Impact of Sexual Assault

Adapted from OVC TTAC: Sexual Assault Advocate and Service Provider Training - Module 6: Impact of Sexual Assault: Participant Manual

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

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 6.1, STI Scenario
- Worksheet 6.2, Physical and Psychological Impact Scenario

1. Physical Impact of Sexual Assault

We will conduct an activity addressing the far-reaching impact of sexual assault.

Nongenital Physical Injury

According to the World Health Organization (2003), only one-third of sexual assault victims sustain visible physical injuries. Most sexual assaults do not involve a significant amount of force; however, a lack of physical injury does not mean a sexual assault did not occur.

Research shows physical resistance by a victim can result in a greater risk of injury and, in some cases, even death (Reid & Beauregard, 2017).

In the United States, sexual assault injuries account for more than 657,000 emergency room visits per year, representing 0.24 percent of all injuries and 3.4 percent of injuries due to violence.

- Most sexual assault cases presented in the emergency department occurred among victims ages 0–14, in the home, and were inflicted by a stranger.
- The average annual incidence of emergency department visits for sexual assault per 10,000 of the U.S. population was 2.39; 0.47 for males and 4.92 for females.
- The average patient age was 19.6; 90.3 percent were female (Loder & Robinson, 2020).

Genital Trauma

Some sexual assault victims sustain significant genital trauma; others have only minor genital trauma or none at all. Magnified examination techniques are helpful for visualizing genital abrasions, bruises, and tears that may be too minute to see with the naked eye. Sexual Assault Nurse Examiner (SANE)s use a colposcope, a special magnifying instrument, to closely examine the cervix, vagina, and vulva. Newer research shows a higher rate of external genital and anal tears in cases where sex is not consensual (Sommers & Fargo, 2021). Race may also impact the rate of injury, where studies of females with lighter skin tones appear to be injured more easily. These findings have important implications for Black and Latinx/Hispanic people in the criminal justice system (Sommers et al., 2019). These minor injuries usually heal completely within 48 to 72 hours.

In a hospital-based study of females, anogenital (including the anus and genital tract) trauma was detected in 68 percent of patients (Rogers et al., 2019; Zink et al., 2010).

According to one study (Zilkens et al., 2018), the majority of post-pubescent males experience no or mild injury following a sexual assault.

- 1 in 20 men who are sexually assaulted experience a genital injury.
- 1 in 5 males had anal injuries when penetration occurred.

The study did not include transgender males who were transitioning; at this time, information regarding the extent of injury among transgender people following sexual assault is limited.

The most common genital injuries, including the anus, include tears, bruising, abrasions, redness, and swelling. Additional nongenital injuries can include bruises and contusions, lacerations, ligature marks, and pattern injuries (e.g., handprints, finger marks, bite marks).

Note the term colposcopy refers to a procedure done by physicians. SANE use a colposcope, which is a piece of equipment that magnifies and provides illumination.

Sexually Transmitted Infections (STI)

As an advocate, you may find many victims of sexual assault have concerns about STIs and HIV. As information and treatments change over time, it is important to establish relationships with medical providers so you can obtain the latest information on behalf of survivors, or you can connect the survivor with the provider if they so choose. In addition to SANEs, student health providers can also be important collaborative partners for campus-based advocates.

The *National Protocol for Sexual Assault Medical Forensic Examinations* (Office on Violence Against Women, 2013) recommends all medical facilities offer sexual assault victims medications to prevent contracting STIs, pregnancy, and HIV. The risk of contracting HIV from a sexual assault is less than 1 percent, but trichomonas, gonorrhea, chlamydia, bacterial vaginosis, and the human papillomavirus (HPV) are relatively prevalent. Although the post assault presence of an STI does not necessarily mean the STI resulted from the assault, the exam provides an opportunity to treat the infection (CDC, 2010) and provide referrals for contact tracing and followup care.

Nonoccupational postexposure prophylaxis (nPEP) is the delivery of antiretroviral therapy to persons who have experienced a nonoccupational exposure that represents a substantial risk for HIV transmission within the past 72 hours. All patients should discuss the risks and benefits of nPEP with the SANE. Additionally, the SANE can address any misconceptions about the medication, and any followup needed.

nPEP should be considered for victims at high risk of contracting HIV in order to decrease the risk of HIV acquisition. While some patients are at a higher risk of contracting HIV, the patient should make the decision right for them. The decision to offer nPEP should be based on specific circumstances of an assault (e.g., bleeding, which often accompanies trauma) that may increase the risk for HIV transmission in cases involving vaginal, anal, or oral penetration (CDC, 2021). In addition, high-risk transmission includes the unknown HIV status of the offender, other STIs, offender IV drug use, male offender history of sex with males, and time from exposure to treatment.

Victims of sexual assault are considered at high risk for contracting HIV if it involved anal/rectal contact or vaginal contact with tearing or if existing vaginal STIs caused ulcerations or open sores disrupting the integrity of the vaginal mucosa (Ledray, 2006).

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 to initiate the medication regimen (Association of Nurses in AIDS Care et al., 2013). You should become familiar with the options available in your area so you can explain them to victims. The SANE should review them as well.

The provision of nPEP should be supported by institutional policies 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 is needed at the time of provision so that patients can make fully informed decisions about choosing nPEP.

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

We will conduct an activity presenting a group process scenario.

Pregnancy

- Female sexual assault victims often fear becoming pregnant as a result of a sexual assault. The actual risk is around 5 percent among victims ages 12–45 who are not on birth control (Holmes et al., 1996).
- Just more than 2 percent of females experience a sexual assault-related pregnancy during their lifetime. Victims who become pregnant after being sexually assaulted by an intimate partner are more likely to experience reproductive coercion, which can include the partner having power and control over reproduction by pressuring the victim to become pregnant or interfering with access to contraception (Basile et al., 2018).
- While it is inappropriate to ask questions relating to transitioning or a person's genitalia, the information you provide to victims relating to risk for STIs and pregnancy should be inclusive of gender identities. Transgender people are often reluctant to access care due to fears of discrimination or disrespect.
- Most SANE programs and medical facilities offer emergency contraception to women at risk of becoming pregnant, provided they are seen within 3–5 days of the sexual assault and have a negative pregnancy test (depending on the emergency contraceptive provided).
- If the test is negative, and the patient had unprotected intercourse within the last 10 days and would continue that pregnancy if conception occurred, then the patient may be considered pregnant, and emergency contraception would not be administered (Office on Violence Against Women, 2013).
- Determination of the probability of conception also depends on 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 take the victims' fears seriously.

- Plan B (levonorgestrel) is commonly used 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. However, this treatment is not 100 percent effective in preventing pregnancy.
- The sooner a person takes Plan B after unprotected sex, the more effective it is against pregnancy. If taken between 48–72 hours after unprotected intercourse, Plan B has a 61 percent chance of successfully preventing pregnancy; however, if taken within 24 hours after unprotected intercourse, the effectiveness rate increases to 95 percent (www.planbonestep.com).
- Culturally competent and sensitive care is achieved by building awareness about and sensitivity to how culture can impact a person's experience in the immediate aftermath of sexual assault and across their lifespan. Be aware and responsive to how cultural identities (e.g., race, ethnicity, gender, religion, ability/disability, language [limited English proficiency], immigration status, socioeconomic status, sexual orientation, gender identity or expression, age) may influence a person's experience during the exam process. Education for responders on issues facing a specific population may serve to enhance care, services, and interventions provided during the exam process.
- Building an understanding of the perspectives of a specific population may help increase the likelihood the actions and demeanor of responders will mitigate a victim's trauma. However, do not assume patients hold certain beliefs or have particular needs and concerns merely because they belong to a specific population (Office on Violence Against Women, 2013).

General Health Risk

While sexual assault affects victims' health directly and immediately, there is convincing evidence it also can have a significant and chronic impact on their general health for years to come (Frazier & Ledray, 2011). Among women in the United States, the adjusted odds of experiencing asthma, irritable bowel syndrome, frequent headaches, chronic pain, difficulty sleeping, activity limitations, poor physical or mental health, and use of special equipment (e.g., a wheelchair) were significantly higher for the lifetime of sexual assault victims compared with nonvictims (Basile et al., 2020).

Stress appears to suppress the immune system and increase susceptibility to disease. Stress such as a sexual assault also may result in injurious behaviors, such as substance use or eating disorders (Felitti, 1991; Golding, 1994; Messman-Moore & 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, bloating, and abdominal pain (Golding, 1994; Golding, 1996).

Intimacy

Research shows some survivors of sexual assault experience ongoing challenges with intimacy, although most research has focused on females. Victims report a loss of interest in sex or increased sexual behavior and an increase or change in sexual partners. Some victims experience triggers or flashbacks, and others may lose a relationship with their partner post assault (O'Callaghan et al., 2019).

Gynecological impacts may also be present among female victims, including pelvic pain and excessive menstrual bleeding (Hassam et al., 2020).

Substance Use

While drug-facilitated sexual assault (DFSA) has received considerable attention, it is important to remember the most frequently used drug to facilitate a sexual assault continues to be alcohol. Of 1,000 cases of alleged DFSA in the United States, the majority of substances found were alcohol, followed by cannabis. Just more than 20 percent of the cases were negative for intoxicating substances. Negative test results do not mean drugs or alcohol were not used to facilitate a sexual assault. There are several reasons why a negative test might not detect drugs or alcohol, e.g., some substances are only detectable in blood and urine samples for short periods of time, and routine testing regimens may test for specific substances but not others (National Sexual Violence Resource Center, 2018). Victims ages 16–29 had the highest alcohol and cannabis use rates, followed by opioids (Fiorentin & Logan, 2019).

Victims who voluntarily drink alcohol and take drugs often experience feelings of guilt and worry they will not be believed or taken seriously. In one study of 388 women who had experienced an alcohol-facilitated sexual assault (AFSA), almost half (47 percent) reported minimizing, victim-blaming, or stigmatizing responses when they disclosed their victimization. In another study, more than one-third of DFSA or AFSA victims who declined to report their sexual assaults feared law enforcement and criminal justice professionals would treat them poorly (National Sexual Violence Resource Center, 2018).

As an advocate, it is essential to provide trauma-informed information and support regarding the role of substances. It can also be helpful to build relationships with service providers with expertise in supporting individuals who use substances; for example, using motivational interviewing to help enhance survivors' motivation to make positive changes (Miller & Rollnick, 2013).

2. Psychological Impact of Sexual Assault

Research finds positive social reactions to sexual assault disclosure predicted greater perceived control over recovery, which in turn was related to fewer PTSD symptoms. Positive social reactions to sexual assault disclosure include providing support that is both emotional (i.e., listening) and practical (i.e., seeking and reaching resources) and telling the victim it was not their fault.

Health psychology research shows social support increases feelings of self-efficacy, thereby improving health outcomes (Chlebowy & Garvin, 2006). Conversely, unsupportive responses to victims can lower victims' perceived control over recovery (Frazier et al., 2011). In the context of sexual assault, supporting the victim in ways such as spending time with them, giving them somewhere to stay, and 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 et al., 2007).

We will conduct an activity exploring the potential psychological impact of sexual assault.

Anxiety

Female victims of sexual assault in college experience higher levels of anxiety than non-sexually assaulted females (Neilson et al., 2018), and 12–40 percent of adult sexual assault survivors experience symptoms of anxiety (Campbell et al., 2009).

Fear

In one study, nearly 300 women who arrived at an emergency clinic were surveyed regarding a recent sexual assault. Of those, 80 percent reported experiencing significant fear during a sexual assault, 70 percent reported significant immobility or a "freeze" response, and almost 50 percent experienced extreme immobility (Möller et al., 2017).

Death is the most common fear during a sexual assault, and continued generalized fear after the assault is a very common response (Dupré et al., 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 & Borgida, 1997).

Girelli et al. (1986) found the subjective distress of fear of injury or death during a sexual assault was more significant than the actual violence in predicting severe post-sexual assault fear and anxiety.

Thus, it is crucial to recognize the threat of violence alone can be psychologically devastating (Goodman et al., 1993).

Depression

Depression is one of the most mentioned long-term responses to sexual assault (Abel & Rouleau, 1995; Frazier & Borgida, 1997; Ledray, 1994).

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

As with anxiety, symptoms of depression also overlap with those of PTSD. Such overlapping symptoms may include:

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

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.

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

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

Self-Blame and Shame

A number of studies identified posttraumatic guilt, self-blame, and shame as common responses following a sexual assault, and ones linked to PTSD, more depression, and poor adjustment after the sexual assault (Vidal & 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 & Vernon, 2008).

Posttraumatic Stress Disorder (PTSD)

Definition of 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" (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 et al., 2007).

One study found 78 percent of sexual assault 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 et al., 2001).

Sexual assault also has been identified as the most common cause of PTSD in women (Frans et al., 2005).

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

1. Intrusive symptoms include repeated, involuntary memories, distressing dreams, or flashbacks of the traumatic event. Flashbacks may be so vivid people feel they are reliving the traumatic experience or seeing it before their eyes.

2. Avoiding reminders such as people, places, activities, objects, and situations 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; and 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, and having problems concentrating or sleeping.

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

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 was shown to have no utility in predicting the onset of PTSD.

The disturbance must continue for more than a month and cause significant distress or problems in the individual's daily functioning to be classified as PTSD (American Psychiatric Association, 2022).

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).

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

We will conduct an activity presenting another group process scenario.

3. Impact on Partners, Family, and Close Friends

Family members and those close to the victim are recognized as secondary or indirect victims. 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.

Victim-blaming can cause a lot of psychological trauma. Dr. Anju Hurria, a psychologist and assistant clinical professor at the University of California–Irvine, told U.S. News, “It’s really considered a secondary trauma or a secondary assault.” She says people who experience victim-blaming experience “greater distress, increased amounts of depression; [it] usually complicates their posttraumatic stress disorder, if they’re experiencing that, because they’re dealing with two different assaults” (Schroder 2016).

Often family members, partners, and friends suffer significant levels of trauma after their loved one is sexually assaulted, including experiencing symptoms of PTSD. They may also find difficulty in supporting the victim due to insecurities in how to help, refusal by the victim to receive help, reactions of the victim, and their own feelings about the assault.

Often, the relationship with the victim is affected by the sexual assault; the person either feels closer to the victim or feels the relationship worsened for some time after the assault.

Family and friends may become overly protective, further limiting the victim’s activities. 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 upset family members (e.g., “It didn’t happen to them, so they have no right to be so upset”).

This is particularly true when family members appear more upset than the victim. Sometimes victims may also take out their anger about the sexual assault on family members. 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.