Phoenix AUSTRALIA

Specific Populations and Trauma Types
Sexual assault

This *Sexual assault* information sheet addresses background issues and provides presentation, assessment, and treatment advice for practitioners working with victims of sexual assault.

Background issues

The mental health practitioner treating survivors of sexual assault should be aware of several important background issues. Sexual assault is a crime that is usually carried out in private. It is shrouded in secrecy, can involve a victim who blames herself or himself and, with children, can involve grooming and manipulation. In children, the majority of sexual abuse is perpetrated by a family member or a trusted person known to the child. As a consequence, many children who have experienced abuse, and adult survivors of child sexual abuse, may still have contact with their abuser. They will also have learnt in some cases that adults are not to be trusted.

Sexual assault was rarely discussed in Australia until the 1970s and childhood sexual assault was almost never disclosed. Unfortunately, when childhood sexual abuse *was* disclosed, the victim risked being accused of fantasising, lying, seeking attention, or seeking revenge. In the past 40 years survivors of sexual assault have increasingly reported the assault, but there is still considerable societal, familial, and individual pressure to remain silent. People alleging sexual assault are the least likely of all crime victims to report the offence to the police. Of those reported, only a small proportion are prosecuted – one in six rapes and less than one in seven reports of incest/sexual penetration of a child. In addition, conviction rates are substantially lower than for other offences and there is no trend towards successful convictions over time.

Negative stereotypes that portray sexual assault survivors as unworthy, undeserving, or contributing to the crime continue to prevail in both the legal system and broader society. These stereotypes inevitably impact on the individual, creating additional distress beyond the traumatic experience itself.

Given the 'hidden' nature of sexual assault and low reporting and conviction rates, it is perhaps not surprising that there is little reliable information on the prevalence of sexual assault or childhood sexual assault in the Australian population. Existing data is based on police statistics, and victimisation surveys such as the Australian Institute of Criminology's studies on sexual assault and the Australian Bureau of Statistics Women's Safety Survey. To date there has been no large-scale national population survey that includes childhood violence against boys. As a result, current knowledge about childhood sexual assault on boys is dependent on reports made to statutory child protection agencies and to the Royal Commission into Institutional Responses to Child Sexual Abuse.

It is estimated that the prevalence of sexual assault before the age of 18 years in the Australian community ranges between 6.9 and 26.8 per cent for females, and between 5.2 and 10.4 per cent for males.[1] As adults, those at greater risk of sexual assault are female, young and single, have a prior history of sexual assault, and have existing relationships with offenders. In an Australian representative sample, it was found that 8.1 per cent of women and 2.2 per cent of men reported experiencing a rape; 14.7 per cent of women and 4.5 per cent of men endorsed the broader category of sexual assault.[2] These results align with recent figures from the Personal Safety survey, which found 17 per cent of women and 4.3 per cent of men experience sexual assault.[3] Meta-analytic results indicate a significant association between sexual assault and a lifetime diagnosis of PTSD (odds ratio estimated to be 2.34).[4] Of women who reported that the most traumatic event they had experienced was rape, 9.2 per cent met criteria for PTSD in the past 12 months.[5] Males who are raped or molested appear to report a higher prevalence rate of PTSD.

It is important to acknowledge the intergenerational transmission of abuse. Women abused as children may repeatedly form relationships with abusive, violent partners who may, in turn, sexually and/or physically abuse her children. Additionally, if female caregivers are experiencing the psychological impact of abuse (e.g., depressed, anxious, withdrawn), children may receive little protection and/or no positive parenting guidance or strategies. Alternatively, children may be overprotected and taught that the world is a dangerous place, impeding the development of resilience.

Presentation

For adults with PTSD following sexual assault, the trauma may range from a discrete adult trauma of rape to repeated sexual abuse during childhood, or a combination of both. The nature of childhood sexual abuse itself is highly variable. Sexual abuse involving penetration (digital or otherwise) as opposed to touching or fondling has been found to be the most harmful of the abuse experience/s. This is also true of sexual abuse involving degradation and violence. Not surprisingly, typical presenting problems differ according to the type and number of sexual assaults experienced. The clinician should be aware of these typical presentations (outlined below) and ensure a comprehensive assessment, especially if a prior history of assault or sexual abuse is suspected. In some cases, the individual who has been sexually abused as a child will present for treatment of PTSD for the first time as an adult.

Common presenting problems in survivors of adult sexual assault

- Recurrent daytime intrusive memories/flashbacks and distressing dreams
- Physical symptoms of hyperarousal such as palpitations, sweating, breathing difficulties
- Hypervigilance (e.g., fear of going out)
- Sleep problems
- Eating difficulties
- Mistrust of males/females, affecting the formation of relationships
- Loss of interest in usual activities
- Shame/guilt associated with memories of assault
- Depression and PTSD are commonly diagnosed following adult sexual assault.
- Difficulties with intimacy

Common presenting problems in adult survivors of childhood sexual assault

1. PTSD symptoms are often part of the client's presentation with prominent avoidance/numbing symptoms. Depressive and anxiety symptoms are also common.

2. Childhood sexual abuse can also lead to persistent self-regulation issues including:

    - affect regulation and impulse control (self-harming, acting out sexually, engaging in dangerous activities)
    - attention (regular dissociative episodes)
    - self-perception (identity disturbance)
    - relationships (attachment, sexual difficulties, parenting problems).

These self-regulation issues can lead to a range of diagnoses including personality disorders (e.g., borderline personality disorder) and attachment disorders. Substance use problems and eating disorders are also common. Comorbid presentations are the norm for this group.

Note that interactions with the medical or legal systems may parallel abuse scenarios for many survivors of sexual assault. Some medical procedures, for example, or requests for the removal of clothing by authority figures, may trigger re-experiencing symptoms.[6]

Assessment

As noted above, many survivors of sexual assault have experienced prior assault in adulthood or as children. It can be difficult in some cases to assess whether the most recent assault is the cause of PTSD or whether it is the result of previous or repeat assault/s. A comprehensive assessment should include a detailed lifetime history of sexual assault and other trauma, as well as the psychological sequelae of any previous trauma. Practitioners should bear in mind the potential for the assessment process to be highly distressing for some clients. A 'thumbnail' sketch may be sufficient in the first instance to provide an indication of the client's trauma history and likely physical and psychological health sequelae, with a more comprehensive assessment conducted once trust and safety has been established. In addition, with survivors of childhood sexual assault it is important to gain an understanding of their family background and developmental milestones. Sexual assault can have a significant impact on a child's development and attachment, particularly if it occurs during early childhood. In addition, children's responses to traumatic experiences are influenced by their parent's attachment style and parenting capacity.

While many survivors feel comfortable disclosing their assault history, some will be reluctant to do so and will require extra time and sensitivity from the practitioner conducting the assessment. Some survivors prefer direct questioning, while others find this too intrusive and favour indirect methods. Some will feel more comfortable if the practitioner maintains a professional distance, while others interpret this as the practitioner ignoring their emotional wellbeing.[7] Sensitivity to the individual's needs is therefore essential in promoting a sense of safety and allowing a more effective assessment. While a comprehensive assessment is important, the process should not be so difficult for the client that he or she drops out of therapy.

Given the societal context of sexual assault, it is essential that the practitioner accept the person's account of their traumatic experience for the purposes of treatment without seeking to investigate the authenticity of their claims. Victims/survivors have often had negative responses to their disclosures from friends, family, police, or the criminal justice system and may anticipate disbelief and denial from the clinician.

The gender of the practitioner needs to be given due consideration in working with survivors of sexual assault. It cannot be assumed that a female or male will prefer to work with a practitioner of either the

same or the opposite gender. This matter needs to be discussed and if possible, the person given the choice of therapist gender.

Treatment

Recommended treatments for PTSD apply to survivors of sexual assault – indeed, many of the treatments were developed, refined and evaluated with rape victims. Of course, the Guidelines are not a substitute for clinical judgement; the suitability and acceptability of recommended treatments need to be determined in each case. The recommendation to allow more time for establishing a therapeutic relationship and teaching emotional regulation skills in those with prolonged and/or repeated traumatic experiences is generally relevant to survivors of childhood sexual assault. In addition, the following specific considerations apply to sexual assault survivors with PTSD.

Given the broader legal context, practitioners working with survivors of sexual assault should have knowledge of relevant reporting, compensation, and restorative justice approaches in order to provide the person with appropriate support and advice.

If the person has ongoing involvement with the criminal justice system there is a high risk of additional distress from a variety of sources, including contact with the alleged offender, cross examination, and the general experience of the court system, which may be perceived as unfair and irrational. This will inevitably impact on treatment and should be taken into consideration in treatment planning. In general terms, it would not be reasonable to postpone treatment until the end of (often lengthy) legal proceedings, but the clinician and person with PTSD should give careful consideration to the appropriate timing of trauma-focussed work in this context. In circumstances when the decision *is* made to defer treatment, the practitioner should consider referring the person to a specialist sexual assault service for support during legal proceedings. Services such as these are able to assist a sexual assault survivor with the wide range of issues related to the court case much more easily than a single practitioner. Workers at these specialist services have an understanding of the criminal justice system and can provide support and advocacy to clients during legal proceedings as well as assistance in dealing with their reaction to the proceedings.

In cases of complex PTSD, expert opinion suggests a sequential treatment approach, with the use of multiple interventions targeting the most prominent symptoms.[8] Following an initial period of stabilisation and ensuring patient safety, providing education about trauma, narration of the trauma memory, cognitive restructuring, and emotion regulation interventions are viewed as effective first-line interventions for complex PTSD.[8] However, some authors suggest that a phase-based approach to treatment for complex PTSD is empirically and methodologically limited.[9]

Working with children

A child's response to sexual assault will be influenced by age and level of development. It is important to note that ongoing sexual abuse, particularly during early childhood, can alter the child's developmental trajectory. Common symptoms include:

- nightmares
- sleeping difficulties
- withdrawn behaviour
- aggressive behaviour

- in younger children, sexual knowledge or behaviours that are inappropriate for the child's age (e.g., explicit drawings or simulations with toys or other children)
- affect dysregulation
- in adolescents, indiscriminate sexual partnering
- in adolescents, substance use
- in adolescents, self-destructive/impulsive behaviours.

Behavioural difficulties and disorders (e.g., oppositional defiant disorder, engaging in risky behaviour) can also be associated with abuse, particularly in boys. Anxiety, depression and PTSD can also be seen amongst children who have been sexually abused with comorbidity not being uncommon.

Children and young people with PTSD, including those who have been sexually abused, should be offered a course of trauma-focussed cognitive behavioural therapy adapted appropriately to suit their age, circumstances, and level of development.

Research suggests that health professionals often use overly complex language when discussing sexual abuse with children. It is important to keep questions simple and concrete, avoiding abstract questions such as asking about 'bad things' that happened. It is suggested instead, to ask direct questions[10]. For example, ask "Did X do something (or ask you to do something) that made you feel uncomfortable?", and then ask more directly about sexual abuse behaviour "Did X touch you on your private parts/here (pointing)", "Did they ask you to touch their private parts (for younger children they can point to their own body, or using a cartoon depiction of bodies can be a useful tool). As always, when working with children, questions should to be appropriate to the age and developmental stage of the child, taking into account their level of language and cognitive ability and cultural considerations (see Chapter 3). Allowing time for neutral discussion before focussing on the abuse can help the child to feel more at ease and provides the practitioner with an idea of the child's language ability/level.[11]

Particular issues arise when sexual abuse has occurred within a family. There are often significant losses in terms of familial relationships after a disclosure, which can compound the difficulties children are experiencing. In addition, it may be helpful to teach some protective behaviours to try and give children some control over their environment, particularly if the offender is still present or other relatives are not being supportive. This is particularly important when sexual abuse occurs in the context of neglect, poor attachment, or disorganised family functioning.

Directions for future research

A victim rights model that involves therapy, advocacy, groups, and support is widely used in specialist sexual assault services. Future research should evaluate the effectiveness of this model.

Source and contributors

The *Sexual assault* information sheet was developed in collaboration with Ms Carolyn Worth AM, specialist in social work practice in the area of sexual assault.

Citation

Phoenix Australia - Centre for Posttraumatic Mental Health. Specific Populations and Trauma Types: *Sexual assault* in Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder and Complex Posttraumatic Stress Disorder. Melbourne: Phoenix Australia; 2020.

Recommended reading

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