

Module 5: Impact of Sexual Assault

Purpose

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

Lessons

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

Learning Objectives

By the end of this module, you 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

1. Physical Impact of Sexual Assault

The activity addresses the far-reaching impact of sexual assault.

Nongenital Physical Injury

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, prevalence of genital injury was about one-third of victims, with nearly 40 percent of victims having no injuries. However, these prevalence rates varied widely across studies, with some studies finding considerably fewer injuries, and some finding injuries among the vast majority of victims. Injuries also vary in severity and location around the genital area (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).

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. 2006), 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). However, further research is needed to determine whether such findings are consistently identified across studies.

Genital Trauma

Some rape victims sustain significant genital trauma, others have only minor genital trauma or none at all. Colposcopic (magnified) examination has been helpful to visualize vaginal abrasions, bruises, and tears that may be too minute to see with the naked eye (Frank 1996; Slaughter and Brown 1992).

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

In a review of visual rape evidence used in legal contexts, researchers have noted that tools such as the colposcope can document more and greater numbers of injuries and may be useful in distinguishing between consensual and nonconsensual sex.

The researchers held focus groups with SANEs, 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 use of colposcopy 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 both for clinical judgment and is part of the patient's right to evidence-based medicine (Brennan 2006). Thus, preparation for cases should document as thoroughly as possible using technologies available (Brennan 2006; White and Du Mont, 2009).

Sexually Transmitted Infections (STIs)

About two-thirds of sexual assault victims who seek medical attention have concerns about sexually transmitted infections and HIV (Zinzow et al. 2012a). The National Protocol for Sexual Assault Medical Forensic Examinations (OVW 2013) recommends that all medical facilities offer rape victims medications to prevent contracting STIs.

The risk for contracting HIV from a sexual assault is less than 1 percent, but trichomonas, gonorrhea, chlamydia, and bacterial vaginosis are relatively prevalent. Although post-assault presence does not necessarily mean that the STI resulted from the assault, the exam provides an opportunity to treat the infection (CDC 2011).

Post-exposure prophylaxis (PEP) should be considered for victims at high risk of contracting HIV. The decision to offer PEP 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, PEP, 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. Its use is often reserved for high-risk cases because of the high cost and the serious side effects of the treatment (Simpson 2001).

The activity presents group process scenarios.

Pregnancy

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 5 days of the rape and have a negative pregnancy test in the emergency department.

Oral contraceptives such as Ovral are still used in some areas; however, 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 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 eight would become pregnant without post-coital interception. With interception, only two (a reduction of 75 percent) of the 100 would become pregnant (American College of Obstetricians and Gynecologists 2002).

General Health Risk

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

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 Borgidia 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 post 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

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 problem drinking was predicted by childhood victimization (Najdowski, Ullman, 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).

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

2. Psychological Impact of Sexual Assault

Researchers agree that 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).

The activity explores the psychological impact of sexual assault.

Anxiety

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

Fear

Death is the most common fear during the assault, with continued generalized fear after the assault a very common response to 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 post-rape fear and anxiety. Thus, it is important to recognize that the threat of violence alone can be psychologically devastating (Goodman, Koss, and Russo 1993).

Depression

Depression is one of the most commonly mentioned long-term responses to rape (Abel and Rouleau 1995; Frazier and Borgida 1997; Ledray 1994). 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., 2012b). As with anxiety, symptoms of depression also overlap with those of PTSD. Such overlapping symptoms include:

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

Suicidal Ideation

While the number of suicides following a 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

A number of studies have identified posttraumatic guilt, self-blame, and shame as a common response following sexual assault, and one that is linked to PTSD, more depression, and poor adjustment post-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)

The definition of posttraumatic stress disorder is:

“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 2014).

The National Women's Study, an epidemiological survey of 4008 women, found the lifetime prevalence of PTSD resulting from rape and sexual assault to be 32 percent and 30.8 percent respectively, compared with a prevalence of 9.4 percent caused by non-crime-related trauma such as a car accident (Kilpatrick, Amstadter, Resnick, and Ruggiero 2007).

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).

Symptoms of PTSD fall into four categories (APA 2014):

1. Intrusive symptoms such as repeated, involuntary memories, distressing dreams, or flashbacks of the traumatic event.
2. Avoidance of reminders such as people, places, activities, objects, and situations that bring on distressing memories.
3. Negative thoughts and feelings such as persistent and distorted beliefs about oneself and others (e.g., fear, shame, anger), diminished interest in activities, or feeling detached.
4. Arousal and reactivity symptoms such as angry outbursts, reckless behavior, problems concentrating, or sleep problems.

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 onset of PTSD. The disturbance must continue for more than a month to be classified as PTSD (APA 2014).

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.

The activity explores the physical and psychological impact of sexual assault.

3. Impact on Partners, Family, and Close Friends

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

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

A study of over 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 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 on 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.

4. Individual Factors That Affect Reactions to Sexual Assault

Sexual assault is traumatic for all victims; however, individual factors can have an impact on the nature and extent of the trauma. These include gender and sexual orientation, age, disability, race, culture, refugee and immigration status, and past experiences of victimization.

Part of being a conscientious victim service provider is the ability to be flexible and to remember that each person will react to assault differently.