

Death is the most common fear during the assault, with continued generalized fear after the assault a very common response to rape (Dupre, Hampton, Morrison, and Meeks 1993; Ledray 1994). Post-rape fear can be specifically related to factors associated with the sexual assault or widely generalized to include fear of all men (Ledray 1994). Since fear is subjective, it is generally evaluated using self-report measures.

While evidence of the type and duration of fear varies, up to 83 percent of victims report some type of fear following a sexual assault (Frazier and Borgida 1997). Girelli et al. (1986) found that the subjective distress of fear of injury or death during rape was more significant than the actual violence in predicting severe post-rape fear and anxiety. Thus, it is important to recognize that the threat of violence alone can be psychologically devastating (Goodman, Koss, and Russo 1993).

Depression

Depression is one of the most commonly mentioned long-term responses to rape (Abel and Rouleau 1995; Frazier and Borgida 1997; Ledray 1994). As with anxiety, symptoms of depression also overlap with those of PTSD. Such overlapping symptoms include:

- Weight loss or gain.
- Sleep disturbance.
- Feelings of worthlessness.
- Diminished interest in pleasurable activities.
- Inability to concentrate.
- Depressed mood.
- Suicidal thoughts.

Suicidal Ideation

While the number of suicides following a rape is considered low, suicidal ideation (i.e., thoughts about suicide) is a significant issue. One study found up to 20 percent of rape victims may attempt suicide (Kilpatrick et al. 1985), and a more recent study found 39 percent of rape victims reported a subsequent suicide attempt (Ackard and Neumark-Sztainer 2002). Many more rape victims—33 to 50 percent—report that they considered suicide at some point after the rape (Ullman 2004; Ullman and Brecklin 2002). During the immediate post-rape period, rape victims are nine times more likely than nonvictims to attempt suicide (Kilpatrick, Saunders, Veronen, Best, and Von 1987).

Self-Blame and Shame

A number of studies have identified posttraumatic guilt, self-blame, and shame as a common response following sexual assault, and one that is linked with PTSD, more depression, and poor adjustment post-rape (Vidal and Petrak 2007; Frazier 1990; Ledray 1999).

Posttraumatic Stress Disorder

One-third to one-half of victims who have experienced a sexual assault that meets the legal definition of rape, without requiring participants to label the experience rape, met the criteria for PTSD at some point in their lives. They, too, are more likely to meet the PTSD criteria than nonrape victims. One study found 78 percent of rape victims met the criteria for PTSD at 2 weeks; 63 percent at 2 months; 58 percent at 6 months; and 48 percent at 1 year (Frazier, Conlon, and Glaser 2001).

Sexual assault also is more likely to result in PTSD than exposure to other types of traumatic events. For example, the National Women's Study, an epidemiological survey of 4008 women, found the lifetime prevalence of PTSD resulting from rape and sexual assault to be 32 percent and 30.8 percent respectively, compared with a prevalence of 9.4 percent caused by non-crime-related trauma such as a car accident (Kilpatrick, Amstadter, Resnick, and Ruggiero 2007).

It appears that the more severe forms of sexual assault result in more severe symptoms of distress, and that women who report a sexual assault to the police or other authorities report higher PTSD rates (Rothbaum et al. 1992). Sexual assault also has been identified as the most common cause of PTSD in women (Frans, Rimmo, Aberg, and Fredrickson 2005).

The basic elements of a PTSD diagnosis are:

- Exposure to a traumatic event.
- Re-experiencing the trauma (flashbacks or intrusive memories).
- Symptoms of avoidance and numbing (attempts to avoid thoughts or situations that remind the survivor of the traumatic event, inability to recall certain aspects of the traumatic event, or feeling disconnected from others).
- Symptoms of increased arousal (exaggerated startle response, feeling easily irritated, constant fear of danger, or physiological response when exposed to similar events).
- Symptoms must be present for at least 1 month and must cause clinically significant distress or impairment (American Psychological Association 1994).

Factors Associated with Higher Levels of Post-Rape Trauma

Pre-assault, assault, and post-assault factors all play a role in recovery, although studies present a conflicting picture of them (Resick 1993). Resick concluded from her review of available studies that the victim's psychological functioning before the rape and during the assault accounted for some of the variance. The degree of actual violence may not be as significant as the victim's perception of the threat of danger.

Significant factors associated with more severe and prolonged post-rape trauma include prior sexual victimization; the use of avoidant coping strategies; self-blame; prior mental health history, especially depression; a history of substance abuse (Resnick, Acinero, Kilpatrick, and Holmes 2005; Ledray 2009), and lack of social support following the sexual assault (Resick 1993).

Campbell, Patterson, Adams, Diegel, and Coats (2008) found more positive psychological outcomes among victims seen by SANEs who “empowered” them by providing health care, support, and resources; treating them with respect and dignity; believing them; helping them regain control; and respecting their decisions.

These factors are important for the advocate or counselor to consider when making initial referrals for followup, and when attempting to contact the survivor for followup.

3. Impact on Partners, Family, and Close Friends

Family members and those close to the victim have been recognized as secondary or indirect victims (Koss and Harvey 1991; Ledray 1994). As a result, they, too, often suffer many of the same initial and long-term symptoms of distress experienced by the rape survivor, including shock and disbelief, fear, anxiety, a sense of helplessness, depression, and anger. Understandably, female partners, friends, and family members are more likely to become fearful than are males (Davis, Taylor, and Bench 1995).

Family and friends may become overly protective, further limiting the victim’s activities. Or, they may blame the victim for the assault. This type of blame is often a misdirected attempt to deal with their own feelings of guilt and self-blame for not protecting their loved one somehow and not preventing the assault (Ledray 1994).

It also may be a misdirected way of preserving their own sense of safety and security by blaming the victim for a characteristic or behavior that they can convince themselves they would never have or do. They are thus able to maintain a sense of their ability to prevent the same thing from happening to them. The more similar they are to the victim, the more they may need to find something about the victim to blame in order to maintain their own sense of safety and security (Ledray 1994).

A partner’s, friend’s, or family member’s high stress does not necessarily correlate with the level of distress the victim is experiencing. Nor does it necessarily interfere with the ability of the significant other to support the victim. It is, however, associated with unsupportive behaviors such as egocentric behavior, emotional withdrawal, and blaming the victim (Davis, Taylor, and Bench 1995).

It is common for the victim to become angry with family members who are themselves upset (“It didn’t happen to them, so they have no right to be so upset”). This is especially true when family members appear more upset than the victim. Victims may also take out their anger about the rape on family members (Ledray 1994; Mitchell 1991). If the family is not prepared and does not understand the motivation behind this behavior, they may reject the victim, and victims may lose their social support when they need it most.

4. Individual Factors That Affect Reactions to Rape

Sexual assault is traumatic for all victims; however, individual factors can have an impact on the nature and extent of the trauma. These include gender, age, disability, race, culture, and refugee and immigration status. This section will look at information from studies of a range of factors and their impact on victims. It is important that participants use this information as a general guide, not to stereotype how they expect victims to react.

Part of being a good first responder is the ability to be flexible and to remember that each person will react to assault differently.

The activity provides you the opportunity to explore factors that affect reactions to rape.