

Module 4: Impact of Sexual Assault

Purpose

This module helps you explore the physical and emotional impact of sexual assault.

Lessons

- Physical Impact of Sexual Assault.
- Psychological Impact of Sexual Assault.
- Impact on Partners, Family, and Close Friends.
- Individual Factors That Affect 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 individual factors.

Physical Impact of Sexual Assault

Nongenital Physical Injury

It is typically assumed that rape victims experience physical injury during a rape. It also is assumed they fight back and are injured as a result. This 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 (Ledray, 1999). As discussed earlier, injury is more common in stranger rapes than in rapes by someone the victim knows intimately (Bownes, O’Gorman, and Saters, 1991; Ledray, 1998). Older victims may be more likely to sustain injury. One study showed that victims older than age 50 were twice as likely to be injured (63 percent) than younger victims (32 percent) (Tintinalli and Hoelzer, 1985). Another study indicated that male victims are injured more often than female victims. In this 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 (Pettrak and Claydon, 1995).

Genital Trauma

Few rape victims sustain significant genital trauma as a result of the sexual assault. In one study, vaginal injuries represented only 19 percent of the total injuries, and these injuries were always accompanied by complaints of vaginal pain, discomfort, or bleeding (Tintinalli and Hoelzer, 1985). The literature also suggests that colposcopic (magnified) examination is often 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 naked-eye visualization alone, genital trauma is seen in only 10 to 30 percent of sexual assault cases (Cartwright et al., 1986; Tintinalli and Hoelzer, 1985). With colposcopic examination, genital trauma has been identified in up to 87 percent of cases (Slaughter and Brown, 1992). Because 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 explained to them (Ledray, 1999).

Sexually Transmitted Infections

Although one study found that 36 percent of rape victims coming to the emergency department stated that their primary reason for coming was concern about the possibility of having contracted a sexually transmitted infection (STI) (Ledray, 1991), the actual risk is rather low. The Centers for Disease Control (CDC) (1993) 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 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 and colleagues (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.

Even if the survivor did not inquire about HIV in the emergency department, studies have shown that within 2 weeks, this typically became a concern of theirs or their sexual partner's. Based on the rape survivors' recommendations, the researchers propose that even if the survivor does not raise the issue of HIV or AIDS in the emergency department, the Sexual Assault Nurse Examiner (SANE) or another medical professional should in a matter-of-fact manner provide information about their risk, testing, prevention, and safe-sex options. This enables the victim to make decisions based on facts, not fear (Ledray, 1999).

How best to deal with the issue of HIV is a complicated and controversial matter (Blair and Warner, 1992). Rates of infection vary by locale, as does the actual risk of infection. The decision to offer prophylactic treatment should be based on an assessment of the risk level of the rape combined with HIV prevalence in the specific geographic area. A rape is considered high risk if it involves rectal contact, 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 her assailant is an IV-drug user, HIV-positive, or bisexual (Ledray, 1999).

The risk of HIV exposure after sexual contact is generally reported to be lower than through other types of exposure, such as needle sticks, needle sharing, mother-to-infant transmission, 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 from a needle stick (Royce et al., 1997).

STI Scenario

A caller who was sexually assaulted the night before is concerned about STIs, including HIV/AIDS. What should the counselor tell her?

IV

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 72 hours of the rape and have a negative pregnancy test in the emergency department.

Oral contraceptives such as Ovral or Plan B (levonorgestrel) are often used 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 postcoital 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 may also inhibit implantation by altering the lining of the uterus.

General Health Risk

Sexual assault not only affects victims' health directly and immediately, it also can have a significant and chronic impact on their general health for years to come. Stress appears to suppress the immune system and increase susceptibility to disease (Cohen and Williamson, 1991). Stress caused by 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 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 a heightened concern about health integrity (Cohen and Williamson, 1991). Emotional reactions to the assault also can be interpreted as physical disease symptoms (Koss, Woodruff, and Koss, 1990).

Psychological Symptoms Perceived as Physical

Rape victims may seek physical rather than mental health care following a sexual assault because it is less stigmatizing. Physical symptoms often are more obvious than those of 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 likely identified gynecological problems and sexual dysfunctions. The victims of more severe or multiple crimes were the most likely to seek medical care. The researchers suggest that disease resistance may be compromised by the stress of victimization.

Walker and colleagues (1995) found that women with chronic pelvic pain were significantly more likely than women without it to be survivors of sexual abuse. Those suffering from chronic pain 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 with 2 percent in nonvictim groups.

Sexual Dysfunction

Not surprisingly, studies have found that sexual dysfunction is a common, and often chronic, problem following a sexual assault. Reactions may include loss of sexual desire, inability to become sexually aroused, slow arousal, pelvic pain associated with sexual activity, lack of sexual enjoyment, inability to achieve orgasm, fear or 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; Burgess and Holmstrom, 1979; Kimerling and Calhoun, 1994; Koss, 1993; Ledray, 1994, 1998).

This subject has not, however, received the attention it would appear to deserve, considering the extent of the problem. 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 with 31 percent of a control group, experienced some form of sexual dysfunction for 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 still may not enjoy sex years later. Celibacy may be a coping strategy. Counselors run the risk of delegitimizing assault-related sexual problems by not recognizing both the sexual and aggressive components of rape.

Substance Abuse

In a college sample of 6,159 students surveyed by Koss (1988), 73 percent of the assailants and 55 percent of the victims had been using alcohol or other drugs before the sexual assault. While rape victims may indeed be more vulnerable to being raped as a result of substance abuse, which leads to intoxication and increased vulnerability (Ledray, 1998), it is important to recognize that rape also can result in substance abuse, possibly as an attempt to dull the memory and avoid thinking about the rape (Goodman, Koss, and Russo, 1993; Koss, 1993; Ledray, 1994). In a national sample of 3,006 survivors, both alcohol and drug use significantly increased after a sexual assault, even for women with no prior history of drug or alcohol use or abuse (Kilpatrick et al., 1997). This study also found that women who already were 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 at an even greater risk.

Psychological Impact of Sexual Assault

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

Studies usually refer to short-term impact as effects experienced within the first year after the sexual assault; long-term impact is described as beyond that first year. Fear, anxiety, depression, and symptoms of PTSD are the most frequently recognized and documented reactions to sexual assault (Kilpatrick and Veronen, 1984; Ledray, 1994; Resick and Schnicke, 1990).

Anxiety

Rape victims consistently are found to be more anxious than nonvictims during the first year after a rape (Frazier et al., 1993), reporting more trait and phobic anxiety (Kilpatrick, Veronen, and Resick, 1979). In one study, 82 percent of rape victims met the DSM criteria for generalized anxiety disorder compared with 32 percent of nonvictims (Frank and Anderson, 1987). Some studies of long-term anxiety have found differences between victim and nonvictim groups (Gidycz et al., 1993; Gidycz and Koss, 1991; Gold et al., 1994; Santiago et al., 1985), while others have not (Frazier and Schauben, 1994; Riggs, Kilpatrick, and Resnick, 1992; Winfield, et al., 1990). In one study, 53 percent of the rape victims reported long-term tension, nervousness, and anxiety, which they attributed to the sexual assault (Siegel et al., 1990). Two studies also found that rape victims were more likely to meet the criteria for panic disorder several years after the rape (Burnam et al., 1988; Winfield et al., 1990).

Fear

Death is the most common fear during the assault, with a more generalized fear commonly continuing after the assault (Dupre et al., 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). Because 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, 1997; Nadelson et al., 1982). Girelli and colleagues (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; Atkeson et al., 1982; Frazier, 1997; Kilpatrick and Veronen, 1984; 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 completed suicides following a rape are considered low, suicidal ideation is a significant issue. Up to 20 percent of rape victims may attempt suicide (Kilpatrick et al., 1985), and many more rape victims—33 to 50 percent—report that they considered suicide at some point after the rape (Ellis, Atkeson, and Calhoun, 1981; Resnick et al., 1988). During the immediate post-rape period, rape victims are nine times more likely than nonvictims to attempt suicide (Kilpatrick et al., 1987).

Self-Blame and Shame

Self-blame is a common response in rape victims (Ledray, 1994; MacFarlane and Hawley, 1993) and is associated with more depression and poor adjustment following the rape (Frazier, 1990).

Post-Traumatic 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 specifically to label the experience rape, met the criteria for PTSD at some point in their lives. They also are more likely to meet the PTSD criteria than nonrape victims. 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 and Foa, 1992).

The basic elements of a PTSD diagnosis are

- Exposure to a traumatic event.
- Reexperiencing 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 Psychiatric 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, a prior mental health history, especially depression, a history of substance abuse (Frazier, 1990; Ruch et al., 1991), and lack of social support following the sexual assault (Resick, 1993). These factors are especially important for the counselor to consider when making initial referrals for followup and when contacting the survivor for followup.

Psychological Scenario

A caller who was sexually assaulted 6 months ago is experiencing sleeplessness and weight gain and having trouble concentrating. She is experiencing recurrent pelvic pain, but her doctor has not been able to find a physical cause. What are some of the psychological effects of assault that this caller might be experiencing?

Impact on Partners, Family, and Close Friends

Family members and those close to the victim have been recognized as secondary or indirect victims (Heinrich, 1987; 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 of the victim, further limiting her activities, or they may blame her for the assault (Heinrich, 1987). As Ledray (1994) points out, this type of blame is often a misdirected attempt to deal with their own feelings of guilt for not protecting their loved one and

not preventing the assault. It also may be an attempt to preserve their own sense of safety and security by blaming the victim for a behavior in which they believe they would never engage. 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 feel compelled 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 level of stress does not necessarily correlate with the degree of distress the victim is experiencing. Nor does it necessarily interfere with the ability of the significant other to support the victim. However, it can be associated with unsupportive behaviors such as an egocentric attitude, emotional withdrawal, and a tendency to blame 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 on family members (Ledray, 1994; Mitchell, 1991). If the family is not prepared and does not understand the reasons for this behavior, they may reject the victim and she may lose her social support when she needs it most.

Individual Factors That Affect Reactions to Rape

Sexual assault is traumatic for all victims; however, a number of factors can affect the nature and extent of the trauma. These include gender, age, disability, race, culture, and refugee and immigration status. This section examines these factors and their potential impact on victims. It is important that you use this information as a general guide. Part of being a good first responder is the ability to be flexible and to understand that each person will react to assault differently.

Participant Presentations

When preparing your presentation, please address the following questions. These questions encourage you to think about strategies for working effectively with a person with the particular characteristic you are examining. Focus your presentation on issues an advocate would need to be aware of when dealing with this hypothetical person.

Begin your presentation by noting the page numbers you studied so that other participants can follow along during your presentation.

Name at least two assumptions often made about a victim following a sexual assault.

How might these assumptions affect the way advocates, law enforcement personnel, medical professionals, or friends and family interact with this person?

Given the information you have read, what steps might you take to better respond to this person's needs during a crisis?

What are at least two things advocates must know when helping a person after a sexual assault?

Male Victims

Dynamics and Prevalence of Male Rape

As with the rape of women, the rape of men is not a crime solely of sexual motivation but also and often primarily one of aggression (Groth and Burgess, 1980). Sexual assault treatment centers report that 5.7 to 10 percent of their clientele are males (King and Woollett, 1997; Koss and Harvey, 1991; Lipscomb et al., 1992). Male rape is generally thought to be more underreported than female rape (Rentoul and Appleboom, 1997). According to the 1996 National Crime Victimization Survey, more than two-thirds of sexual assault victims in the United States never report. This is even more prevalent among male victims. Most do not report their assaults, nor do they receive medical attention or counseling (Ellis, 2001). According to Tjaden and Thoennes (1998), only 15 percent of all rape victims ever report the rape to the police. Only 2 of 22 male sexual assault victims studied by Mezey and King (1992) had reported their sexual assault to the police. The remaining 20 cited fear of rejection, disbelief, and stigmatization as their reasons for not reporting. Most men never consider the possibility they could be raped; therefore, when it happens to them, it can be devastating and stigmatizing. Male rape victims are less likely to report than women because of the extreme embarrassment they typically experience and because they fear being misunderstood as homosexual. For this reason, community education and crisis intervention that serve to correct misconceptions about male rape are of critical importance.

The incidence of male rape is difficult to estimate. A survey of 336 agencies that respond to the needs of sexual assault victims found that just over half of these agencies serve male victims (Isley and Gehrenbeck-Shim, 1997). The majority of men seen for sexual assault were white (85 percent) and heterosexual (81 percent). Most of the assaults occurred between ages 16 and 30 (86 percent) and involved a threat to the victim's safety through physical force (60 percent) or physical threat (68 percent) or occurred while the victim was intoxicated (40 percent). Slightly less than half the assaults involved weapons. Most of the offenders were known to their victims (69 percent), and nearly 60 percent of the assaults involved only one offender. The rapists were generally male (94 percent),

white (78 percent), and perceived by the victim to be heterosexual (90 percent).

After the assault, 1 in 5 male victims sought medical treatment; however, only 23 percent of these men revealed the sexual nature of the assault to medical personnel. Less than 15 percent reported the sexual assault to the police, and less than 2 percent of these assaults were reported in the media.

Post-Assault Symptom Data

(n = 1,679 male victims)

Symptom	Percentage of Victims with Symptom
Depression	92
Shame	89
Self-blame	89
Increased anger and rage	78
Flashbacks	69
Increased use of alcohol/drugs	68
Preoccupation with assault memories	66
Guilt	66
Increased interpersonal problems	63
Nightmares	59
Social isolation	58
Disruption in family life	56
Sexual dysfunction	51
Suicidal ideation	46
Suicide attempt	35
Confusion over sexual identity	31
Fear of being perceived as gay	1

In a review of several studies of male rape victims, Frazier (1993) reports that 50 to 83 percent of male victims were raped by only one assailant, most victims knew their assailant, weapons were used in 9 to 25 percent of assaults, victims were threatened in 26 to 100 percent of the assaults, male victims were injured in 25 to 60 percent of the assaults, and most sexual assaults of males did not involve drugs or alcohol. Rates of weapon use, stranger

assault, and injury were greater in studies of men who reported to emergency departments than in studies of men who were sampled in community clinics or who responded to newspaper ads. These findings may indicate that men are more likely to report a sexual assault in the context of seeking treatment for other injuries. It is important to train police and emergency personnel to ask men who report having been robbed or who present for treatment of physical injuries if they were sexually assaulted in any way.

In another study, Frazier (1993) reviewed the emergency department records of 74 male and 1,380 female victims of sexual assault who received care from SANEs. Most victims in this study reported the assault to the police (89 percent of men and 91 percent of women). One-fourth of both male and female victims reported a history of prior incest. More than 75 percent of male and female victims stated that they feared for their lives during the assault; however, 58 percent of women versus 40 percent of men reported being harmed during the assault. Male victims were significantly more likely to have been raped by more than one assailant, and only 48 percent of males and 46 percent of females reported being raped by an acquaintance.

Most studies confirm that male sexual assault victims are less likely than female victims to sustain physical injuries (Calhoun and Atkeson, 1991). King (1992) suggests that submitting to a sexual assault may seem inexplicable or shameful to male survivors.

Erection and Ejaculation During Sexual Assault

In a study of 115 men who have been sexually assaulted, King and Woollett (1997) report that 18 percent of the victims experienced ejaculation during the assault. Having an erection or ejaculating during a sexual assault can upset and confuse a victim. Many people (including significant others, police, juries, judges, and attorneys) share the misconception that a man cannot obtain an erection if he is frightened or anxious. This is not true.

In a review of sexual response literature, Coxell and King (1996) surmised that the physiological mechanism of any emotional response (whether anger, fear, or pain) may be one of sexual response. They point to evidence that high levels of physiological arousal can lead to involuntary erection and ejaculation. Masters (1986) also documents male victims' ability to experience erection and ejaculation during sexual victimization. Donnelly and Kenyon

(1996) have shown that when a man is rectally raped, pressure on the prostate can produce erection and even ejaculation.

When victims have a sexual response to an assault, they often feel as if their body has betrayed them. Victims benefit from hearing that this is a common physiological response. It may reassure them to know that their response was out of their control, in much the same way as tears would be the inevitable physiological response to a sliced onion held under their nose; they would cry regardless of their determination not to. After being sexually assaulted by another man, heterosexual men may struggle with issues surrounding sexual orientation and preference. Gay men may feel they were targeted on account of their orientation or preference. Fear and confusion can be allayed by explaining that the sexual response is a physiological reaction to pressure on the prostate or to fear, anxiety, or pain.

Sexual Preference/Orientation of Rapists

Victim gender is not an indicator of the offender's sexual orientation or preference. In a study of convicted male sex offenders who raped men, Groth (1990) found that at the time of their offense, all the men were actively engaged in consenting sexual encounters or relationships, with 9 percent reporting that those encounters were almost exclusively with other men, and 32 percent reporting sexual activity with both men and women. In Groth's study, 27 percent of the convicted sex offenders reported that they confined their consenting sexual activity to women. Half of them were married.

Post-Traumatic Stress Disorder in Male Survivors

Male victims of sexual assault experience post-traumatic stress reactions similar to those observed among female victims, with fear being most commonly reported, followed by depression or thoughts of suicide, anger, somatic problems, sexual dysfunction, and disturbances in peer relationships (Coxell and King, 1996; Frazier, 1993; Koss and Harvey, 1991). In a study comparing male victims with female victims seen in the emergency department, Frazier (1993) found that males experience slightly more depression and hostility than females immediately following the assault.

Men need the same level of crisis intervention and followup care as women; however, males may be less likely than females to seek and receive support from family and friends. Like women, men need to be able to recount the sexual assault in a safe and supportive environment. Calhoun and Atkeson (1991) point out that male victims may not profit as much as women from social support, most likely because society emphasizes self-reliance in our socialization of men. The ability of male victims to seek support will vary according to the level of stigmatization they feel, the number of supportive relationships they have, the circumstances of the rape, and the sensitivity of care they receive in the emergency department or rape crisis center. Men may experience difficulty recognizing and expressing emotions other than those of anger and aggression and may need particular help doing so in a healthy way.

Responding to Male Victims

Advocates/counselors serve male victims well by taking the time to listen carefully to their account of the rape and their immediate concerns.

In a study to determine the preferred gender for the advocate, it was found that half of female rape victims prefer to be seen by a woman, and the other half have no preference. Of the male victims, however, 100 percent indicated that they felt more comfortable speaking with a woman immediately after the assault (Ledray, 1994). It is helpful to describe common reactions men have after being sexually assaulted and to stress that men do get raped regardless of who they are, what they were doing, or how they look. Men may worry that they appear too effeminate, and that this caused the assault. Gay men may wonder if the offender assaulted them because of their sexual orientation, and therefore they may struggle with self-blame. All men need to be reassured that their sexual orientation, appearance, and sexual preference had nothing to do with their being raped. Men are susceptible to the same techniques used by rapists to gain control over female victims (the use of weapons, entrapment, intimidation, threats, and coercion).

One important function of the immediate crisis response is to help the victim decide whom he wants to tell. While support is critical, some within the victim's circle may respond in a way that further damages his concept of self. Helping family and friends understand

the dynamics of male rape also is essential to the victim's recovery. The most important thing significant others can do for male victims is to believe them and try to understand what they are experiencing. Coming to grips with the fact that any man could be raped is threatening to many people; they find comfort in believing that men can always protect themselves and others.

The majority of people will need to be informed that, as with female rape, male rape is not only about sex, but also about domination. As Dion (1997) points out, ironically, although males are the offenders in both cases, the fathers of female survivors often fear that sexual assault will cause their daughters to turn away from men, whereas fathers of male survivors seem to fear that their sons will turn toward men for sexual gratification.

Men Raped by Women

While reports of men being raped by women are rare, victims in these cases suffer feelings of helplessness, fear, and anxiety similar to those experienced by women who have been raped by men. Men, however, need more guidance to prepare for how friends and family members may react. Many men will react to a man who tells them he was raped by one or more women by laughing and saying, "Why doesn't that ever happen to me?"

As a result, the victim's fear and anxiety are discounted, which can lead to feelings of self-doubt, isolation, stigmatization, and depression. The rate of post-assault sexual dysfunction is high for men who have been raped by women (Coxell and King, 1996; Masters, 1986). Men raped by women also will need an evidentiary exam. Collection of forensic evidence focuses on the presence of the assailant's DNA in vaginal secretions, saliva, or hair on the victim's body or clothing, as well as inspection for and documentation of injuries.

Same-Gender Assaults

Same-Gender Stranger Assaults

It is important for advocates to understand the dynamics involved in same-gender assaults. The term "homosexual assault," which often is used in the literature, is inaccurate because the majority

of the perpetrators and victims of same-gender sexual assaults are not “homosexual.”

The majority of same-gender stranger assaults involve men, usually heterosexual men. When the victim is gay or perceived to be gay, and the perpetrator attempts to humiliate or demean him, the assault may be part of a hate or bias crime involving power and control over the victim. Stermac and colleagues (1996) state that antigay violence, or gay bashing, involves ostensibly heterosexual men committing sexual offenses against other adult males as a means of symbolically defeating unresolved feelings about their own sexuality.

Same-Gender Acquaintance Assaults

The majority of same-gender acquaintance assaults occur as part of a pattern of domestic abuse in same-gender relationships. The rate of same-gender domestic abuse mirrors that of the heterosexual population: about 30 percent (Abbott, 1997). It is important for advocates to sort through their own feelings regarding homosexual relationships so that all survivors are treated with dignity, respect, and compassion. All people who have been abused by their partners report the same range of feelings of fear, anger, guilt, depression, and anxiety about their living situation (Abbott, 1997).

Female Same-Gender Sexual Assault

Although female same-gender assault is rare, it does occur. Women who are forced to have sex with other women experience the same emotional reactions as do women who are forced to have sex with men. If they are heterosexual, they may go through a process of questioning their sexuality; if they are lesbian or bisexual, they may experience an increased sense of vulnerability. A post-assault forensic exam is important and may involve the collection of hair, saliva, or vaginal secretions from the victim's body and clothing, as well as inspection for and documentation of injuries.

Post-Traumatic Stress Disorder in Same-Gender Sexual Assault

Both gay and heterosexual victims of same-gender sexual assault are at high risk for depression, hostility, sexual dysfunction, and

suicidal thoughts or actions (Coxell and King, 1996; Frazier, 1993; Koss and Harvey, 1991). After being sexually assaulted by someone of the same gender, gay men and lesbians often feel even more stigmatized and vulnerable, and heterosexual men and women may go through a process of questioning their own sexuality (Abbott, 1997).

Gay and Lesbian Victims

Prevalence of Sexual Assault for Gay Men and Lesbians

The rate of sexual assault for gay men and lesbians has been found to be higher than the rate of sexual assault for heterosexual men and women. In a study of 412 university students, Duncan (1990) found the percentage of gay men reporting sexual assault to be three times greater than that of heterosexual men (approximately 12 percent compared with 4 percent). Similarly, the percentage of homosexual women who reported sexual assault was approximately two times greater than that of heterosexual women (approximately 31 percent compared to 18 percent).

As with all people who have been sexually assaulted, the degree to which a person who is gay or lesbian will be able to recover from a sexual assault depends on the amount of support he or she receives. Recovery for gay and lesbian victims is also affected by the amount of discrimination they experience from the community around them, including the advocates, health care workers, and legal professionals charged with their care after the assault.

Filing a Police Report May Force “Outing”

People who are gay or lesbian and have not “come out” to their family, friends, or employer may have an intense fear of reporting a sexual assault. They may fear that their cooperation with the prosecution may lead to a disclosure of their sexual orientation, which could endanger their child custody, “out” their partners if the investigation reveals their identity, result in the loss of their job, and prompt negative reactions or rejection by family members, friends, or coworkers. Advocates/counselors play an essential role in helping victims weigh the pros and cons of reporting. Accurate

information about what the person can expect in the reporting and prosecution process is invaluable.

The fact that a victim is gay or lesbian does not necessarily mean they will have more difficulty recovering from the rape than a heterosexual victim. People who are well integrated into the gay and lesbian community may be better equipped to deal with a sexual assault. Their strength may stem from their coming out process, an increased sense of community, and the constant consideration of hate and bias crimes and how to cope with them. However, even for gay and lesbian victims of sexual assault who are open about their sexual preference, fear of disclosure still can be a major issue because it represents a further loss of control. Even when the assault was not a bias or hate crime, it often feels as though it were, and may result in increased anxiety, deep personal doubt, a negative self-image, and depression (Miller, 1997).

Adolescents Struggling With Sexual Identity

At particular risk are adolescents who live in families or communities where homosexuality is not accepted and who are beginning to feel attracted to people of the same gender; often they have no supportive connections in the gay and lesbian community. Being raped by someone of the same gender and considering the ramifications of reporting can produce extreme anxiety.

Understand that the adolescent's sexual identity is unfolding, and that using labels such as "gay" or "lesbian" may be premature and threatening. It is less threatening to talk about attractions and interests. Asking, for example, "Are you attracted to males, females, or both?" is preferable to "Are you gay, lesbian, or bisexual?"

Only half of males who have homosexual experiences involving ejaculation during their teen years go on to identify as gay (Miller, 1997). Advocates must pay special attention to helping youth who have experienced same-gender assaults understand the ramifications of reporting. They will need referral for supportive services as they sort through reactions to the assault and continue to explore issues of sexual identity.

Dynamics for Lesbians

Lesbian survivors of sexual assault by men often experience a unique constellation of concerns. Of all sexually active adults, lesbians as a group have the lowest risk for sexually transmitted diseases and therefore may not be aware of current STI risks from heterosexual exposure. Also, they generally have not had to worry about pregnancy and will need counseling about pregnancy risk and prophylaxis.

For women who have not had sex with a man, vaginal penetration can be painful, both physically and emotionally. Lesbians often report sexual dysfunction after a rape. This can be confusing; they often wonder why the experience of violence with a man has carried over to their nurturing sexual relationship with a woman. Like others, lesbians often wonder if the rape was their fault, but it may also bring up a deep-seated sexual confusion as the woman questions if she somehow wanted the assault to happen and whether it occurred because of how she looks. Confusion about her decision not to resist or about a physical response to the rape can raise doubts in the victim's mind about her complicity or sexuality (Garnets, Herek, and Levy, 1990). Many lesbians feel intense shame at having been violated and forced to have sex with a man. This adds an extra dimension beyond that experienced by straight female or gay male rape survivors. Common emotional reactions include a sense of isolation, vulnerability, punishment, and paranoia ("Did he pick me because of how I look?").

Lesbians who are unaccustomed to feeling dependent on or vulnerable around men may find their sense of safety, independence, and well-being greatly disrupted by a sexual assault motivated by male rage at their sexual preference (Garnets, Herek, and Levy, 1990). It is important that advocates have accurate information about lesbianism and antilesbian crime so that they can provide sensitive, appropriate care to these victims of sexual assault. It may be difficult for a lesbian who has been raped to confide in male physicians, police officers, and other professionals. Her reluctance may be construed as being uncooperative or hostile. The presence of an understanding, accepting advocate in the post-assault period can be very helpful. For victims in relationships, including the significant other and recognizing the deep emotional bond is important to recovery (Orzek, 1988).

People With Developmental Disabilities

For the purpose of clarity in this training, the term “disability” is used despite some discomfort with it. It is preferable to think that all people are “differently abled” and to concentrate on our similarities. However, differences in physical appearance and cognitive ability affect the way victims react and are treated during and after a sexual assault. Moreover, a sexual assault can severely exacerbate the physical aspects of a disability and the associated emotional issues. It is important to appreciate each individual’s uniqueness and strive to understand the survivor’s view of any cognitive, emotional, or physical differences they may have. Therefore, this manual refers to “people with disabilities” rather than “disabled people.”

To disability activists, disability is the direct result of attitudinal, institutional, environmental, and legal barriers that limit a person’s ability to fully participate because of his or her impairment (Fine and Asch, 1995; Neve, 1996). When victims with disabilities are not served by the medical, legal, and advocacy systems, it may be more indicative of the system’s disability than the victims’. Effective victim-service organizations establish relationships with other groups serving people with disabilities and ensure that they are represented at the decisionmaking level. They also make information accessible in locations frequented by women with disabilities (Neve, 1996).

Developmental Disabilities

Many people confuse the terms “developmental disability,” “developmental delays,” and “mental retardation.” These are technical terms that should not be used interchangeably. When responding to people who have been sexually assaulted, it is necessary to understand the distinctions.

The term “developmental disability” is an umbrella term under which “mental retardation” falls. According to Public Law 95-602, a developmental disability is “a severe chronic disability of a person attributable to a physical or mental impairment or combination of physical and mental impairment, manifested before 22 years of age, and likely to continue indefinitely; resulting in substantial functional limitations in three or more of

the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency that reflects the person's need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services of lifelong or extended duration that are individually planned and coordinated" (Schor, 1987: 3). Developmental disability can include conditions such as spina bifida, cystic fibrosis, and cerebral palsy, which may involve impairments to physical function and movement in people with normal or above-normal intelligence.

The term "developmental delay" is used to describe a child who is not progressing, growing, or developing at expected rates or levels for physical or environmental reasons. The term encompasses many children who also have permanent developmental disabilities, but also those who lack appropriate stimulation in their environment. With adequate stimulation and nurturing, the delay may disappear.

Finally, "mental retardation" refers to mental ability and self-help skills significantly below the average level for an individual's age. According to the American Association on Mental Retardation, an individual is considered to have mental retardation if

- Their intellectual functioning (IQ) is below 70–75.
- They experience significant limitations in two or more adaptive skill areas.
- The condition is present before age 18.

In referring to people who meet these criteria, some prefer to use the terms "cognitive impairment," "intellectual disability," or "cognitive disability" rather than "mental retardation." Other people use the broader term, "developmental disability."

This training uses the term "cognitive disability" rather than "mental retardation," except when referencing clinical diagnoses or the work of others.

Cognitive disability affects not only cognitive processing but also daily functioning; it is not IQ alone. Such functioning is also influenced by the amount of nurturing, support, and quality education a person receives. For example, even though an IQ of 65 is considered close to the upper cutoff for mild mental retardation, two people with the same IQ could function at very different levels.

One with an IQ of 65 who grew up in a family where he or she was loved, challenged, taught, and not overly protected could be living independently in the community, holding down a job, and engaged in a loving relationship. Another person with the same IQ but a more limited childhood environment or a background of trauma could be in a residential treatment facility, unemployed, and struggling with interpersonal relationships. By definition, mental retardation begins in childhood. If an injury or illness permanently affects cognitive and social functioning in a person older than age 18, the impairment is termed dementia or encephalopathy (USF Division of Child Development and Neurology, 1997). Mental retardation has many causes, only some of which are associated with physical characteristics such as those of Down's Syndrome.

Many people mistakenly believe that you can tell if someone has a diagnosis of mental retardation by looking at them. Advocates/counselors must realize there are several syndromes (e.g., Noonans and Turners) that cause some physical characteristics similar to those associated with Down's Syndrome, but people with these syndromes have no cognitive impairment. On the other hand, several constellations of learning disabilities can cause a person to be diagnosed with mental retardation even though they have absolutely no physical characteristics. A "normal" looking and sounding 17-year-old, for example, may have a constellation of learning disabilities that render her unable to understand other people's motives or identify potentially dangerous situations. When working with victims, advocates/counselors should not stereotype cognitive functioning based on physical appearance, but rather should develop the ability to assess every victim's capacity to think abstractly and make informed decisions. People with cognitive disabilities often lack the reasoning skills to understand other people's motives, assess risk, and anticipate the outcome of their actions. Because these difficulties affect their risk of and reaction to rape in unique ways, techniques for working with people with cognitive disabilities will be covered in a separate section that also addresses adolescents and people with dementia.

Sexual Assault Rates for People With Disabilities

It is estimated that only 1 in 30 cases of sexual abuse/assault of persons with disabilities is reported, compared with 1 in 5 cases in the general population (Tharinger, Horton, and Millea, 1990). The

actual occurrence of assault in people with disabilities is difficult to determine in that typical prevalence (ever assaulted in their lifetime) and incidence (assaulted within the last year) studies use telephone interviews with randomly selected households from the general population. These studies fail to reach people with cognitive disabilities, those with communication disorders, and those living in institutions (Andrews and Veronen, 1993).

Agency data is equally flawed. Agencies that work with people with disabilities seldom ask about sexual victimization, and agencies that work with victims of sexual assault omit identification of disabilities from their records (Andrews and Veronen, 1993).

A review of assault rates indicates that 68 to 83 percent of people with developmental disabilities will be sexually assaulted in their lifetime, which represents a 50 percent higher rate than the rest of the population (Neve, 1996; Pease and Frantz, 1994). Reviewing data on sexual assaults of people with developmental disabilities, Pease and Frantz point out that 30 percent are assaulted by family members, 30 percent by friends or acquaintances, and 27 percent by service providers, with the likelihood of the latter increasing as the severity of disability increases.

People with cognitive disabilities or difficulty communicating are at especially high risk for sexual abuse and assault. They are more likely to be revictimized by the same person, and more than half of them never seek assistance from legal or treatment services (Pease and Frantz, 1994). Sex offenders deter physical and verbal resistance by seductively offering attention, affection, rewards, and bribes in exchange for sexual contact, backing these by threatening loss of residential security, family disruption, humiliation, or physical or emotional harm if the victim tells anyone (Andrews and Veronen, 1993). Reporting often involves a loss of independence; if a person is enjoying a sense of independence in a group home or is living alone, reporting an ongoing assault by a caretaker or someone who lives in the building poses the threat of being reinstitutionalized or being moved back home with the family (Berkman, 1986).

When someone who is cared for by a state-licensed agency is sexually assaulted by a person from that agency, a criminal report may be filed by the victim; however, the SANE, as a mandated reporter, will need to ensure that the state licensing agency receives a report of the abuse to investigate misconduct and/or failure to

protect. Some states have vulnerable-adult protection agencies that serve as contact points for such reports.

Preventive Education for People With Disabilities

One factor that exposes people with developmental disabilities to a greater risk for sexual assault is the lack of quality educational curricula covering the nature of sexual assault and how people can assert themselves to establish and maintain self-protective sexual boundaries. Although 99 percent of assaults of people with disabilities involve offenders known to the survivor, most self-protection curricula are geared toward stranger rape (Seattle Rape Relief, 1997). A complex level of social skills is required to repel exploitative sexual behavior in its early stages, before it becomes aggressive. Without specific, appropriate training for handling such situations, the victim may feel discomfort, guilt, and powerlessness when the offender becomes aggressive (Andrews and Veronen, 1993). Some literature suggests that offenders target people with disabilities because they believe there to be less risk of discovery (Andrews and Veronen, 1993). Advocates/counselors may purchase videos or a manual titled *Your Safety, Your Rights: Personal Safety and Abuse Prevention Education Program to Empower Adults with Disabilities and Train Service Providers* (Pease and Frantz, 1994).

Helping Family Members Help Victims

The rape of someone with a disability, particularly a young person with a developmental disability, can cause extreme distress for family members who have been in the role of protector and caretaker. They may feel guilty for allowing the person too much independence and be compelled to step in to make sure this never happens again.

It is crucial at this time to support family members as they weigh their need to protect with the victim's need to regain her sense of confidence, safety, trust, and independence. Immediately placing the person in a more protective environment disrupts the victim's healing by shattering the belief that the world is generally a safe place, that people can usually be trusted, and that the person is able to live independently. Families can be reassured that their desire to protect is normal. Many whose loved ones have been raped react in the same way. Overwhelmed by the pain of what has happened,

they want to keep their loved one in a protective bubble. The victim, however, then would be left with the traumatic stress of the assault combined with grief over her loss of independence; this will bring to the surface and magnify any sense of loss and grief over the disability. The victim and her family need to hear that anyone can be raped and that it is impossible to absolutely prevent it from happening. They do, however, have control over their healing process, and the advocate/counselor will be there to guide and support them. Providing families with helpful words and phrases (“We’re so sorry this happened to you”; “You didn’t deserve it”; “You’re going to be okay”) will benefit them.

People With Cognitive Disabilities (Mental Retardation)

The overarching ethical dilemma facing members of the Sexual Assault Response Team (SART) in responding to people with cognitive disabilities is protecting them from sexual abuse and exploitation while still enabling fulfillment and expression of their sexuality (Tharinger, Horton, and Millea, 1990). The trend to fully integrate people with cognitive disabilities into the community has resulted in many vulnerable people working in minimum wage jobs during evening or night hours. Their coworkers often have drug, alcohol, or untreated emotional problems. Group homes are frequently located in high-crime areas, and persons with disabilities must rely on such risky transportation as buses, taxis, and rides from coworkers (Andrews and Veronen, 1993). As a special class, persons with cognitive disabilities are entitled to special legal protection from abuse and neglect, comparable to that for children and for the elderly (Tharinger, Horton, and Millea, 1990).

Approximately 1 percent of the U.S. population (slightly more than 2 million people) have cognitive disabilities (Tharinger, Horton, and Millea, 1990). Their ability to function and the level of disability depend on intelligence, social skills, communication skills, personal independence, self-confidence, daily living skills, and self-sufficiency. The trajectory of sexual development and sexual interest is the same for people with mild cognitive disability (mental retardation) as for people without any cognitive disability. However, people with cognitive disabilities often have fewer opportunities to explore and understand their sexuality (Tharinger, Horton, and Millea, 1990).

Young people with cognitive disabilities are at an especially high risk for sexual abuse. Youth with cognitive disabilities are aware of cultural norms surrounding coupling and dating. They watch the same TV programs as other youth and have the same desires to fit in, to be valued and accepted, and to be intimate. This places them at risk and makes them especially vulnerable to coercion because many will do almost anything they believe or are told will help them to fit in with the “normal” crowd. Their emotional and social insecurities increase their vulnerability. Having the same sexual drives and development as the general population, and being confronted with a similar variety of sexual stimuli, they respond in the same way; however, their impaired abstract reasoning skills prevent them from perceiving danger and understanding the possible motives of others.

Factors Affecting Disclosure of Sexual Assault

Tharinger, Horton, and Millea (1990) offer a number of possible reasons why victims with mental retardation may not want to disclose that they were sexually assaulted, including not wanting to be stigmatized as “vulnerable,” having difficulty communicating, not knowing who to tell, feeling guilty and responsible, being coerced, fearing that they will not be believed, and being willing to put up with the abuse to be liked/feel normal/receive rewards. For these reasons, there is often a delay in reporting.

If made comfortable by an investigation style that follows developmentally sensitive procedures, victims with cognitive disabilities usually can provide reliable evidence leading to the prosecution of offenders. Investigators may need to be reminded that people with cognitive disabilities usually have no impairments in memory. Accounts of what they remember are reliable.

When severe cognitive disabilities exist, the ability to communicate the fact that abuse occurred is often limited. Behavioral and emotional signs of sexual abuse/assault are important evidentiary aspects; however, they are not as conclusive as physical evidence. A cluster or pattern of indicators is sought rather than a single sign.

Counseling Victims With Cognitive Disabilities

People with cognitive disabilities need post-assault counseling support as much as, and possibly more than, victims without

such disabilities. The following guidelines may help advocates/counselors when responding to sexual assault victims with cognitive disabilities. In the immediate post-assault period

- Reassure the victim that she is not in any trouble and did not do anything wrong. Use kind words and gentle actions. Use simple instructions that are easy to remember.
- Allow time to process. A few days off from work or school may be required so the victim can process what happened and do so with counselors and support people rather than people at work, school, or on the street.
- Assist the victim in deciding whom to tell. Anticipatory guidance is helpful. She will think everybody knows. Tell her, "You may think people know about this, but they don't. No one will know unless you tell them."
- Ask the victim who she trusts and who has helped her in the past when something bad has happened to her. For example, "You say Ann has always been a help to you. You trust Ann. It's okay to talk to Ann about what happened. But you might not want to tell the people at your bus stop."
- Help significant others understand the importance of not blaming and providing positive feedback. Tell them they will need to exaggerate their positive comments and avoid criticism. Victims will pay more attention to negative comments than to positive ones. Help significant others and caregivers understand that the immediate post-assault period is not the time for safety lectures.
- Followup supportive counseling is recommended as with all victims, and may need to include family, significant others, and caretakers.
- Assess for depression.

Ability To Consent

When responding to victims of sexual assault, issues often arise surrounding the victim's ability to consent to sexual contact, investigative interviewing, counseling, and medical treatment. Some people lack the cognitive capacity to consent and are considered more vulnerable to sexual abuse and assault. The

concept of legal consent is fundamental to protection. It is generally defined to encompass three elements (Andrews and Veronen, 1993; Tharinger, Horton, and Millea, 1990):

1. The capacity or aptitude to acquire knowledge and become informed about the nature of an activity.
2. The ability to understand the risks and benefits associated with a decision and to choose an appropriate course of action.
3. The lack of coercion or force throughout the decisionmaking process.

Many people erroneously confuse the concept of a vulnerable adult with someone who lacks the cognitive capacity to consent to sexual contact. This is not always the case and can lead to infringements on the rights of people to express themselves sexually. A vulnerable adult can be defined by the following criteria (see, e.g., Minn. Stat. § 626.557, Vulnerable Adult Act, 1995):

- An adult (age 18 or older) who has some type of physical, mental, or emotional impairment.
- The impairment necessitates that regular assistance or service be provided by a caregiver.
- Because of the impairment, the individual cannot protect herself from maltreatment or harm.

The definition and protection of vulnerable adults vary by state. It is essential to know what the mandatory reporting guidelines are in your state.

The first step in assessing a person's ability to provide consent involves listening to the victim to determine what the sexual encounter in question meant to her. When a person who is vulnerable has been used by someone they liked and trusted, coming to terms with the fact that she was exploited involves not only mourning the loss of that relationship, but also facing her vulnerability and the potential loss of freedom and trust from family and caregivers. Coming to terms with this vulnerability is often a difficult, painful process that takes considerable time and support.

Each state defines ability to consent to sexual contact in their criminal sexual conduct statutes. Ability to consent is influenced

by abstract reasoning skills, drug and alcohol intoxication, medications, thought disorders, mood disorders, and the relationship of the offender to the victim (Dexheimer Pharris, 1998). Advocates must know the legal parameters that apply in their state. Factors that place a person at increased risk for sexual abuse include dependence on others, social isolation, lack of cognitive ability to fully understand the motives of the offender, and lack of education regarding sexuality and abuse prevention.

In determining decisionmaking competence, two very important ethical values are balanced: protecting and promoting the individual's well-being, and respecting the individual's self-determination (Buchanan and Brock, 1989). A first consideration is discerning whether the person is her own guardian and whether she functions independently in the community. In cases in which the person has been deemed legally unable to provide informed consent, it may be necessary to contact a legal guardian to obtain consent to do an evidentiary exam. If a legal guardian is unavailable, the SANE usually proceeds with evidence collection, acting in what she perceives to be the victim's best interest, and then informs the legal guardian as soon as that person becomes available.

Exams are never done against a person's will. The reason for the exam is explained in terms that victims understand, and their consent is obtained regardless of legal ability to provide informed consent.

People with limited abstract reasoning skills need help in determining who to tell about the assault and who they want to know about it. Often, upon returning home or to school or work, people with cognitive disabilities and adolescents freely disclose details of the assault and become revictimized by the attention of those around them. The advocate can assist the survivor by talking through how different people will react, who needs to know, how much to share with whom, and what the possible ramifications are of sharing information. For victims who are unable to imagine other people's possible reactions and who are very verbal, it may be best to encourage a few days off from school or work so they can process their feelings and reactions with family, staff, or counselors.

In deciding whether to share information about the assault with other professionals in the victim's life, the advocate considers the

victim's well-being, her right to confidential care, and her need to be in control of who is told. When staff from group homes or other social service agencies are present, it is important to honor the victim's right to confidentiality and verify with her which information can be shared. Confidentiality should not be broken except when there is a clear need to involve another caring person to protect the victim from additional harm.

People With Physical Disabilities

People with physical disabilities also may be at greater risk for sexual assault, especially if they depend on others for personal care. When the offender is someone who is supposed to be in a helping relationship, the person with a physical disability may be concerned about a loss of services and independence. Victims experience fear and anxiety over the potential of harm from people on whom they rely for assistance and support. This can lead to overwhelming feelings of vulnerability, stigmatization, and depression. When people with physical disabilities are sexually assaulted, they often experience compounded feelings of isolation, powerlessness, low self-esteem, and a sense of being different (Neve, 1996).

After having been sexually assaulted, people with physical disabilities respond emotionally in all the same ways as able-bodied victims. They may, however, need to talk through the role they believe their disability played in making them more vulnerable to the assault. The advocate/counselor can listen to the victim's concerns and recollections of the experience. Victims benefit from reviewing how force, threats, and coercion are a part of rape and being reminded that even strong, able-bodied men sometimes cannot get out of the situation and are raped.

Understanding these differences, the advocate has a very important role to play in ensuring the survivor's needs are appropriately met.

In the rush of an emergency response to sexual assault, medical and legal personnel may miss important aspects of the victim's experience. The following examples demonstrate ways in which advocates can work with the medical and legal systems to ensure that victims are properly understood, assessed, and treated immediately after the assault (Stuart, 1986):

- The advocate can make sure that appropriate interpreters are available for deaf or hard-of-hearing victims.
- A blind person may not be able to positively identify her assailant through standard visual means such as a lineup, but her ability to do so through verbal identification is still intact. When one sense is impaired, the other sensory systems become more acutely accurate.
- Anxiety almost always exacerbates speech impairments, so victims with such a condition need patient, reassuring questioning. Repeating what the victim said assures her that her words were correctly understood and frees her from having to start from the beginning each time. If a certain word cannot be understood after several repetitions, ask her to spell it out.
- Emotional trauma can affect blood sugar levels, which, in the case of those with diabetes, can make people appear to be intoxicated when they are actually experiencing a medical emergency. People with cerebral palsy also can be perceived (incorrectly) to be intoxicated. Advocates should ask victims if they are diabetic or what kind of assistance they need and then see to it that their needs are met. It is important that advocates/counselors make no assumptions about the person's ability or disability and instead ask as many questions as necessary (Aiello, 1986). The victim should have total control over what is done to her and should direct any assistance that is provided. For example, if someone who is paralyzed needs to be moved, she should direct who does what in moving her; if a person usually catheterizes herself, the hospital personnel should be encouraged to allow her to do so in the emergency department. Caregivers must realize that a person with a disability faces the complex challenges of coping not only with the victimization but also with her disability and the barriers posed by agencies providing services (Aiello, 1986).

People Who Are Deaf or Hard of Hearing

Much post-assault care involves an exchange of information (e.g., giving an account of the assault, discussing feelings, deciding whether to file a police report, explaining the evidentiary exam, teaching about common symptoms of rape-related PTSD, suggesting strategies for coping with the trauma). People who are

deaf or hard of hearing require sensitive, appropriate care. “Deaf” is defined as a hearing loss of such severity that the individual must depend primarily on visual communication such as writing, lip reading, manual communication, and gestures. “Hard of hearing” is defined as a functional hearing loss, but not to the extent that the individual must depend primarily on visual communications (Schumacher and Hung Lee, 1997). Deaf and hard-of-hearing people are further handicapped by the limited number of services that provide sign-language interpreters. Advocacy programs must have a way to communicate with people whose primary means of communication is signing. The program also should provide access to a TTY/TDD (teletypewriter/telecommunications device).

The following guidelines for assisting people who are deaf or hard of hearing were compiled by Kathy Schumacher, edited by May Hung Lee, and published in the *Minnesota Coalition Against Sexual Assault Training Manual* (1997, Section 2, pp. 49–51):

If a deaf or hard-of-hearing woman seeks services, she will have the same basic needs and fears as a hearing woman.

- She needs to feel welcome. Motion her to follow you to a quiet office. Tell her your name. Write it down on paper if she does not seem to understand. Ask if she would like an interpreter and which kind (there are sign language interpreters as well as oral interpreters). At her request, let her know (on paper, if necessary) that you will call for an interpreter.
- It is important to have the deaf and hard-of-hearing woman's attention before speaking. Since she cannot hear the usual call for attention, she may need a tap on the shoulder, a wave of the hand, or other visual signals.
- If she is wearing a hearing aid, do not assume she will have good hearing.
- Never ask if she can read lips and use it as a means of communication. Stress affects a person's ability to attend to details, and even under optimal conditions lip reading provides about 30 percent accuracy in

interpretation, which is not acceptable in a post-assault situation.

- Whether she independently indicates that she can read lips or not, body language and gestures help with communication. Write down anything she has trouble understanding. Be sensitive to the fact that she is closely observing your body language and will pick up on your frustration. Try to relax and to help her relax.
- Do not speak to a deaf and hard-of-hearing person with your back (and thus, her face) to a light, window, or mirror. Have the light in your face, not hers.
- Every deaf and hard-of-hearing person communicates in a different way. Some speak; others use American Sign Language (ASL); and others use a combination of sign language, finger spelling, and speech. Some people use body language and facial expressions to supplement their interactions.
- Just as each individual has a speaking style, grammar usage, vocabulary, and favorite idioms and clichés, deaf and hard-of-hearing people have individualized ways of speaking in sign language.
- Often, enlisting a sign language interpreter will be your only way to communicate effectively with someone whose primary language is ASL, which is not the same as English. The interpreter is trained to recognize and use similar signs as the deaf and hard-of-hearing person.

Examples of ASL written out would be: Movie last night. Wow good. Should see you. Laugh roll. (Translated: "The movie I saw last night was very good. You should see it. I laughed so hard I was almost falling on the floor.") Or: Home many problems. Not good my house. Want out finish trouble. (Translated: "There are a lot of problems at home. My house is not a pleasant place right now. If my husband/boyfriend/partner

leaves, the trouble may stop.”). To someone familiar with sign language, this manner of expression is quite clear. To someone who is not, however, word for word interpretation is not always understandable.

- Maintaining eye contact with the deaf person helps convey the feeling of direct communication. If the interpreter is present, continue to talk directly to the deaf person. Do not use phrases such as “Tell her that. . . .” Speak directly to her.
- People with some hearing loss find it is hard to hear in the presence of background noise, so be sure to move away from such noise.
- If she does not understand, change the wording. Use other expressions to get the same point across. Do not repeat the same phrase over and over.
- Ask her to let you know what to do to better enable her to understand you. Her hearing ability will vary with rooms, background noise, fatigue, and other factors.

People With Visual Impairments

People with impaired vision usually do not need assistance in familiar surroundings but do when they are at the hospital or clinic being examined, the police station filing a report, the rape crisis center receiving advocacy counseling, the district attorney’s office, or in the courtroom.

- Talk about everything being done around them and provide verbal orientation to the surroundings.
- Before you touch them, explain that you will be touching them, how and why.
- When moving from one room to another, offer your arm to grasp above the elbow for guidance. Verbally point out obstructions. Always tell them when you are leaving the room. If the survivor has a guide dog, do not be distracted by it or ask about the dog’s reaction to the assault; this diverts the blame from where it belongs—with the rapist (Erb, 1996).

Providing Barrier-Free Services

Victim service agencies can ensure availability of care to persons with disabilities in a number of ways, including (Andrews and Veronen, 1993)

- Public awareness activities targeting people with disabilities.
- 24-hour availability of appropriate transportation, interpreters, communication assistance, and public transportation for emergency intervention.
- Physical accessibility of all facilities.
- Designated personnel who are trained to respond to people with disabilities.
- Designated personnel trained to monitor risk reduction and respond to victims.
- Adaptation of services provided by medical practitioners, psychotherapists, and others to meet special needs (for example, home-based crisis and recovery counseling).

Older Victims

National statistics for victims of rape older than age 50 vary from 4 to 7 percent (Tyra, 1993). For victims age 65 or older, U.S. Department of Justice statistics show the 1990 rate of reported rapes to be 10 per 100,000 versus 41 per 100,000 in the general population (Tyra, 1993). The effects of assault on older victims are well documented. Victims older than age 50 are more likely to suffer physical injuries (Muram, Miller, and Cutler, 1992; Ramin et al., 1992). Older victims perceive the physical, financial, and psychosocial costs of rape as more severe than do younger victims. (Andrews and Veronen, 1993).

Older victims experience more pain, soreness, and exhaustion and are at increased risk for STIs. The assault may exacerbate chronic conditions already present, such as high blood pressure, arthritis, gastrointestinal problems, urinary tract disturbances, heart disease, diabetes, and dementia. Older victims of sexual assault also are more likely to suffer genital trauma. In a study comparing 129 postmenopausal women age 50 and older with 129 women ages 14 to 49, all of whom had been sexually assaulted, Ramin and

colleagues found that the older women came to the emergency department sooner after the assault, had significantly more genital trauma (43 percent versus 18 percent), were more likely to need surgical repair of vaginal lacerations (5 percent versus 0 percent), but had suffered less nongenital trauma (49 percent versus 66 percent). Another study done by Muram, Miller, and Cutler (1992) compared 53 women age 55 and older to the same number of women ages 18 to 45. They found that the two groups differed in significant ways. The older women were more likely to have been the victim of a previous sexual assault (25 percent versus 9 percent). However, in their most recent assault, they experienced fewer instances of genital injury (13 percent versus 51 percent) and required less surgical repair (6 percent versus 28 percent). Moreover, they were less likely than the younger women to have been raped in their own home (36 percent versus 72 percent) or raped by a stranger (57 percent versus 79 percent).

Men Who Rape Older Women

Studies show that men who rape older women perceive these women as authority figures against whom they want revenge (Tyra, 1993). These rapes are more likely to be brutal and involve more severe psychopathological processes. Groth (1978) reported on a sample of 30 sex offenders who selected victims older than age 50 and found these rapes to be exceptionally violent and motivated more by hostility than sexual desire. Based on his interviews with male rapists, Groth also suggested that the sexual assault of older women was even more underreported than sexual assault in general.

Sexual Assault in Extended Care Facilities

People with impaired cognitive functioning or who live in a group home or long-term care facility are especially vulnerable to sexual assault. Their risk increases when they have difficulty communicating, have physical impairments, or are isolated from family and friends. The result is a reduced ability to protect themselves from sexual assault and to report sexual assault should it occur. Rape often goes undetected in health care facilities because health care professionals overlook the signs. Those working in facilities with large populations of older women need to be educated about the symptoms of sexual assault and how

staff should respond when an assault is suspected. Health care facilities should have a policy in place for responding to allegations of sexual assault. When an assault occurs, health care personnel should notify the appropriate governmental adult protection agency. They in turn must report the incident to the state regulatory agency, which conducts an investigation into the alleged failure to meet standards of practice. This investigation does not replace the law enforcement investigation for criminal sexual conduct.

When someone who is cared for by a state-licensed agency is sexually assaulted by a person from that agency, the victim may file a criminal report; however, the SANE or advocate may be a mandated reporter, in which case they need to ensure that the appropriate agency receives a report of the abuse.

Traditional Beliefs Affect Reporting and Recovery

Even though research shows that there is no upper age limit to sexual activity and that a significant proportion of older people remain sexually interested and active, the topic of sexuality in later life often is seen as taboo (Benbow and Haddad, 1993). Because of the era in which older victims were raised, they may find it difficult and embarrassing to talk about sexual matters. Sodomy and oral copulation may be especially traumatic to older women, yet they may be reluctant to mention it. Asking specific questions often is necessary to make it possible for the survivor to talk. Older people may be more likely to hold traditional beliefs and misconceptions about rape, which may limit or slow their recovery. People age 70 and older grew up in a time when sexual involvement outside of marriage was regarded negatively, so much so that some unmarried women were placed in institutions if they became pregnant. Rape was seen as a sexual crime in which the woman was to blame for inciting her assailant (Benbow and Haddad, 1993). Older victims need to hear that they did not do anything to cause the sexual assault and that any embarrassment or shame belongs to the assailant.

Exacerbation of Grief and Loss

Older victims may experience exacerbated feelings of grief and loss related to their sense of vulnerability and diminished physical capability. While still attending to the victim's grief and loss,

advocates/counselors can remind them that all victims experience these feelings and that even healthy young men get raped.

Some older people may be quite isolated, having lost members of their support systems to death or relocation. If a partner or friend has died recently, that person's absence will be felt even more acutely because the rape intensifies the victim's loneliness.

Older people with a more extensive support system fare better; their many family members and friends will be outraged at the victimization of an elder and may shower the victim with helpful emotional and physical assistance.

Older Women Raped in Their Homes

In the vast majority of rape cases involving older women, the rape occurred in the home by a stranger who gained access. Many of these women need to move to regain their emotional sense of security. For someone who has lived most of her life in one place, who loves her home and/or whose children have an emotional attachment to the house, a move can cause great turmoil and grief. Victims benefit from assistance in making sound decisions about what is best for them. If the victim decides to stay in her home, she should receive help in developing a plan to reclaim the home as a safe place where she is not constantly reminded of the assault. It may involve improving security, rearranging furniture, changing decor, reclaiming the space with a gathering of good friends, and so forth. Women on fixed incomes may need financial assistance to make such changes. Crime victim reparation boards are an excellent resource in most communities.

Such assistance, however, must be balanced with the woman's need to be in control of her own recovery and to preserve her sense of dignity, which has been threatened by the assault. From a practical perspective, she may need assistance replacing broken locks and stolen items, especially credit cards; repairing broken windows and doors; and collecting emergency funds on which to live. The advocate can stress that the victim should not have to pay the price of the assailant's actions; she deserves assistance. Transportation to followup medical visits, counseling sessions, support groups, and court appearances also may be an issue. Victims who are isolated in their homes may benefit greatly from home visits. Well-meaning

relatives may wish to place an elderly family member who has been raped in a care facility; however, this greatly limits the victim's independence. The advocate can help older victims and family members make plans that maximize autonomy while ensuring safety.

People With Dementia

People with dementia, or loss of intellectual functioning, pose a significant challenge to members of the SART. Their level of orientation and attachment to reality influences how they perceive an assault and heal from the trauma, as well as their ability to communicate what happened and when. When you first meet someone in an acute state of trauma, it is difficult to determine if disorientation and confusion are normal for that person or if it is the result of traumatic stress. A sexual assault is very disorienting, even to people who do not have cognitive impairments. The effects of trauma often mimic dementia (e.g., forgetfulness, being jumpy, disorientation). Conversely, caretakers of people with dementia often misinterpret the symptoms of PTSD. When someone is exhibiting disorganized or agitated behavior and showing signs of PTSD such as intense fear, helplessness, or horror, these symptoms often are misinterpreted as confusion or anxiety related to the dementia (McCartney and Severson, 1997).

When dementia is suspected in a person who has been sexually assaulted, it is helpful to consult someone who knows the victim well to discern whether the thought processes and behavior being observed are normal for this person. Ask caregivers about the person's behavior and orientation under less stressful conditions. When a caregiver, social worker, or family member is not present after the assault, try to assess the victim's ability to understand what is going on and her ability to give informed consent for any treatment. Medical professionals use several screening tools to detect the presence of dementia, including establishing whether the person is oriented to person, time, and place; and whether she is capable of abstract reasoning. After someone is sexually assaulted, it would be an additional assault to start asking these sorts of questions. However, some of the routine questions that need to be asked give an adequate picture of the level at which the person is functioning. The advocate will get a good sense of the

victim's level of orientation by listening to answers to questions about where the person lives, when and where the assault occurred, who the person usually turns to for support, how the victim thinks specific support people might react, and so forth.

Can People With Dementia Have Consensual Sex?

Caregivers are faced with ethical questions when there has been sexual contact with someone who is clearly disoriented to person, time, and place. Can someone who has dementia engage in an intimate sexual relationship? Who decides what is healthy sexual contact and what constitutes sexual abuse? Benbow and Haddad (1993) draw on the work of Litchtenberg and Strzepek (1990) in attempting to provide a framework to answer these questions. They propose three guidelines for assessing the competency of a person with dementia to engage in an intimate relationship:

- The person's awareness of the relationship.
- Their ability to avoid exploitation.
- Their awareness of possible risks.

Benbow and Haddad propose that these guidelines be applied sensitively and flexibly, and that the concept of substituted judgment be used (what that individual would have chosen to do had she been capable of making a choice). The employment of substituted judgment requires that the decision be made with thorough knowledge of who the person is and what their value system was before becoming disoriented. Sexual abuse of older people with dementia quite likely occurs more often than statistics suggest, but usually is neither recognized nor reported by the victim. The key to assessing the extent of trauma in people who are disoriented or unable to communicate verbally lies in observing behavioral and affective changes. People who have been traumatized will show clusters of intrusive symptoms, avoidance symptoms, and hyperarousal symptoms. It is well known that people with dementia can remember significant events and information. Memory of a traumatic event is multifaceted, with multiple cognitive and affective connections. In people with dementia, the emotional meaning of an experience may be retained even when the cognitive meaning is gone (McCartney and

Severson, 1997). In post-assault support of victims with dementia, caregivers should focus on noncognitive interventions such as providing a safe, calm environment; approaching the victim from the front and speaking in a soft, nonthreatening voice; touching in a gentle manner; avoiding any situations that mimic the assault; and paying attention to what calms the victim and makes her feel safe.

People With Mental Illness or Personality, Mood, or Anxiety Disorders

Four million people in the United States are diagnosed as severely mentally ill. If it seems that there are more people with mental illness these days, it is because, during the past 20 years, the trend has been to deinstitutionalize people and move toward community-based treatment (Malloy, 1991). People with severe mental illness are at higher risk for sexual assault (Goodman, Dutton, and Harris, 1997). Victims often feel powerless and have trust issues related to past treatment by the legal and medical systems. Advocates/counselors must be aware of the stigma of mental illness and take time to establish communication and a trusting relationship.

People with severe mental illness usually have psychological symptoms that are worse in the post-assault crisis period than in their day-to-day living. For instance, someone who was depressed and anxious before a rape may become severely depressed or anxious afterwards. Someone who was suspicious of others or paranoid will likely be much more so after a rape. Therefore, the goal of initial post-assault interaction is to establish a safe environment, treat the person with respect, listen with understanding, and establish trust. Advocates must remember they are seeing this person when she is under extreme stress.

Goodman, Dutton, and Harris (1997) report that 11 recent studies of women with mental illness have shown rates of childhood physical abuse ranging from 35 to 51 percent, childhood sexual abuse from 20 to 54 percent, adult physical abuse from 42 to 64 percent, and adult sexual assault from 21 to 38 percent. Homeless women with severe mental illness are believed to have much higher rates of abuse and assault.

Understanding Psychiatric Diagnoses

Given the high incidence of sexual assault in people who have clinical diagnoses of mental disorders, it is helpful to have a working knowledge of these diagnoses. *The Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994) describes the following categories of mental disorders that might affect a person's experience of sexual assault:

- **Bipolar disorder.** Characterized by extreme mood swings. The person may be manic, have a lot of energy, display “wild behavior,” have racing thoughts, need less sleep, and be overconfident, then have normal energy and feelings followed by feelings of depression. Each of these periods may last for days or months.
- **Depression.** Characterized by difficulty deriving pleasure from life, irritability, sleeping a lot or hardly at all, a lack of energy, feelings of worthlessness, and thoughts of death and suicide. The causes of depression and bipolar disorder are thought to be a chemical imbalance in the brain, heredity, stress, or other factors.
- **Schizophrenic disorders.** A group of disorders marked by unusual thoughts, actions, and emotions. People with schizophrenia often cannot get along with others and may be unable to take care of themselves. They may not make sense when talking and may have strong fears, hallucinations (experiences of visions or voices), obsessions, and delusions (false beliefs). They often withdraw from everyday life. The causes are thought to be a chemical or hormonal imbalance, genetic abnormalities of the brain, infections, and other factors.
- **Anxiety disorders.** Consist of fear or anxiety that is severe and lasting. They include general anxiety (tension or irritability that lasts a month or more), phobias (strong fears about an object, place, or situation), panic attacks (sudden fear or terror that causes heart flutters, dizziness, and sweating), and obsessive-compulsive disorders (thoughts, images, or actions that are constantly repeated). Many factors are possible causes of anxiety disorders, including the brain's inability to control anxiety chemically.

- **Personality disorders.** These include antisocial personality disorder (pervasive pattern of disregard for and violation of the rights of others beginning by age 15) and borderline personality disorder (unstable relationships, self-image, affect and marked impulsivity beginning by early adulthood). Personality disorders are often associated with severe and persistent childhood abuse and neglect.
- **Dissociative disorders.** Dissociative amnesia is characterized by an inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be the result of ordinary forgetfulness. Dissociative identity disorder (formerly multiple personality disorder) is characterized by the presence of two or more distinct identities that recurrently take control of the individual's behavior. Depersonalization disorder is characterized by a persistent or recurrent feeling of being detached from one's mental processes or body, yet still being able to determine what is or is not real. Dissociative disorders are strongly associated with childhood trauma.

Responding to Anxious, Irritable, or Disoriented People

When working with someone who is extremely anxious, irritable, or disoriented, the following actions may help de-escalate the situation (Malloy, 1998):

- Strive to understand what the experience means to them.
- Use a calm, reassuring tone of voice.
- Provide a quiet, well-lit, safe environment.
- Give an agitated/psychotic patient more personal space than normal.
- Give one direction or make one request at a time.
- Use simple language; repeat proper names instead of using pronouns.
- Speak to the person at their level of comprehension.
- Pace your questions to their responses.

- Reassure the person that they will be safe, then take steps to make certain they will be.
- Maintain eye contact as is culturally appropriate.
- Correct misconceptions.

Survivors of Childhood Sexual Abuse

When survivors of childhood sexual abuse have been raped, they often strongly re-experience the trauma of their childhood abuse. To what extent will depend on the nature and frequency of the abuse, whether they were believed and rescued from it, and whether the survivor's parents or other adults reacted in a nonhysterical, helpful manner (Ledray, 1994). Survivors' reactions depend on the amount of stress they experienced and support they received at the time of the assault, and the extent to which the current rape resembles the childhood abuse.

Followup counseling for people who have been sexually abused as children involves healing from the present rape as well as exploring how the dynamics and trauma of childhood abuse have resurfaced. Issues of self-blame and feelings that they will never get away from abusers dominate the victims' reactions (Ledray, 1994). The recovery process is multifaceted for these survivors. Support groups can be combined effectively with individual counseling to aid recovery.

If a person has experienced childhood incest, which is childhood sexual abuse by a family member, she or he may have a reaction such as self-injury or a traumatic re-experiencing of the incest. These special reactions are discussed below.

Self-Injury

Incest victims who injure themselves constitute an extremely small percentage of those who report being raped and are a special subcategory that may make false reports (Ledray, 1994). Some victims of incest who have not resolved their childhood trauma may injure themselves and then deceptively report having been raped in an attempt to relieve their distress and get help. They may actually have re-experienced the incest in its totality while they

were alone which can be terrifying, exhausting, and overwhelming. This usually occurs during times of stress, such as following the first disclosure of incest or the recent loss of a supportive loved one or at the beginning of a new intimate relationship. The Sexual Assault Response Team (SART) must be alert to clues indicating false reports and recognize them as calls for help.

When injury has been self-inflicted, the survivor usually will describe the assailant too vaguely for the described circumstances of the assault. For example, she may describe an assault that involved prolonged torture, yet not be able to even remotely describe the assailant's general height, weight, skin color, voice, smell, distinguishing features, or clothing. Other characteristics that may indicate self-injury include reports of stalking or of receiving notes telling the survivor how beautiful or terrible she is; superficial cuts or scratches of the neck, inner thigh, or inner arm at an angle consistent with the survivor's handedness; an unusual event reported as part of the rape, such as dirt and leaves in the vagina; unusual patterned injuries such as superficial straight-patterned cuts intersecting the nipples, described as having occurred during a struggle; and multiple similar reports. The survivor also may report a history of incest that resembles the current trauma (Ledray, 1994).

Considering the possibility that an assault may have been self-inflicted can be uncomfortable for advocates. It helps to remember that in this person's mental and emotional experience, the assault really happened. When they come to the rape crisis center or the emergency department, they need to be treated with respect. It is the role of the law enforcement officer to determine what actually did or did not happen; the advocate supports the victim in her recovery regardless. The pain she is feeling is real. The crisis intervention she needs is the same as someone who experienced the reported event at the hands of another person. It is quite likely that the victim did in fact experience what she is reporting, maybe many times when she was younger, but no one was there to help her. It is helpful to make comments that focus on what the person is feeling rather than on what actually happened, such as, "What you are telling me sounds terrifying," or, "You must feel really scared."

Helping people who self-injure may be challenging because of their reluctance to follow through with counseling and because survivors who self-inflict injury are usually angry and volatile and exhibit severe mood shifts with little control over their anger (Ledray,

1994). However, the help they get in this crisis may enable them to begin to heal once and for all. Rarely in the emergency situation do people admit that their injuries were self-inflicted. A complete forensic exam should be done by the SANE and the survivor's injuries assessed and treated. Objective evidence is collected. As with all victims, it is important not to push police notification with those who are uncomfortable reporting. The police will need to establish quickly whether the case is unfounded, which involves a process that can be very disturbing to a survivor in crisis. A mental health referral should be made to a therapist skilled in working with incest survivors. The objective evidence collected by the SANE may be invaluable to the counselor and survivor in the post-crisis period. This evidence will enable the survivor to face what actually happened and eventually discover healthy ways of recognizing and dealing with the pain of past sexual abuse.

Traumatic Re-experiencing of Incest

A person may come to the emergency department reporting a rape after a traumatic re-experiencing of incest during a sexual encounter with someone who thought the sex was consensual. The survivor withdrew and dissociated from the partner, was unable to stop the encounter, and emotionally re-experienced the incest. While this incident leaves the victim with acute traumatic stress related to sexual assault, the experience may not meet the legal criteria for rape and be deemed an unfounded case. In these situations, the presence of an advocate to provide support before and after police investigative interviews is essential.

Adolescents

Although sexual violence is perpetrated against all age groups, the highest incidence is among adolescents and young adults. Nearly 15 percent of women and 3 percent of men in the United States are victims of rape, and an additional 2 percent of women and 1 percent of men are victims of attempted rape. More than 52 percent of these victims are younger than age 25 (Ellis, 2001). According to Tjaden and Thoennes (1998), the figures for young female victims are higher still: 54 percent are younger than age 18, and 83 percent are younger than age 25. Adolescents respond to sexual assault differently than adults. Muram and colleagues (1995) found that

adolescents are much more likely to delay reporting a sexual assault beyond 24 hours and to have been assaulted in a situation involving drugs and alcohol. They also are significantly less likely than adults to have been injured or to have had a weapon used against them (Muram et al., 1995). This data suggests that sex offenders can more easily coerce an adolescent to submit to sexual contact without using a weapon or injuring them.

Minor Consent to Sexual Contact and Medical Care

Adolescents are more vulnerable to social pressure and more likely to use denial as their first defense mechanism. For this reason, most states have passed statutory rape laws that make it illegal for people more than a few years older than an adolescent to have sex with them, with the victim's consent not admissible as a legal defense. Statutory rape laws are based on the belief that until a person reaches a certain age, they are legally incapable of consenting to sexual intercourse under certain stressful conditions.

Most states have statutes allowing adolescents to grant consent for their own care after a sexual assault; however, minor consent laws vary by state. Be aware of the laws in your service area.

Cross-Cultural Considerations, Refugees, and Immigrants

When Cultures Blame or Stigmatize Victims

If a female victim comes from a culture that blames the victim for the rape or does not consider her able to marry once raped, she may deny that rape occurred. If married, she may reasonably fear that her husband will blame her and/or reject her if she admits to being raped. Both male and female victims may admit to a physical assault, especially if there are injuries to explain; however, they may deny any sexual contact, even when asked directly. This will be problematic for the SANE, the police, and the prosecutor. Valuable evidence will have been lost, and the victim's credibility as a witness will have been jeopardized. To facilitate a truthful and early disclosure, the victim must be interviewed privately, and a trusting relationship must be developed.

Women from non-Western cultures may not seek treatment immediately following a rape, waiting instead until an injury, pregnancy, or sexually transmitted disease forces them to seek medical care. This is true even though they are nearly twice as likely to be raped as women in Western cultures (Howard, 1988). Because the consequences of rape within their cultural context are so grave, these women may be in extreme emotional crisis, even suicidal. Understanding the meaning of rape in the victim's culture and knowing appropriate, culturally sensitive referral sources is crucial. Strict confidentiality must be maintained, even with family members and staff from the victim's culture (Mollica and Son, 1989). The social stigma associated with sexual assault in the victim's community can be so powerful that it may prevent her from telling what actually happened and getting needed care. The victim needs to have control over whether a professional interpreter is used and, if the interpreter is from his or her community, which one is brought in. Although it is always essential to explain the person's legal right to confidential care, many people from war-torn countries do not believe promises of confidentiality, no matter how confidentiality is explained, because of the extensive use of informants in their home countries. They may even be reluctant to confide in close friends.

Working With Interpreters

Employing highly skilled, professional interpreters is an essential component of providing comprehensive services to non-English speaking victims of sexual assault. Interpreter services need to be planned in advance for immigrant groups residing in the area of service. Family members or friends should never be used as interpreters in providing care and collecting evidence. Likewise, followup counseling involves discussing very personal information, and survivors have a right to professional services that allow them to express themselves and fully participate in the healing process. Many programs use the interpreter services of local medical and legal agencies. It is not sufficient to use a bilingual staff person to interpret. Professional interpreters not only speak both languages, but also are trained to make a person's message clear and are held accountable for confidentiality and accurate, unbiased interpretation of what has been said.

Providing interpreter services is legally mandated. The U.S. Department of Health and Human Services considers lack of interpretation to be a form of discrimination. Title VI of the Civil Rights Act of 1964 (601 78 Stat. 252, 942 U.S.C. 2000d) states that “no person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”

The following guidelines adapted from the Center for Cross-Cultural Health's handbook, *Caring Across Cultures: The Provider's Guide to Cross-Cultural Health Care* (1997), outline important principles in working with interpreters:

- Briefly meet with the interpreter before the interview to explain the situation and the type of questioning and educating you will be doing. Attend to any personal issues the interpreter may have regarding sexual assault. Discuss how the interaction will proceed and where the interpreter should sit.
- When speaking, address yourself to the victim, not the interpreter. Maintain eye contact with the victim, not the interpreter, as appropriate.
- Do not say anything you do not want the victim to hear. Expect everything to be translated. Realize that what may be said in a few words in one language may require lengthy paraphrasing in another.
- Speak clearly in a normal voice and at a measured pace. Stop at comfortable intervals for the interpreter so she can translate what you are saying accurately and completely. A general rule of thumb is one long sentence, or three or four short ones.
- Avoid jargon and technical terms. You may need to repeat what you have said in different words if your message is not understood.
- Meet with the interpreter afterwards to assess how things went and to ask if she is satisfied with the accuracy of the information passed along. Attend to any traumatization she may be experiencing from having translated the story of the sexual assault.

- In situations in which an interpreter for the victim's language is not available or when the available interpreter is a member of the victim's community and she prefers a stranger, medical interpreter services can be accessed over the telephone. Such services are expensive, however, and nonverbal cues cannot be picked up.

Providing Culturally Congruent Care

The way people react to and recover from sexual assault is largely determined by the culture(s) in which they live. An essential part of advocacy/counselor training involves developing competence in providing culturally congruent care. "Culture" does not simply refer to ethnic origin or race; rather, it implies all the groups and subgroups that surround and support individuals. Culture refers to the learned, shared, and transmitted knowledge of values, beliefs, norms, and ways of life of a particular group. These guide an individual or group in its thinking, decisions, and actions (Leininger, 1995). Subculture is closely related to culture and refers to a group that deviates in certain areas from the dominant culture in values, beliefs, norms, moral codes, and ways of living with some distinctive features of its own.

To provide culturally congruent care and be of the greatest assistance, advocates/counselors need to acquire essential knowledge about cultures and subcultures in their service area and to assess the degree to which each individual ascribes to cultural values and mores governing sexual assault and recovery from trauma. There is a temptation to use a cookbook approach to caring for people from various cultural backgrounds by listing how each individual culture sees sexual assault. While broadly informative, this approach carries the danger of stereotyping individuals and not responding in a way that is comfortable or helpful to them. Advocates/counselors do, however, need to know the potential differences and similarities between their own culture(s) and the culture(s) of the people they serve. The following process is recommended:

- Analyze your own values and beliefs about your culture and other cultures. Formal cultural assessment guides can assist in this process (Center for Cross-Cultural Health, 1997).

- Get to know the cultures represented in your service area. Formal cultural guidebooks provide an overview of different cultures (Geissler, 1993; Lipson, Dibble, and Minarik, 1996), but it is best to meet with members of that cultural community who know how sexual assault is responded to within their culture. Listen to their experiences and beliefs surrounding rape, reporting, and recovery. Optimally, you will form a partnership to best serve people from that community. Representatives from all subgroups in the community should be equally represented within all service organizations.
- Become proficient in conducting assessments of the unique values, beliefs, and lifestyles of a variety of individuals, including those from the gay, lesbian, transgender, and bisexual communities; homeless people; the deaf community; and so forth. A good sense of the person's cultural influences can be gained by asking how people who are important to the victim will react to this assault and exploring the meaning of the rape in her community. Listen to how the survivor perceives the ramifications of reporting or not reporting, telling others, etc. In some communities, an adolescent girl who is vaginally raped may be ostracized from the community or no longer considered a good marriage prospect. The limits of confidentiality within the legal system should be thoroughly explained. The advocate must listen to how the young woman feels, what she thinks might happen, and what she wants to do. Victims of color may be reluctant to further stigmatize people of their race; many women who have been raped by men from their own racial group are intensely conflicted because they want to hold the assailant accountable yet do not want to send another man of their race to jail. If victims perceive the legal system as racist and untrustworthy, they may fear sending an innocent man to jail for their assailant's crime (White, 1994; Wilson, 1994). Advocates must be aware of and sensitive to such community dynamics.
- Be aware of culturally appropriate referral sources for followup care and develop partnerships with them. To meet the myriad needs of sexual assault victims, coalitions should be formed with cultural groups in your service area. Get a list of counselors from the cultural group. Culture shapes the way we frame traumatic experiences and how we heal from them.

For example, Southeast Asians influenced by Buddhism may believe in “determinism,” which results in the philosophical acceptance of difficult life situations as having a purpose beyond the control or understanding of mortals. Thus, they may reach for a larger lesson to be learned from the experience and not be so overwhelmed by feelings of guilt and shame, instead dealing with the painful situation by using tolerance, denial, or stoicism (Kanuha, 1997).

Other cultures may have a specific ritual for healing post-traumatic stress, such as the Navajo Enemy Way ceremony. In this ritual, the family and tribe accept responsibility for the impact of trauma on young returning warriors. A healing ceremony facilitates the processing of war trauma and reintegration into the peacetime community (Marsella et al., 1996). Other Native rituals, such as smudging and sweats, also serve to purify victims from the effects of sexual assault.

Draguns (1996) points out that cultures vary in their interventions of post-traumatic stress disorder in the following ways:

- Use of interpretations and their rationale and basis.
- Extent and nature of verbal interaction between client and therapist.
- Role of verbal communication.
- Role differentiation between client and therapist.
- Respective weights of physical, somatic, or psychological distress.
- Role of ritual in psychotherapy.
- Use of metaphor, imagery, myth, and storytelling.
- Nature of the relationship between therapist and client.

Refugees and Immigrants

Refugees have left their native countries to seek asylum in the United States because it was too dangerous to stay in their homelands. Immigrants chose to come to the United States. In recent years, many men and women came to this country from Southeast Asia, South America, Central America, northern Africa,

and Bosnia as a result of war. Refugees and new immigrants are especially vulnerable to victimization, even more so if they do not have legal residency. Sexual predators assume that people who are undocumented will not report an assault to the legal authorities for fear of being deported.

History of Sexual Torture

When people who have a history of having been sexually tortured are raped, they not only experience the trauma of the rape but also are vulnerable to a traumatic re-experiencing of the sexual torture. Although exact numbers are not available, a review of studies of the prevalence of sexual torture in refugee populations shows rates of 20 to 80 percent (Mollica and Son, 1989). In many countries that employ the use of torture to control populations, it often takes place in a room that looks much like an exam room and in the presence of a doctor or nurse. For this reason, being in a closed exam room or near medical personnel after a rape may cause profound anxiety. Likewise, the sex crime investigation interview mimics the interrogation process of the torture that resulted in severe physical and emotional pain. Members of the SART should be aware of this possible history and realize that, because of the devastating nature of the torture experience and its emotional impact, most torture survivors will not readily admit to a history of torture. Extra care must be taken to assure the refugee rape survivor that they do not have to do anything they do not want to do and, if something hurts or a discussion becomes too painful, to tell the examiner or investigator and they will stop. Being in control is essential for people with traumatic histories. Victims need to know why examiners and investigators are doing what they are doing and asking what they are asking. Encourage the survivor to keep her eyes open during the pelvic exam to reduce the likelihood of flashbacks to the torture experience.

Torture survivors who have been raped need to be reassured that they have sustained no permanent physical damage and that their bodies will heal, if indeed this is the case. As with incest survivors, torture survivors need additional support.

Module 4 References

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Module 4: Impact of Sexual Assault

Purpose

This module will help you explore the physical and emotional impact of sexual assault.

Module 4 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.

Brainstorm Activity

Physical Impact of Sexual Assault

Nongenital Physical Injury

- Physical injury resulting from sexual assault is relatively rare.
- It is more common in stranger rapes.
- Older victims are more likely to sustain injury.
- Male victims who report are injured more often than female victims.

Genital Trauma

- Few rape victims sustain significant genital trauma.
- Colposcopic (magnified) examination is helpful to visualize injuries too minute to see with the naked eye.

Sexually Transmitted Infections

- Concern is often high, but actual risk is rather low.
- HIV is a concern of victims or sexual partners.
- Medical professionals should provide information.
- Rape victims are at a lower HIV risk than those exposed to needle sticks, needle sharing, mother-to-infant transmission, or blood transfusions.

Pregnancy

- The actual risk is the same as that from any one-time sexual encounter: an estimated 2 to 4 percent.
- Medical facilities offer emergency contraception.

General Health Risk

- Sexual assault not only affects a victim's health directly and immediately, it can also have a significant and chronic impact on their general health for years to come.
- Stress appears to suppress the immune system.
- Increased sexual activity with multiple partners sometimes follows rape.

Psychological Symptoms Perceived as Physical

- Rape victims may seek physical versus mental health care.
- Low levels of social support = higher use of medical services.
- Symptoms most likely to manifest are gynecological problems and sexual dysfunctions.
- Victims of more severe crimes and multiple crimes are most likely to seek medical care.

Sexual Dysfunction

- Sexual dysfunction is a common reaction and often a chronic problem.
- This may include 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 and avoidance of sex, intrusive thoughts of the assault during sex, vaginismus, and abstinence.

Substance Abuse

- Rape victims may be more vulnerable to being raped as a result of substance abuse.
- Rape can also *result* in substance abuse.

Brainstorm Activity

Psychological Impact of Sexual Assault

Anxiety

- Rape victims are more anxious than nonvictims.
- 82 percent of rape victims met criteria for generalized anxiety disorder.

Fear

- Death is the most common fear during the assault.
- Continued generalized fear occurs after the assault.

Depression

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

Suicidal Ideation

- The likelihood of completed suicide following a rape is low, but suicidal ideation is a significant issue.
- In the period immediately following the rape, victims are nine times more likely than nonvictims to attempt suicide.

Self-Blame and Shame

- Common response.
- Associated with more depression and poor adjustment after the rape.

Post-Traumatic Stress Disorder

- Exposure to a traumatic event.
- Reexperiencing the trauma.
- Symptoms of avoidance and numbing.
- Symptoms of increased arousal.
- Symptoms present at least 1 month, clinically significant.

Factors Associated With Higher Levels of Post-Rape Trauma

- Victim's perception of the threat of danger.
- Prior sexual victimization.
- Use of avoidant coping strategies.
- Self-blame.
- Prior mental health history.
- History of substance abuse.
- Lack of social support following the sexual assault.

Group Process Scenario: Psychological Impact

A caller who was sexually assaulted 6 months ago is experiencing sleeplessness and weight gain and having trouble concentrating. She is experiencing recurrent pelvic pain, but her doctor hasn't been able to find a physical cause. What are some of the psychological effects of assault that this caller might be experiencing?

Impact on Partners, Family, and Close Friends

- Secondary or indirect victims.
- Often suffer many of the same initial and long-term symptoms.
- Overprotection or blame.
- Partner's, friends', and family's high stress associated with unsupportive behaviors (emotional withdrawal, blaming).

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