

Module 5: Impact of Sexual Assault

Time Required

1 hour, 5 minutes

Purpose

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

Lessons

1. Physical Impact of Sexual Assault (30 minutes)
2. Psychological Impact of Sexual Assault (30 minutes)
3. Impact on Partners, Family, and Close Friends (5 minutes)

Learning Objectives

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

- Describe the physical and psychological impact of sexual assault.
- Describe the impact of sexual assault on partners, family, and close friends.

Participant Worksheets

- Worksheet 5.1, STI Scenario
- Worksheet 5.2, Physical and Psychological Impact Scenario

Equipment and Materials

No special equipment or materials are required.

Preparation

- Carefully review the group process scenarios and be prepared to present an “ideal” response. As protocol, facilities, and resources vary from community to community, the response should be based on existing procedures at participants’ agencies.
- Refer to the U.S. Department of Justice’s *A National Protocol for Sexual Assault Medical Forensic Examinations-Adult/Adolescents* for best practices (www.ncjrs.gov/pdffiles1/ovw/241903.pdf).



Show Visual 5-1.

Introduce the module.



Show Visual 5-2.

Review the purpose and learning objectives for this module.

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

- Describe the physical and psychological impact of sexual assault.
- Describe the impact of sexual assault on partners, family, and close friends.

1. Physical Impact of Sexual Assault (30 minutes)

Tell participants that, in order to best meet the needs of sexual assault victims, they must first understand the far-reaching impact of sexual assault.



Show Visual 5-3.

Introduce the activity.



Activity: Brainstorm—Potential Physical Impact of Sexual Assault (5 minutes)

- 1. Ask participants to close their manuals for this activity. Explain that the group is going to brainstorm a list of some of the potential physical impacts of sexual assault. Ask a volunteer to be a note taker and work on a tear sheet.**
- 2. Allow participants to come up with suggestions for impacts, and to note whether the suggestion is a likely physical impact of sexual assault. Correct any misconceptions or inaccurate responses. The note taker should write down all of the appropriate answers on the tear sheet.**
- 3. When participants have offered all of their suggestions, tell them that you are now going to explore the physical impacts of sexual assault in greater detail.**

Nongenital Physical Injury



Show Visual 5-4.

Paraphrase:

The typical assumption is that rape victims experience physical injury during a rape. A recent review of research on injuries from rape indicates that it is difficult to show how often rape-related injuries occur given wide variation in research methodology, clinical setting, and training of medical staff identifying nongenital and genital injuries.

Across studies, the average prevalence of general bodily injury was about half of victims, and the prevalence of genital injury was about one-third of victims, with nearly 40 percent of victims having no injuries.

These prevalence rates varied widely across studies, with some studies finding considerably fewer injuries, and some finding injuries among the vast majority of victims (Sommers 2007).

Numerous factors may relate to whether a victim of rape experiences injury. Some might assume that victims will fight back and be injured as a result.

Based on data from the National Crime Victimization Survey, researchers indicate that most self-protective actions undertaken by rape victims appear to reduce the risk of rape completion and do not significantly affect the risk of additional injuries (Tark and Kleck 2014).

The relationship to the perpetrator may also impact rates of injury. Some research indicates that rapes committed by spouses or boyfriends are characterized by more coercion and injury than those committed by other known assailants or by strangers (Logan et al. 2007; Stermac et al. 2004), consistent with the idea that some sexual violence is part of a continuum of intimate partner violence.

Although some studies have found differences in levels of nongenital injury for male victims versus female victims or older victims versus younger victims, research findings have been conflicting, and further research is needed to clarify nature and degree of difference (Del Bove et al. 2005; Kimerling et al. 2002; Petrak and Claydon 1996; Stermac et al. 2004).

Genital Trauma



Show Visual 5-5.

Paraphrase:

Some rape victims sustain significant genital trauma, others have only minor genital trauma or none at all. Examination utilizing magnification (use of colposcope) has been helpful to visualize genital abrasions, bruises, and tears that may be too minute to see with the naked eye (Frank

1996; Slaughter and Brown 1992). These minor injuries usually heal completely within 48 to 72 hours.

While recent studies demonstrated a significant consent group difference in genital injury prevalence and the highest macroscopically detected genital injury prevalence rate resulting from nonconsensual vaginal penetration identified to date (Lincoln et al. 2013), forensic examiners cannot differentiate between consensual and nonconsensual injuries (Anderson 2008).

In a review of visual rape evidence used in legal contexts, researchers have noted that tools such as the colposcope may document a greater number of injuries.

The researchers held focus groups with Sexual Assault Nurse Examiners (SANE), however, and noted high levels of concern that physical injuries may be absent, and that those observed through microvisualization may be explained away as resulting from consensual activity. SANEs also expressed concern that visual documentation may be dehumanizing for victims.

SANEs also acknowledged that the legal context overemphasizes physical injury as evidence that an assault occurred (White and Du Mont 2009).

Although the use of a colposcope has been controversial due to the argument that injury does not differentiate between nonconsensual and consensual activity, theorists argue that visualization is an invaluable tool that provides information for clinical judgment and is part of the patient's right to evidence-based medicine (Brennan 2006). Thus, preparation for cases should be documented as thoroughly as possible using technologies available (Brennan 2006; White and Du Mont 2009).

NOTE: The term colposcopy refers to a procedure done by physicians. SANEs use a colposcope, which is a piece of equipment that magnifies and provides illumination.

Sexually Transmitted Infections (STI)



Show Visual 5-6.

Paraphrase:

About two-thirds of sexual assault victims who seek medical attention have concerns about sexually transmitted infections (STI) and HIV (Zinzow et al. 2012).

The *National Protocol for Sexual Assault Medical Forensic Examinations* (U.S. Department of Justice 2013) recommends that all medical facilities offer rape victims medications to prevent contracting STIs.

The risk of contracting HIV from a sexual assault is less than 1 percent, but trichomonas, gonorrhea, chlamydia, and bacterial vaginosis are relatively prevalent. Although postassault presence does not necessarily mean that the STI resulted from the assault, the exam provides an opportunity to treat the infection (Centers for Disease Control and Prevention 2010).

Nonoccupational postexposure prophylaxis (nPEP) should be considered for victims at high risk of contracting HIV. The decision to offer nPEP should be based on the risk of the rape combined with HIV prevalence in the specific geographic area.

Rape is considered high risk if it involves rectal contact or vaginal contact with tearing, or existing vaginal STIs that have caused ulcerations or open sores disrupting the integrity of the vaginal mucosa. It also is considered high risk if the victim knows or suspects that the assailant is an IV-drug user, HIV positive, or bisexual (Ledray 2006).

Even if the survivor does not ask questions about HIV during the initial exam, the SANE or medical professional should, in a matter-of-fact manner, provide information about risk, testing, nPEP, and safe-sex options, which allows the victim to make decisions based on facts, not fear (Ledray 1999). When used, it should be started within 72 hours of exposure.

Anti-HIV medications should be available where and when patients present after sexual assault. To the extent possible, patients who want nPEP need to be able to obtain it as a component of their sexual assault medical-forensic examination, rather than potentially have to visit additional agencies at a later time in order to initiate the medication regimen.

Provision of nPEP should be supported by institutional policies that are current and well understood by staff in order to facilitate the process and ensure consistent access within the agency. Appropriate counseling regarding followup testing and medication side effects are needed at the time of provision so that patients are able to make fully informed decisions about choosing nPEP.

People who have been sexually assaulted should not be expected to carry the financial burden for HIV nPEP. Communities should have a streamlined and accessible process for nPEP payment so that medication costs are not a barrier.

Payment for anti-HIV medications is a complex issue. Some communities have a simple process for paying for nPEP so that individuals are not burdened with the cost. Other locations may require health care providers, patients, and advocates to navigate a complex web of rules and procedures in attempting to obtain medications (Association of Nurses in AIDS Care 2013).

Instructor Note:

The following activity presents group process scenarios. These are good exercises to enhance participants' understanding of specific issues and to warm up for formal role plays. This group process scenario will help you to determine whether the participants are learning the material. If you do not get appropriate suggestions in response to the scenario from a range of participants, you may need to review the information. After suggestions are offered, summarize the ideas and model an appropriate response, or reinstruct on the issue as necessary.



Show Visual 5-7.

Introduce the activity.

 **Activity: Group Process Scenario I (10 minutes)**

- 1. Read the STI scenario below to the group, and ask the participants to offer ideas on how to handle the situation.**
- 2. Tell participants they may use Worksheet 5.1, STI Scenario, found in the Participant Manual, for their notes.**

STI Scenario: A caller who was sexually assaulted the night before is concerned about STIs, including HIV/AIDS.

- 3. Ask participants: What can you tell the caller?**

Debrief the activity by **emphasizing** that specific responses to the caller depend on each organization's procedures. Regardless of procedures, victims should never be made to feel as if they did something wrong, or that the assault was their fault.

Pregnancy

 **Show Visual 5-8.**

Paraphrase:

Rape victims of reproductive age often fear becoming pregnant as a result of a rape. The actual risk is around 5 percent (Holmes et al. 1996; Gottschall and Gottschall 2003).

Most SANE programs and medical facilities offer emergency contraception to women at risk of becoming pregnant, provided they are seen within 3 to 5 days of the rape and have a negative pregnancy test (depending on the emergency contraceptive provided).

If the test is negative and the patient has had unprotected intercourse within the last 10 days and would continue that pregnancy if conception has occurred, then she may be considered to be pregnant and emergency contraception would not be administered (U.S. Department of Justice 2013).

Determination of the probability of conception also depends upon other variables, for example, the use of contraceptives, regularity of the menstrual cycle, fertility of the victim and the perpetrator, time in the cycle of exposure, and whether the perpetrator ejaculated intravaginally.

Pregnancy resulting from sexual assault often is a cause of great concern and significant additional trauma to the victim, so victims' fears should be taken seriously. Although many transgender male individuals believe they are infertile as a result of using testosterone, cases have been reported of unexpected pregnancies.

Therefore, if a transgender male individual has not had a hysterectomy, is still within childbearing years, and the nature of the assault suggests it, the possibility of pregnancy should be discussed, even if he has not been menstruating (U.S. Department of Justice 2013).

Oral contraceptives such as Ovral are still used in some areas; however, Plan B (levonorgestrel) is more commonly used today for emergency contraception. Plan B was developed specifically to prevent pregnancy after unprotected intercourse.

It is believed to act as emergency contraception by preventing ovulation or fertilization by altering tubal transport of sperm and/or ova. It also may inhibit implantation by altering the lining of the uterus.

This treatment is not 100 percent effective in preventing pregnancy. A review of 10 studies using Ovral found an overall effectiveness rate of at least 75 percent.

This statistic does not mean that 25 percent will become pregnant; rather, if 100 women have intercourse in the middle 2 weeks of their cycle, approximately 8 would become pregnant without postcoital interception. With interception, only 2 (a reduction of 75 percent) of the 100 would become pregnant (American College of Obstetricians and Gynecologists 2002).

The sooner you take Plan B after unprotected sex, the better effectiveness it has against pregnancy. If taken within 72 hours after unprotected intercourse, Plan B has an 89 percent chance of successfully preventing a pregnancy; however, if taken within 24 hours after unprotected intercourse, the effectiveness rate goes up to 95 percent.

General Health Risk



Show Visual 5-9.

Paraphrase:

Rape, like other types of sexual assault, not only affects victims' health directly and immediately; there is convincing evidence that it also can have a significant and chronic impact on their general health for years to come (Frazier and Ledray 2011).

Stress appears to suppress the immune system and increase susceptibility to disease (Cohen and Williamson 1991).

Stress such as a sexual assault also may result in injurious behaviors, such as substance abuse or eating disorders (Felitti 1991; Golding 1994; Messman-Moore and Garrigus 2007).

Survivors of sexual assault also may experience chronic back and facial pain, chest pain, shortness of breath, insomnia and fatigue, heart palpitations, cardiac arrhythmia, nausea, vomiting, diarrhea, bloatedness, and abdominal pain (Golding 1994, 1996).

Sexual Dysfunction



Show Visual 5-10.

Paraphrase:

Not surprisingly, studies have found that sexual dysfunction is a common reaction and often a chronic problem after rape.

Mentioned repeatedly in the literature are avoidance, loss of interest in sex, loss of pleasure from sex, painful intercourse, and fear of sex (Abel and Rouleau 1995; Frazier and Borgida 1997; Ledray 1998).

In a review of studies exploring sexual problems following sexual assault, researchers found that frequency of sexual contact decreases after the assault, satisfaction and pleasure in sexual activities diminishes for some victims for at least 1 year after the assault, and some victims develop sexual problems that persist for years after the assault (Van Berlo 2000).

Survivors of rape also may experience painful menstruation, excessive menstrual bleeding, menstrual irregularity, and genital burning (Golding 1996).

Recent research on young female rape victims points to pelvic floor dysfunction as a possible mediator between rape and symptoms of sexual or reproductive dysfunction; this indicates that treatment strategies for physical dysfunction might be included in treatments for trauma exposure (Postma et al. 2013).

It also is well documented that sexual assault victims engage in risky sexual behaviors, such as more sexual partners and more current sexual partners (Upchurch and Kusunoki 2004).

This has been found to be true in large national samples of adolescents who were victims of a sexual assault (Upchurch and Kusunoki 2004), college women who were victimized (Brener, McMahon, Warren, and Douglas 1999), Native American victims (Evans-Campbell, Lindhorst, Huang, and Walters 2006), and military women who were sexually assaulted (Lang, Rodgers, Loffaye, Satz, Dresselhaus, and Stein 2003).

Increased risky sexual behavior among victims may stem from factors such as the psychological distress associated with sexual assault (Campbell and Lewandowski 1997) or reproductive coercion (forcing a woman to become pregnant) by relationship partners (Miller et al. 2011). Increased sexual activity with multiple partners may further increase exposure to disease (Ledray 1994).

Substance Abuse



Show Visual 5-11.

Paraphrase:

Individuals are clearly more vulnerable to assault when intoxicated.

A recent study of college women found that nearly a third of women experienced alcohol- or drug-related sexual assault or rape, and 5 percent experienced forcible sexual assault or rape. The vast majority of the drug- and alcohol-related assaults involved voluntary (self-induced) incapacitation and alcohol use, with only 15 percent representing involuntary incapacitation (Lawyer et al. 2010).

In a study conducted at the Sexual Assault Resource Service (SARS) in Minneapolis, 55 percent of rape victims (N=130) self-reported using alcohol at the time of the rape. Sixty percent of these reported the alcohol use was voluntary (Ledray, Frazier, and Peters 2007).

While drug-facilitated sexual assault (DFSA) has received considerable attention because of the use of “designer” memory-erasing drugs, it is important to remember that the most frequently used drug to facilitate a sexual assault continues to be alcohol (Horvath and Brown 2007).

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

In a national sample of 3,006 female survivors, both alcohol and drug use significantly increased after a sexual assault, even for women with no prior drug or alcohol use or abuse history (Kilpatrick, Acierno, Resnick, Saunders, and Best 1997).

This study also found that women who were already using drugs and alcohol to cope were more likely to have a history of prior sexual abuse.

Similarly, a study that followed female survivors of child sexual abuse over time found that problem drinking was predicted by childhood victimization (Ullman, Najdowski, and Filipas 2009).

Researchers concluded that sexual abuse plays a significant role in initiating and maintaining substance abuse in women, with younger women being even more at risk.

In a more recent study, researchers reported that victims of rape are 13.4 times more likely to develop two or more alcohol-related problems and 26 times more likely to have two or more serious drug-related problems (Kilpatrick 2003).

2. Psychological Impact of Sexual Assault (30 minutes)



Show Visual 5-12.

Paraphrase:

Researchers agree that sexual assault victims experience more psychological distress than do victims of other crimes.

Compared to nonvictim control groups, rape and sexual abuse victims consistently report more symptoms of anxiety, fear, depression, and posttraumatic stress disorder (PTSD) (Frazier and Borgida 1997; Trickett et al. 2011).

Positive social reactions to assault disclosure could affect both perceived control over recovery and positive social coping, and perhaps in turn help reduce PTSD symptoms.

Health psychology research shows that social support increases feelings of self-efficacy, which in turn improves health outcomes (Chlebowy & Garvin 2006). In the context of sexual assault, support such as spending time with the survivor, giving her somewhere to stay, or providing resources following an assault can increase victims' perceived control over their recovery process (i.e., their perceived self-efficacy for coping with the assault).

Positive reactions to assault disclosure may also lead victims to feel better and therefore engage in more adaptive forms of coping and fewer maladaptive forms of coping (Ullman, Townsend et al. 2007). It is also possible that positive social reactions to assault disclosure are more strongly related to social forms of adaptive coping, rather than to individual forms of adaptive coping.

Thus, it is important to separate the effects of social reactions to assault disclosure on these different types of coping, because social reactions to assault disclosure might affect one form and not another.

Finally, positive social reactions to sexual assault disclosure may lead to more PTSD symptoms, even though research shows that general measures of social support (not specific to assault) are related to fewer PTSD symptoms in sexual assault survivors (Ullman 1999, 2010).

Perhaps this surprising positive relation exists because victims who disclose to more people typically get a mix of both positive and negative reactions from others to assault disclosure (Ullman 2010), and perhaps victims of more severe trauma are more likely to both disclose to more people and to develop PTSD symptoms, not because of a causal link between positive reactions to assault disclosure and PTSD symptoms.



Show Visual 5-13.

Introduce the activity.

 **Activity: Brainstorm—Potential Psychological Impact of Sexual Assault**
(5 minutes)

1. *Ask participants to close their manuals for this activity. Explain that the group is going to brainstorm a list of some of the potential psychological impacts of sexual assault. Ask for a volunteer to be a note taker and work on a tear sheet.*
2. *Allow participants to come up with suggestions for impacts, and to note whether the suggestion is a likely psychological impact of sexual assault. Correct any misconceptions or inaccurate responses. The note taker should write down all of the appropriate answers on the tear sheet.*
3. *When participants have offered all of their suggestions, tell them that you are now going to explore the psychological impacts of sexual assault in greater detail.*

Anxiety

 **Show Visual 5-14.**

Paraphrase:

Rape victims are consistently found to be more anxious than nonvictims during the first year after a rape (Frazier, Harlow, Schauben, and Byrne 1993).

In one study, 82 percent of rape victims met the Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria for generalized anxiety disorder, compared with 32 percent of nonvictims (Frank and Anderson 1987).

Fear

 **Show Visual 5-15.**

Paraphrase:

Death is the most common fear during the assault, with continued generalized fear after the assault a very common response to sexual assault (Dupre, Hampton, Morrison, and Meeks 1993; Ledray 1994).

While evidence of the type and duration of fear varies, up to 83 percent of victims report some type of fear following a sexual assault (Frazier and Borgida 1997).

Girelli et al. (1986) found that the subjective distress of fear of injury or death during rape was

more significant than the actual violence in predicting severe postrape 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



Show Visual 5-16.

Paraphrase:

Depression is one of the most commonly mentioned long-term responses to rape (Abel and Rouleau 1995; Frazier and Borgida 1997; Ledray 1994).

Compared to nonvictims, depression is more than three times as prevalent among victims of forcible rape and twice as prevalent among victims of drug-facilitated or incapacitated rape (Zinzow et al. 2012).

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



Show Visual 5-17.

Paraphrase:

While the number of suicides following a sexual assault is considered low, suicidal ideation (i.e., thoughts about suicide) is a significant issue.

One study found 39 percent of rape victims reported a subsequent suicide attempt (Ackard and

Neumark-Sztainer 2002).

In other studies, between 33 and 50 percent of victims reported that they considered suicide at some point after the rape (Ullman 2004; Ullman and Brecklin 2002).

In a study of female survivors of sexual assault, researchers found that women at the most risk for suicidal ideation were younger, ethnic minority, or bisexual. Those with more traumas and drug use enacted more suicide attempts (Ullman, Najdowski, and Filipas 2009).

Self-Blame and Shame



Show Visual 5-18.

Paraphrase:

A number of studies have identified posttraumatic guilt, self-blame, and shame as common responses following a sexual assault, and ones that are linked to PTSD, more depression, and poor adjustment after the rape (Vidal and Petrak 2007; Frazier 1990; Ledray 1999).

One study compared college students' retrospective reports of different emotions during and after sexual assault. While emotions such as fear peaked during the trauma, other emotions such as shame, guilt, anger, and sadness often increased after the trauma (Amstadter and Vernon 2008).

Posttraumatic Stress Disorder (PTSD)



Show Visual 5-19.

Read the definition of posttraumatic stress disorder:

“A psychiatric disorder that can occur in people who have experienced (directly or indirectly) or witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, war/combat, or rape or other violent personal assault” (American Psychiatric Association 2013).

The National Women's Study, an epidemiological survey of 4,008 women, found the lifetime prevalence of PTSD resulting from rape and sexual assault to be 32 percent and 30.8 percent respectively, compared with a prevalence of 9.4 percent caused by non-crime-related trauma such as a car accident (Kilpatrick, Amstadter, Resnick, and Ruggiero 2007).

One study found 78 percent of rape victims met the criteria for PTSD at 2 weeks; 63 percent at 2 months; 58 percent at 6 months; and 48 percent at 1 year (Frazier, Conlon, and Glaser 2001). Sexual assault also has been identified as the most common cause of PTSD in women (Frans, Rimmo, Aberg, and Fredrickson 2005).



Show Visual 5-20.

Symptoms of PTSD fall into four categories (American Psychiatric Association 2013):

1. Intrusive symptoms such as repeated, involuntary memories; distressing dreams; or flashbacks of the traumatic event. Flashbacks may be so vivid that people feel they are reliving the traumatic experience or seeing it before their eyes.
2. Avoidance of reminders such as people, places, activities, objects, and situations that bring on distressing memories. People may try to avoid remembering or thinking about the traumatic event. They may resist talking about what happened or how they feel about it.
3. Negative thoughts and feelings may include ongoing and distorted beliefs about oneself or others (e.g., “I am bad,” “No one can be trusted”); ongoing fear, horror, anger, guilt or shame; much less interest in activities previously enjoyed; or feeling detached or estranged from others.
4. Arousal and reactivity symptoms may include being irritable and having angry outbursts; behaving recklessly or in a self-destructive way; being easily startled; or having problems concentrating or sleeping.

In 2013, the American Psychiatric Association made several key changes to criteria for PTSD, moving the disorder from classification as an anxiety disorder to a new chapter on Trauma- and Stressor-Related Disorders in the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5).

Other changes in the criteria include explicitly including sexual assault as a traumatic event and deleting criteria regarding the individual’s response to the event (e.g., fear, horror), as this has been shown to have no utility in predicting the onset of PTSD.

The disturbance must continue for more than a month to be classified as PTSD (American Psychiatric Association 2013).



Show Visual 5-21.

Paraphrase:

The severity of PTSD symptoms in sexual assault survivors is associated with the victim’s trauma history, perceived life threat during the assault, feelings of self-blame for the assault, avoidance coping, and negative social reactions from others (Ullman 2007).

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

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



Show Visual 5-22.

Introduce the activity.



Activity: Group Process Scenario II (10 minutes)

- 1. Read the *Physical and Psychological Impact* scenario below and ask participants to offer ideas on how to handle the situation.**
- 2. Tell participants they may use Worksheet 5.2, *Physical and Psychological Impact Scenario*, in the *Participant Manual*, for their notes.**

Physical and Psychological Impact Scenario: A caller who was sexually assaulted 6 months ago is experiencing sleeplessness, weight gain, and trouble concentrating. She is experiencing recurrent pelvic pain, but her doctor hasn't been able to find a physical cause.

- 3. Ask participants: *What are some of the physical and psychological effects of assault that this caller might be experiencing?***

Debrief the activity by **emphasizing** that victims may exhibit some or all of these effects, or they may demonstrate no effects at all—however, just because a victim shows no effects of having been assaulted doesn't mean she is okay. Talking to the victim compassionately will help you determine exactly how the victim has been affected.

3. Impact on Partners, Family, and Close Friends (5 minutes)



Show Visual 5-23.

Family members and those close to the victim have been recognized as secondary or indirect victims (Koss and Harvey 1991; Ledray 1994). As a result, they, too, often suffer many of the same initial and long-term symptoms of distress experienced by the sexual assault survivor, including shock and disbelief, fear, anxiety, a sense of helplessness, depression, and anger.

Also, they may blame the victim for the assault. This type of blame is often a misdirected attempt to deal with their own feelings of guilt and self-blame for somehow not protecting their loved one and not preventing the assault (Ledray 1994).

A study of more than 100 secondary victims of rape, including family members, partners, and friends, found that these persons suffered significant levels of trauma, with about one-quarter experiencing PTSD. They also reported difficulty in supporting the victims due to insecurities in

how to help, refusal by the victim in receiving help, reactions of the victim, and their own feelings about the assault.

Many reported that their relationship with the victim was affected by the assault, with about one-quarter feeling closer to the victim and another quarter reporting that the relationship had gotten worse for some period of time after the assault.

Family and friends may become overly protective, further limiting the victim's activities. In a large study of reactions to sexual assault disclosure among college women, researchers found social reactions that attempted to control the survivor's decisions were associated with greater symptomology for PTSD, depression, and anxiety. This may impede the survivor's perception of being in control of the recovery process.

It is common for the victim to become angry with family members who are themselves upset ("It didn't happen to them, so they have no right to be so upset").

This is especially true when family members appear more upset than the victim. Victims may also take out their anger about the sexual assault on family members (Ledray 1994; Mitchell 1991). If the family is not prepared and does not understand the motivation behind this behavior, they may reject the victim, and victims may lose their social support when they need it most.



Show Visual 5-24.

Review the learning objectives and **ensure** that these were met.

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

- Describe the physical and psychological impact of sexual assault.
- Describe the impact of sexual assault on partners, family, and close friends.



Show Visual 5-25.

Ask if there are any final questions or comments before moving to the next module.

Module 5
Impact of Sexual Assault



Learning Objectives

- Describe the physical and psychological impact of sexual assault.
- Describe the impact of sexual assault on partners, family, and close friends.

5-2



Activity



*Brainstorm—
Potential Physical Impact
of Sexual Assault*

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5-3



Nongenital Physical Injury

- It is difficult to show how often rape-related injuries occur.
- Most self-protective actions undertaken by rape victims do not significantly affect the risk of additional injuries.
- Less common in stranger rape.
- Further research is needed.



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5-4

Identified Genital Trauma

- Rates of identified genital injury vary from significant to no injury.
- Examination utilizing magnification (use of colposcope) has been helpful in visualizing genital abrasions, bruises, and tears too minute to see with the naked eye.
- Visualization is an invaluable tool that is part of the patient's right to evidence-based medicine.

5-5

Sexually Transmitted Infections (STI)

- Concern about STIs is one key difference between victims who seek medical care and those who do not.
- Risk of contracting HIV is low.
- Risk of contracting other diseases is relatively prevalent.
- Allow victims to make decisions based on facts, not fear.

5-6

Activity

 **Group Process Scenario I**
Worksheet 5.1
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STI Scenario:

A caller who was sexually assaulted the night before is concerned about STIs, including HIV/AIDS.

5-7

Pregnancy

- The actual risk is around 5 percent.
- Medical facilities offer emergency contraception.
- Pregnancy resulting from sexual assault is often a cause of great concern and significant trauma to victims— their fears should be taken seriously.



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5-8

General Health Risk

- Sexual assault affects a victim's health directly and immediately.
- It can also have a significant and chronic impact on their general health for years.
- Stress appears to suppress the immune system.
- Injurious behaviors and health problems sometimes occur after sexual assault.



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5-9

Sexual Dysfunction

Sexual dysfunction is a common reaction and often a chronic problem. This may include:

- Avoidance of sex.
- Loss of interest, loss of pleasure in sex.
- Painful intercourse and periods.
- Risky sexual behaviors.



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5-10

Substance Abuse

- Individuals are more vulnerable to assault when intoxicated.
- Alcohol is the most frequently used drug to facilitate a sexual assault.
- Alcohol/drug use by female survivors significantly increased after sexual assault.
- Sexual abuse plays a role in substance abuse.



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5-11

Psychological Impact of Sexual Assault

- Sexual assault victims experience more psychological distress than victims of other crimes.
- Positive social reactions to assault disclosure could affect both perceived control over recovery and positive social coping.
 - ◆ This could help reduce PTSD symptoms.

5-12

Activity



Brainstorm— Potential Psychological Impact of Sexual Assault

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Anxiety

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



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5-14

Fear

- Death is the most common fear during the assault.
- Continued generalized fear occurs after the assault.
- The threat of violence alone can be psychologically devastating.



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5-15

Depression

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



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5-16

Suicidal Ideation Studies

- Studies indicate that suicide ideation after sexual assault is a significant issue.
- Women at the most risk for suicidal ideation were younger, ethnic minority, or bisexual victims.
- Victims with more traumas and drug use enacted more suicide attempts.



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5-17

Self-Blame and Shame

- Posttraumatic guilt, self-blame, and shame are common responses following sexual assault.
- Emotions such as fear may increase during the trauma, but other emotions such as shame, guilt, anger, and sadness often increase after the trauma.



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5-18

Posttraumatic Stress Disorder (PTSD)

“A psychiatric disorder that can occur in people who have experienced (directly or indirectly) or witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, war/combat, or rape or other violent personal assault.”



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(American Psychiatric Association 2013)

5-19



PTSD Symptoms

- Intrusive symptoms such as distressing dreams and flashbacks.
- Avoidance of reminders.
- Negative thoughts and feelings.
- Arousal and reactivity symptoms.



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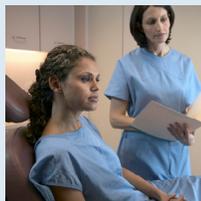
(American Psychiatric Association 2013)

5-20



Severity of PTSD Symptoms

- Associated with trauma history, perceived life threat during the assault, and feelings of self-blame, among other issues.
- SANEs empower victims with PTSD by:
 - ♦ Providing health care, support.
 - ♦ Treating them with respect and dignity.
 - ♦ Respecting their decisions.



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Activity



Group Process Scenario II
Worksheet 5.2

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Physical and Psychological Impact Scenario:

A caller who was sexually assaulted 6 months ago is experiencing sleeplessness, weight gain, and trouble concentrating. She is experiencing recurrent pelvic pain, but her doctor hasn't been able to find a physical cause.

5-22

Impact on Partners, Family, Close Friends

- Secondary or indirect victims.
- Often suffer many of the same initial and long-term symptoms.
- May suffer from PTSD.
- May have difficulty supporting the victim.
- Relationship with the victim is affected.



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Review of Learning Objectives

- Describe the physical and psychological impact of sexual assault.
- Describe the impact of sexual assault on partners, family, and close friends.

5-24

End of Module 5

Questions? Comments?



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