

SEXUAL VIOLENCE - THE VICTIM

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INTRODUCTION

Sexual violence refers to molestation and rape in childhood or adulthood. **Childhood sexual violence** is usually referred to as "sexual abuse", and is most commonly associated with someone who is known to the child, usually in the role of caretaker. In five studies of sexual abuse between 1940 and 1978, one fifth to one third of all women reported having been sexually abused in childhood (Herman, 1981). A poll of parents estimated 19 per 1,000 suffered sexual abuse (Gallup Organization, Inc., 1995). The Third National Incidence Study of Child Abuse found girls are sexually abused three times more often than boys, and the risk of being sexually abused does not vary among races, but children from lower income groups or from single parent families are more frequently victims (U.S. Department of Health and Human Services, 1996). Further, from age three on, children are at a constant rate of risk, meaning an especially broad range of vulnerability (Sedlak and Broadhurst, 1996). Finally, the number of sexually abused children in the U. S. rose by 83 percent from 1986 to 1993 (U.S. Department of Health and Human Services, 1996). In the United States, more than six out of ten of all rape cases (61 percent) occur before victims reach age 18, and 29 percent of all forcible rape occur before the age of eleven (National Victim Center, 1993). Of the adolescents ages 12-17 in the United States, an estimated 8 percent have been victims of serious sexual assault (Kilpatrick and Saunders, 1997).

Sexual abuse in childhood often results in prolonged exposure to overwhelming stress and conflict. A large study of female adults sexually abused as children found that their abuse lasted an average of 7.6 years and began at age six. Fifty-three percent were abused by biological fathers, nearly 15 percent by stepfathers, and 8.8 percent by uncles. Only 6.2 percent of the perpetrators were female. The study also found that the younger the person disclosing the abuse, the more negative and unsupportive the reaction. In 77.2 percent of the cases in which the disclosure was made during childhood, the abuse continued for at least one year (Roesler and Wind, 1994). Recent research suggests that at an initial intervention, child sex abuse victims are equally traumatized regardless of whether the perpetrators were intra- or extrafamilial (Whitcomb, 1994).

The long-term consequences of sexual assault in childhood are extensive. Child sexual abuse (CSA) has been found to be co-morbid with many later psychiatric and physical

problems. In a review of long-term consequences Polusny and Follette (1995) found that sexually abused subjects report higher levels of general psychological distress and higher rates of both major psychological disorders and personality disorders than non-abused subjects. Adult survivors of child sexual abuse report poorer social and interpersonal relationship functioning, greater sexual dissatisfaction, dysfunction and maladjustment including high-risk sexual behavior, and a greater tendency toward re-victimization through adult sexual assault and physical partner violence. In a study of male survivors sexually abused as children, over 80% had a history of substance abuse; 50% had suicidal thoughts; 23% attempted suicide; and almost 70% received psychological treatment. Thirty-one percent had violently victimized others (Lisak, 1994). Among children who were sexually abused, the odds are 27.7 times higher that they will be arrested for prostitution as an adult than non-victims (Widom, 1995). Comparing long-term gender differences, there seems to be a greater likelihood that men who were sexually abused as children will express some sexual interest in children (Finkelhor, 1994).

ADULT SEXUAL ASSAULT

Estimates for adult sexual assault also support the proposition that most violence directed against women is perpetrated by intimates. Twenty-two percent of women polled say they have been forced to do sexual things against their will, usually by an intimate (Laumann et al., 1994). In 1990, 683,000 American women were forcibly raped, which equals 56,916 per month; 1,871 per day; 78 per hour; and 1.3 per minute, and only 16 percent were reported to the police (Kilpatrick, et al, National Victim Center and Crime Victims Research and Treatment Center, 1992). One out of every eight adult women or at least 12.1 million American women, will be the victim of forcible rape sometime in her lifetime (Kilpatrick et al. 1992). In 1994, the rape/sexual assault rate for females was 3.7 per 1,000 persons age 12 or older - a total of 407,190 victimizations. The rape/sexual assault rate for males was .2 per 1,000 persons age 12 or older, a total of 25,570 victimizations (Bureau of Justice Statistics, 1997). Another survey revealed that 1,000 rapes were reported on college campuses during 1991-2 academic year (Nichols, 1995).

The effects of victimization often generate psychiatric dysfunction, and are of special interest to mental health professionals. In a survey of over 2,000 women asked about victimization experiences, rates of "nervous breakdowns," suicidal ideation, and suicide attempts were significantly higher for crime victims than for non-victims. Nearly one rape victim in five (19.2 percent) had attempted suicide, whereas only 2.2 percent of non-victims had done so. Most sexual assault victims' mental health problems came after their victimization (Kilpatrick et al., 1985).

The prevalence of PTSD after rape is extraordinarily high. De Girolamo and McFarlane (1996) have reviewed nine studies that investigated the prevalence of PTSD among victims of rape or other sexual violence. In four studies the rate was greater than 70% and less than 25% in only five studies. Kessler and colleagues (1995) found similar rates in men (46.4%) and women (48.4%). In addition, the prevalence of other psychiatric co-morbidity after sexual victimization is higher than in the general population (See Chapter Seven).

Women who are victimized also have a greater rate of physical co-morbidity. Rape and life threatening physical abuse seem to have worse health effects than less serious physical violence and milder forms of sexual abuse (Leserman, 1996). One study on 239 female patients with gastrointestinal disorders found that 66.5 percent of the women had experienced sexual and/or sexual abuse. Further, the women with a sexual abuse history had more pain, other somatic symptoms, bed disability days, lifetime surgeries, and functional disabilities than those without sexual abuse. Walker et al (1996) looked at the co-morbidity between chronic pelvic pain, irritable bowel syndrome, and a past history of abuse. They found that compared to women with irritable bowel syndrome alone, those with both irritable bowel syndrome and chronic pelvic pain were significantly more likely to have a lifetime history of dysthymic disorder, current and lifetime panic disorder, somatization disorder, childhood sexual abuse, and hysterectomy (1996). In a randomized survey of 1599 women, 31.5 percent of participants reported a diagnosis of gynecologic problems in the past 5 years. Those with problems were more likely to report childhood abuse, violent crime victimization, and spouse abuse (Plichta and Abraham, 1996). Another study looked at the connection between chronic intractable pain and histories of childhood sexual abuse in 112 women sampled from a large university campus health center. Fifty-nine (59) women with chronic back pain were sampled and compared with 53 control subjects obtained simultaneously from the same clinical population. The women with chronic intractable back pain had a significantly higher percentage of childhood sexual abuse experiences than controls (Pecukonis, 1996).

COSTS OF SEXUAL VIOLENCE

One in 5, about 61,000, offenders in State prisons in 1991 had been convicted of a crime against a victim under age 18 (Greenfeld, 1996). Comparing these offenders with adult victimizers were particularly striking with respect to sexual abuse. While an estimated 22 percent of child victimizers reported having been sexually abused, less than 6 percent of adult victimizers reported such backgrounds. Among all violent offenders with a history of having been sexually abused, nearly half had child victims. Among all violent offenders with a history of having been physically abused, nearly 30% had child victims. Among violent offenders with no history of physical or sexual abuse, 15.5 percent had child victims. About 95 percent of child victimizers and 86 percent of adult victimizers who reported having been abused physically or sexually said that such abuse had occurred while they were

children. Among those who suffered physical or sexual abuse before age 18, 36 percent had child victims; among those who suffered abuse after entering adulthood, 13 percent had child victims. For about 9 out of 10 violent offenders experiencing prior physical or sexual abuse, the abuser was someone they had known. For both inmates with child victims and inmates with adult victims, about half reported that the abuse they suffered was by a parent or guardian (Greenfeld, 1996). In a study of serial rapists serving time in U.S. prisons, 56.1 percent were judged to have at least one forced or exploitative abuse experience in boyhood, as compared to a study of 2,972 college males reporting 7.3 percent experiencing boyhood sexual abuse. Also, the rapist sample revealed higher rates of a family member as an abuser compared to the college sample. When they obtained more details from the men on their sexual activities as boys, they found that 51 percent re-enacted their own abuse as a preadolescent with their earliest victims being girls they knew in the neighborhood, their sisters, or a girlfriend. Rape fantasies in mid-adolescence emerged as behaviors of spying, fetish burglaries, molestations, and rapes. Finally, the repetition of these juvenile behaviors established a pattern of criminal behavior as they sought out their next group of victims - strangers (Burgess, 1988). Rivera and Widom looked at the official criminal histories for a large sample of substantiated cases of physical and sexual abuse and neglect (908 cases) from the years 1967 through 1971 in a U. S. Midwestern county and compared them to individuals with no official record of abuse or neglect. Childhood victimization increased overall risk for violent offending and particularly increased risk for males and blacks (1990). Luntz and Widom (1994) looked at these cases and discovered that childhood victimization was a significant predictor of the number of lifetime symptoms of antisocial personality disorder and of a diagnosis of antisocial personality disorder. Another group of researchers studied children aged 9 - 14 years of age who were sexual offenders. The sex offenders were found to exhibit a significant history of nonsexual antisocial behavior, physical abuse, and psychiatric co-morbidity - 65 percent of the boys had been sexually abused (Shaw et al., 1993). Browne and Bassuk (1997) studied 436 homeless and poor housed women and found that 42 percent of childhood sexual molestation and 83 percent of very low income mothers had been victims of severe physical and/or sexual violence.

Another way of looking at costs is to attempt valuations based on specific kinds of traumatic events. For example, every incident of child sexual abuse has been estimated to cost the victim and society at least \$99,000 (Miller, Cohen, and Wiersema, 1996).

Normative standards about the acceptability of the sexual assault of women remain confused. In a 1993 national study of 1,700 sixth to ninth graders, a majority of the boys considered rape "acceptable" under certain conditions and many of the girls agreed (Wallis 1995). According to several sources, 51 - 60 percent of college men report that they would rape a woman if they were certain that they could get away with it. One out of twelve college men surveyed had committed acts that met the legal definition of rape; 84 percent

of these men said what they did was definitely not rape (Tavris and Wade, 1984; Warshaw, 1988).

Finally, system responses are often considered to be inadequate. Forty-three percent of responding physicians indicated that multidisciplinary centers responding to child sex abuse were occasionally, rarely, or never adequate (Kerns, Terman, and Larson, 1994). Unfortunately, many of our most resistant social problems have a relationship to a past history of sexual violence.

BEST PRACTICES

Training - Clinicians need to be thoroughly trained in recognizing the signs and symptoms of PTSD, dissociative disorders, other complex trauma-related syndromes, and the many masked and co-morbid presentations associated with a past history of sexual violence. One of the obstacles to recognizing the markers of sexual violence is the continuing social (including psychiatric) denial of the frequency with which children are sexually abused. Unresolved childhood experiences on the part of the clinician can also be an obstacle to recognizing sexual abuse in one's patients.

Screening - Screening for a history of sexual violence in childhood and in adulthood should be a fundamental part of every psychiatric evaluation.

Safety - Assessing the present level of safety is critical to good management.

Clinicians who work with children and adolescents must be thoroughly versed in their state's reporting laws as well as services that are available in the community for victims and their families. Treatment cannot be effective as long as safety issues remain paramount in the treatment setting (See Chapter Seven).

Self-destructive Behavior - Addressing safety concerns must include a thorough evaluation and the development of a treatment plan to address all self-destructive behavior (suicidality, self-mutilation, or substance abuse disorders) as well as violent behavior directed at others. Unsafe practices like dangerous, excessive or addictive sexual practices, other forms of risk-taking behaviors, involvement in dangerous relationships, and excessive working or exercising must also be assessed. Violence directed at others may be the primary manifestation of the patient's clinical presentation or may be very carefully disguised. Victims often experience extreme shame about their inability to control their own impulses toward perpetration, particularly against children. Clinicians must become comfortable in asking frank questions about violent impulses, wishes, fantasies, and actions.

Goal-setting - Treatment of traumatized victims, particularly those suffering from the complex syndromes associated with childhood sexual abuse, may require extended

treatment over years. As a result, treatment contracts, focused goal-setting, and optimally a team-treatment approach, are critical. The goals of treatment should focus on: 1) Developing authority over the remembering process so that the past stops haunting and the present, 2) The integration of memory and affect, 3) The ability to tolerate affect, 4) Symptom mastery, 5) The development of self-esteem and self-cohesion, 6) The ability to create and sustain safe attachment relationships, and 7)

The need to make sense out of one's previous negative life experiences, place them in some form of life narrative, and ultimately transform those experiences into a survivor mission (Harvey, 1996). Although it is often necessary for a victim to review their previous experiences in detail, it is important that the ability to function in the present is supported and promoted.

Memory - Clinicians need to keep current about the latest advances in memory science ! both in the ways memory can be influenced and altered as well as in the ways traumatic memory appears to differ from normal memory. Competent clinicians recognize that memory is fallible and that certain therapeutic approaches may increase the likelihood of distortion or confabulation (See Chapter Seven). Hypnosis or amytal interviews conducted for the purpose of uncovering past experiences and that contain suggestions regarding possible trauma may also produce false memories. Thus neither procedure, when used, should contain suggestions that affect post hypnotic or post amytal memories. Clinicians should be aware that when a client is hypnotized or given amytal, they may not thereafter, in some US states, be allowed to testify in any kind of civil or criminal legal proceeding. For childhood sexual abuse, psychiatrists, as health-care providers, have a duty to report sexual abuse. In cases of adult recall of childhood sexual violence, it is the responsibility of the patient to seek confirmation of any previous memories. Unless there are current issues of physical safety at stake, clinicians should urge patients to address the work of trauma resolution and symptom reduction before making any major life changes, including confronting alleged perpetrators or engaging in legal action around the history of abuse.

Psychoeducation - Patient education is critical to the process of recovery from sexual trauma. Psychoeducation about the effects of traumatic experience on the body, the concept of the self, relationships with others, and one's overall adjustment helps empower patients to make changes that are critical for recovery. This is particularly important in eliciting the necessary commitment to give up self-destructive behavior.

Medication - Medication is frequently necessary to effectively manage many of the comorbid and presenting symptoms of trauma-related disorders. Patients require treatment for depression, overwhelming anxiety, and co-accompanying psychotic symptoms. The clinician must also be aware that the pursuit of a medical cure in this population can easily become a substitute for the painful work of trauma resolution, leading both the patient and the doctor on an endless search for the right drug. Such practices can lead to abuse, addiction, and polypharmacy with all the attendant risks.

Treatment techniques. The field of trauma treatment is still young and many different approaches to treatment are being tried and researched.

Supervision and consultation. Clinicians who work with trauma victims are at-risk for secondary traumatic stress, also called vicarious traumatization and compassion fatigue.

This places clinicians at risk for various negative physical, psychological, relational, spiritual, and professional consequences. The professional consequences include: Decrease in quality and quantity of work, low motivation, avoidance of job tasks, increase in mistakes including boundary violations, setting perfectionistic standards, obsession about details, decrease in confidence, loss of interest, dissatisfaction, negative attitude, apathy, demoralization, withdrawal from colleagues, impatience, decrease in quality of relationships, poor communication, staff conflicts, absenteeism, exhaustion, faulty judgment, irritability, tardiness, irresponsibility, overwork, and frequent job changes (Yassen, 1995). The best antidote to the undesirable professional consequences of this exposure is regular supervision.

RESOURCES

INTERNET

Bureau of Justice Statistics on Crime and Victimization.

<http://www.ojp.usdoj.gov/bjs/cvict.htm> <http://www.ojp.usdoj.gov/bjs/cvict.htm>

Violence Against Women Office. <http://www.usdoj.gov/vawo> <http://www.usdoj.gov/vawo>

Rape, Abuse and Incest National Network. <http://feminist.com/rainn.htm>
<http://feminist.com/rainn.htm>

Unifem Home Page. <http://www.unifem.undp.org> <http://www.unifem.undp.org>

MINCAVA Global Links on Violence. <http://www.mincava.umn.edu>

PILOTS Database. <http://dciswww.dartmouth.edu>

International Society for Traumatic Stress Studies. <http://www.istss.org>
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