

Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder

Specific Populations and Trauma Types Sexual assault and PTSD

This *Sexual assault and PTSD* information sheet addresses background issues and provides presentation, assessment and treatment recommendations for practitioners working with survivors of sexual assault. These recommendations are based on the systematic review of the international literature, and the expert opinion and advice presented in the Specific Populations and Trauma Types chapter of the *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder*. www.phoenixaustralia.org/resources/ptsd-guidelines/.

Background issues

The mental health practitioner treating survivors of sexual assault should be aware of several important background issues. Sexual assault is a unique crime in that it is most often carried out in private, is shrouded in secrecy, and involves a victim who often blames herself or himself. In children, the majority of sexual abuse is perpetrated by a family member or 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.

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 30 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. Further, 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. These conviction rates are substantially lower than rates for other offences and there is no trend towards successful convictions over time.

Negative stereotypes that portray sexual assault survivors as unworthy or undeserving 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. It is estimated that the prevalence of sexual assault before the age of 18 years in the Australian community ranges between 7–36 per cent for females, and between 4–16 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] 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.[3] 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.

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)
 - 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.

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

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.[4]

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.[5] 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 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. The key recommendations, graded A through D depending upon the strength of the evidence, are:

Psychological interventions for adults

- For adults exposed to a potentially traumatic event, a one-session, structured, psychological intervention in the acute phase, such as psychological debriefing, should not be offered on a routine basis for the prevention of PTSD. **Grade B**
- For adults displaying symptoms consistent with acute stress disorder (ASD) or PTSD in the initial four weeks after a potentially traumatic event, individual trauma-focussed cognitive behavioural therapy, including exposure and/or cognitive therapy, should be considered if indicated by a thorough clinical assessment. **Grade C**
- Adults with PTSD should be offered trauma-focussed cognitive behavioural interventions or eye movement desensitisation and reprocessing. **Grade A**

Pharmacological interventions for adults

- For adults exposed to a potentially traumatic event, drug treatments should not be used for all those exposed as a preventive intervention. **Grade D**
- The routine use of pharmacotherapy to treat ASD or early PTSD (i.e., within four weeks of symptom onset) in adults is not recommended. **Grade C**
- Drug treatments for PTSD should not be preferentially used as a routine first treatment for adults, over trauma-focussed cognitive behavioural therapy or eye movement desensitisation and reprocessing. **Grade B**
- Where medication is considered for the treatment of PTSD in adults, selective serotonin reuptake inhibitor antidepressants should be considered the first choice. **Grade C**

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.

In cases of complex PTSD, expert opinion suggests a sequential treatment approach, with the use of multiple interventions targeting the most prominent symptoms.[6] 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.[6]

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 (for example, explicit drawings or simulations with toys or other children)
- affect dysregulation
- in adolescents, sexual promiscuity
- in adolescents, substance use
- in adolescents, self-destructive/impulsive behaviours.

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. 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.[7]

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.

Recommended reading

Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. A. (2004). A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(4), 393-402.

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Source and contributors

This information was taken from the Sexual Assault section (p.159-162) of the Specific Populations and Trauma Types chapter of the *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder* www.phoenixaustralia.org/resources/ptsd-guidelines/. The Sexual Assault section was developed by Phoenix Australia in collaboration with Ms Carolyn Worth, Manager, South Eastern Centre Against Sexual Assault.

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