Treating the Adult Sexual Assault Victim: Evidence-Based Assessment and Treatment

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Nykia R. Leach and Lindsay M. Orchowski

Introduction

In their seminal publication within the *American Journal of Psychiatry*, Burgess and Holmstrom (1974) characterized rape as an experience that can be disruptive to a person's physical, emotional, cognitive, and interpersonal functioning. Since Burgess and Holmstrom's (1974) early description of "Rape Trauma Syndrome," research has accumulated to document a range of presentations of mental distress and physical injury among survivors of sexual violence. Specifically, whereas the adverse health effects of sexual assault are dynamic and heterogeneous, survivors of sexual violence may experience psychological distress such as posttraumatic stress, anxiety, substance use and depressive disorders (Acierno, Resnick, & Kilpatrick, 1997; Foa & Riggs, 1993; Thompson et al., 2003; Ullman & Brecklin, 2003), reproductive health consequences (Mason & Lodrick, 2013), and a range of physical injuries and health care concerns (Koss, Woodruff, & Koss, 1991). Survivors of sexual assault also often display high levels of self-blame and guilt (Nishith, Nixon, & Resick, 2005) and often have a slower rate of recovery compared to individuals who experience nonsexual forms of trauma (Foa, 1997; Gilboa-Schechtman & Foa, 2001). Of note, psychological outcomes following sexual violence vary considerably, potentially as a result of psychological well-being prior to the attack. Women with severe/serious mental illness (SMI) also experience high rates of sexual violence compared to individuals without SMI (Goodman, Rosenberg, Mueser, & Drake, 1997; Harris & Landis, 2016; Van Deinse, Macy, Cuddeback, & Allman, 2018). Furthermore, a recent study examining sexual violence among college women documented that pre-existing mental health symptoms were exacerbated following sexual violence (Bonomi, Nichols, Kammes, & Green, 2018). Furthermore, compared to women who have never been sexually assaulted, survivors of this type of crime are at an increased risk of being victimized again in the future (Daigle, Fisher, & Cullen, 2008). Women who have previously experienced sexual assault during their lifetime report higher levels of psychological symptomatology compared to those who experience a single experience of victimization (Cohen & Roth, 1987; Lau & Kristensen, 2010; Shin et al.,

N. R. Leach
Department of Psychiatry, Rhode Island Hospital, Providence, RI, USA

School of Public Health, Brown University, Providence, RI, USA

L. M. Orchowski (✉)
Department of Psychiatry, Rhode Island Hospital, Providence, RI, USA

Department of Psychiatry and Human Behavior, Alpert Medical School of Brown University, Providence, RI, USA
e-mail: Lindsay_orchowski@brown.edu

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2017; Walsh et al., 2012). These findings underscore the importance of developing and testing psychological treatments to ameliorate the aftereffects of sexual trauma, as well as the importance of utilizing a variety of assessment strategies when evaluating and exploring potential treatments.

Purpose of the Present Chapter

This chapter explores the efficacy of psychological and medical treatments for adult survivors of sexual violence. We begin by examining recommendations for clinical responses to victims who access healthcare in a hospital setting immediately after an assault. When discussing medical treatments for individuals who experience sexual violence, we use the term "victim-patient," as the identities of the victim and patient often coincide within a clinical context (Mulla, 2014). Subsequently, we explore both short-term and long-term approaches for ameliorating the aftereffects of trauma and prevent health complications in the future. These treatments include forms of postexposure prophylaxis (PEP) treatments to decrease risk of sexually transmitted infections and diseases (STIs/STDs) as well as evidence-based options for both short-term and long-term psychological care. We conclude with discussing future directions in treatments for adult survivors of sexual trauma.

Acute Care: Immediate Treatments for Sexual Assault

According to Linden (2011), approximately 17–43% of adults who experience sexual violence seek medical treatment following an assault. Estimates vary based on the sample studied. According to Zinzow and her colleagues (2012), less than one in four women seek medical treatment following sexual assault. Most often, individuals who seek medical treatment following sexual violence do so in the emergency department (Hovelson, Scheiman, & Pearlman, 2016), often because they are in physical need of medical attention and must be treated for injury or would like to have a forensic (i.e., "rape-kit") examination performed for evidence collection purposes (Campbell, 2005; see Curoso this volume). Rape kits are commonly performed by trained sexual assault nurse examiners (SANE), forensic nurse examiner (FNE), and/or another *clinical member* of a sexual assault response team (SART) (Linden, 2011). SANE and FNE practitioners receive crime-specific certifications available through the International Association of Forensic Nurses, which strives to ensure that victim-patients receive qualified and interdisciplinary care in a trauma-informed manner (International Association of Forensic Nurses [IAFN], 2017). Upon meeting requirements of the International Association of Forensic Nurses' requirements, SANE certifications are available to anyone who has two or more years of experience in critical/emergency care or maternal/child health (Sexual Assault Nurse Examiners, 2017). Those involved in the larger network of a victim-centered SART team can include general health professionals, members of law enforcement, individuals with legal expertise, clinical advocates from local rape crisis centers, as well as social workers. SART programs and related certification-specific roles are increasingly being adopted by emergency departments across the United States because of evidence suggesting that they are associated with improvements in medical treatment guidelines-related compliances, the quality of evidence collection, and successful prosecutions compared to routine care (Campbell, Patterson, & Lichty, 2005; Riviello & Rozzi, 2013). In fact, as of 2014, there were 700 SANE/FNE programs in the United States and Canada (Draughon, Anderson, Hansen, & Sheridan, 2014).

Treatment Protocols

The protocol for acute treatment of victim-patients of sexual trauma developed by the Department of Justice's Office on Violence Against Women (2013) is endorsed by the International Association of Forensic Nursing. The general guidelines to be followed when treating an adult victim-patient in the emergency

department are as follows: (1) evaluate for traumatic physical injuries; (2) offer post-exposure prophylaxis (PEP) for sexually transmitted infections (STIs), pregnancy, and sometimes human immunodeficiency virus (HIV); (3) collaborate with internal and external entities to provide emotional support while in the hospital; (4) offer to perform evidence collection using a preassembled "rape-kit"; (5) offer to call the police if they would like to report the crime; (6) and coordinate safe, tangible plans for discharge (e.g., treatment plans, referrals, physical/psychological follow-ups) (Linden, 2011). As long as the victim-patient is conscious, informed consent should be obtained before treating any injuries or proceeding with evidence collection (Riviello & Rozzi, 2013). Despite these recommendations, procedures often vary from hospital to hospital. For instance, religiously affiliated institutions may not offer certain recommended treatments (i.e., emergency contraception) (Campbell et al., 2006).

Treatment of Injuries

Victim-patients who present to the emergency department often require treatment for minor injuries such as cuts and scratches, or more major injuries resulting from attempted strangulation, forced penetration, and blunt force trauma (e.g., injury to the head, face torso, limbs; Sugar, Fine, & Eckert, 2004). Other common conditions that warrant treatment include defense injuries; lacerations, abrasions, or bruises on the hands, arms, or thighs (Bowyer & Dalton, 1997). Tears or abrasions to posterior fourchette, labia minora and fossa navivularis abrasions, and hymen tearings are common locations for genital injury (Sommers, 2007). Importantly, a lack of identifiable genital or anal injury does not mean that a sexual assault did not occur (Linden, 2011). The age of the victim-patient, heteronormative virginal status, degree of resistance, the number of assailants, and time between assault and treatment can impact whether or not vaginal injury can be detected (McGregor, Le, Marion, & Wiebe, 1999).

Due to the particularly violating context in which injuries resulting from sexual assault are obtained, a higher level of sensitivity is necessary when interacting with the victim-patient during the process of treatment and evidence collection (IAFN, 2017). Trauma-informed care and practice (TICP) most appropriately aligns with the recommended victim-centered approach (Harris & Fallot, 2001; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Towards the goal of allowing survivors to rebuild a sense of control and empowerment, TICP is a strength-based framework that realizes the multifarious impacts of traumatic lived-experiences, emphasizing physical, psychological, and emotional safety for both providers and their respective patients as they respond to the survivor's needs (SAMHSA, 2014). For example, it is suggested that the victim-patient interact with as few clinicians as possible while in the emergency department so that higher levels of comfort, stability, and privacy can be obtained alongside the development of a rapport with the health professional involved (World Health Organization [WHO], 2003).

Postexposure Prophylaxis

A common concern among victim-patients presenting in the emergency department is risk for sexually transmitted infections (STIs) and diseases (STDs). The Centers for Disease Control and Prevention (CDC) recommends that all victim-patients be offered post-exposure prophylaxis (PEP) treatments for STI/STD while in the emergency department (Riviello & Rozzi, 2013). PEP consists of defensive or protective actions that can be taken by victim-patients with the help of medical professionals to reduce likelihood of infection and disease. All patients can be offered post exposure prophylaxis *treatments* for STIs while in the emergency department. Risk for gonorrhea, chlamydia, and trichomoniasis can be addressed through antibiotics. Whereas syphilis is less prevalent, risk for contracting this infection can be addressed through common prophylaxis drug treatment for gonorrhea (i.e., ceftrioxone,

cefixime, or azithromycin). A hepatitis B vaccination can also be administered if the victim-patient has not already received one (Linden, 2011). Women are also at risk for contracting human papillomavirus (HPV). Accordingly, the CDC recommends offering the HPV vaccine to anyone who is 26 years of age or younger (Markowitz et al., 2014). Furthermore, a tetanus booster is suggested if the case indicates applicability (Workowski & Berman, 2010). Of note, whereas some experts argue that STI *testing* should be offered in a noncritical care setting unless relevant symptoms are clinically identified, others suggest that all victim-patients should receive initial laboratory testing for gonorrhea, chlamydia, trichomoniasis, syphilis, HIV, and hepatitis B when presenting in the emergency department, particularly if prophylactic treatment is declined (see Hovelson et al., 2016).

Although there is a low risk (5%) of pregnancy due to a vaginally penetrative sexual assault, emergency contraception is recommended as a single dose in the emergency department (Luce, Schrager, & Gilchrist, 2010). Ulipristal (Ella) and levonorgestrel (Plan B) should be offered within 72 h of the assault for optimal efficacy in preventing conception. Women with a body mass index (BMI) score of 25 or higher are at a greater risk of becoming pregnant using these emergency contraceptive methods than those with lower BMI scores, as they are not as effective in those with a higher BMI score (Batur, Kransdorf, & Casey, 2016). Thus, more effective alternative for women with a BMI score of 25 or higher is an intrauterine copper contraceptive (Batur et al., 2016). It is important to consider, however, that an intrauterine device may be a particularly invasive option for pregnancy prevention among a recent victim of sexual trauma.

Risk for contracting human immunodeficiency virus (HIV) is also a common concern following sexual assault. The estimated risk of HIV infection or transmission is 1–2 cases per 100,000 vaginal assaults and 2–3 cases per 10,000 anal assaults (Linden, 2011). According to guidelines from the CDC (CDC, 2016), nonoccupation postexposure prophylaxis (nPEP) treatment should be offered within 72 h postassault in cases where an HIV-positive status of the perpetrator is known. While fairly costly ($600–$1200), nPEP is only a fraction of the financial burden that a lifetime's worth of CDC-recommended pharmacological HIV/AIDS treatments are estimated to be ($223,000; Draughon, 2012). Of note, explicit guidance on how to treat a victim-patient who *does not know* the HIV status of the person who assaulted them (which is often the case) is lacking. Rather, judgments on the provision of nPEP are currently made on a case-by-case basis when taking patient preference, the nature of the assault, and an estimated risk of infection from the perpetrator into account (Draughon, 2012). The National Clinicians Post-Exposure Prophylaxis Hotline may also be consulted for guidance on the provision of HIV nPEP (Clinician Consultation Center, 2018).

Notably, compliance with administering HIV nPEP to survivors of sexual violence varies across SANE/FNE programs. Specifically, a recent survey of SANE/FNE professionals regarding the state of HIV nPEP practices found that these services are inconsistently offered across SANE/FNE programs, with medical costs, patient follow-up issues, and pre-/postcounseling being cited as the most common barriers to administration (Draughon et al., 2014; Scannell, MacDonald, Berger, & Boyer, 2018). The immediate short-term use of antiretroviral therapy after exposure (or potential exposure) is notably time and energy intensive and consequently, victim-patients are prone to lack of follow-up and poor completion rates (18–33% success) after the sexual assault (Linden, Oldeg, Mehta, McCabe, & LaBelle, 2005). However, nonadherence to the 1–2 times/day 28 day-long regimen may result in the development of a drug-resistant HIV strain (Linden, 2011).

Forensic "Rape Kit" Exams

Following the presentation of various PEP treatments, clinicians should offer the option to undergo a forensic examination (i.e., "rape kit") for the purpose of collecting evidence (American College of Emergency Physicians, 2014). The decision on

whether or not to have evidence collected is dependent on the victim-patient preference. Following guidelines for trauma-informed care, an individual's decision to decline a rape kit examination should not be challenged by the provider or any law enforcement representatives that may be present.

The specific components of evidence-collection and history-taking generally follow the same protocol, but can vary depending on local and state legal requirements (United States Department of Justice, 2013). SART programs, as well as other clinical respondent groups, should use preassembled rape kits (Hovelson et al., 2016). The process of collecting both an account of the assault and physical evidence to support the statement (i.e., DNA) can take upwards of 6 h. As such, the trajectory and process should be clearly outlined to the victim-patient, so that they clearly understand what exactly will happen during each of the 17 steps of the examination. These steps, generated by Linden (2011), include the following: (1) obtain consent and complete relevant forms; (2) administer control swabs (with the use of sterile water); (3) toxicologic testing within 72 h (indications include period of unconsciousness, lack of motor control, etc.); (4) obtain blood sample or saliva for victims DNA; (5) garner oral swabs and smears if <24 h since oral penetration; (6) obtain fingernail scrapings (if patient scratched assailant or has debris under nail); (7) collect foreign-material (i.e., collect debris that falls as patient takes clothes off); (8) collect clothing (e.g., underwear, ripped or torn clothing worn during assault) and examine full body for injuries or secretions (document on forms and take pictures, if appropriate); (9) if bite marks are present, swab lightly with two moist swabs; (10) conduct head-hair combings; (11) document pubic-hair combings; (12) obtain vaginal swabs and smears; (13) obtain anorectal swabs and smears (if <24 h since penetration); (15) obtain additional swabs (i.e., swabs from any areas of possibly dried semen or secretions) or saliva collection; and (16) finalize forms from step 1 and seal envelopes and sexual assault kit. In addition to the initial agreement to participate, informed consent is required at every step of the examination, and providers should reiterate that they can opt out of any step or the entire proceeding process at any time. The pace at which evidence is collected should also be determined by the victim-patient and can change upon their request (United States Department of Justice, 2013). Notwithstanding, the unfortunate reality is that most rape-kits go untested and most are not prosecuted by the criminal justice system (Campbell, Feeney, Fehler-Cabral, Shaw, & Horsford, 2017).

Psychological Care During Emergency Room Visits

While in the emergency department, victim-patients may also be offered psychological care. Advocates from local rape crisis centers are called to meet the victim-patient at the hospital and stay with them until discharge. Hospital social workers are also often involved in these efforts. Victim-patients may also be encouraged to utilize services offered by the local rape crisis center and to follow up with their primary care provider. Appropriate referrals can also be determined and provided (ACEP, 2014). On-site counselors or psychologists may also initiate brief cognitive–behavioral therapy (bCBT) intended to facilitate healing. For example, one study found that using this immediate therapy (within 8 h postassault) is effective in reducing both PTSD and anxiety following sexual trauma (Foa, Zoellner, & Feeny, 2006). Specifically, women in the trial (90 female recent survivors of sexual assault [$n = 57$] and nonsexual assault [$n = 33$]) who were treated with bCBT including orientation, skill-focusing, and relapse prevention-related components, recovered faster (e.g., PTSD and general anxiety) than women in supportive counseling (SC) over a 3-month follow-up (Foa et al., 2006).

While in the emergency room, individuals who experience sexual trauma may also be provided with psychoeducational materials or videos designed to educate victim-patients on what to expect during and after a rape kit. In one study, the 18-min medical examination preparation and psychoeducation-focused video was implemented to prevent/reduce rates of pre-examination anxiety,

as well as rates of postassault substance abuse among sexual assault survivors (Resnick et al., 2007). Data suggested that over a 6-month follow-up period, individuals who viewed the video reported lower levels PTSD symptoms (Resnick, Acierno, Amstadter, Self-Brown, & Kilpatrick, 2007). Viewing the 18-min medical examination preparation video was also successful in reducing pre-examination anxiety among participants.

With the goal of improving postassault outcomes, other studies have evaluated whether videos can be useful in educating survivors on what to expect following an assault. For example, Walsh et al. (2017) examined whether a brief video intervention for recent sexual assault victims—entitled Prevention of Post-Rape Stress [PPRS]—was associated with reduced alcohol and marijuana use when delivered in an emergency department. Follow-up data were collected over the course of a 6-month follow-up, and PPRS was compared to treatment as usual, as well as an active control condition, entitled Pleasant Imagery and Relaxation Instruction (PIRI). When compared to treatment as usual, the PPRS video resulted in less frequent alcohol use 6 months following sexual assault among participants who reporting binge drinking prior to the assault as well as minority women. When compared to treatment as usual, the PPRS video was also associated with lower rates of marijuana use at the first follow-up assessment among women who reported not using marijuana prior to the assault.

Of note, psychoeducational videos are not uniformly administered as a method for enhancing psychological outcomes among victim-patients presenting for care in the emergency department. However, the dissemination of such psychoeducational videos, as well as program-specific (e.g., SANE/SART) implementation (e.g., cost, staffing) could be relatively simple. Given that preliminary evidence suggests that the use of psychoeducational videos in acute care settings may mitigate adverse mental health outcomes, further research is warranted to explore avenues for uptake and dissemination of this treatment approach.

Brief Behavioral Intervention Procedure (BBIP) is another acute prophylactic treatment used to prevent chronic psychological outcomes postassault. Administered days/weeks posttrauma, BBIP is a 4- to 6-h treatment that also involves psychoeducation, as well as coping skills training and imaginal re-exposure. Only a limited number of studies have examined BBIP use in sexual assault cases (Foa, Hearst-Ikeda, & Perry, 1995; Veronen & Kilpatrick, 1983). As indicated in Vickerman and Margolin's (2009) review of the literature, research findings assessing the efficacy of BBIP in promoting mental health outcomes among sexual assault survivors have been inconclusive, and studies assessing BBIP currently lack methodological soundness (e.g., lacking a control group) and utilize a range of follow-up periods.

Long-Term Care: Treating Sexual Trauma and Its Sequelae

Burgess and Holmstrom (1974) utilized the Crisis Theory Model to describe how sexual trauma results in externally imposed psychological disequilibrium in a person who is confronted with a seemingly inescapable problem that cannot be solved using traditional problem-solving resources. Early approaches to working with survivors of sexual violence employed by rape advocacy organizations were often informed by the Crisis Theory Model (see Koss & Harvey, 1987). Later, researchers and practitioners started to explore how evidence-based cognitive–behavioral therapies (CBTs) used for anxiety diagnoses could be adapted for the purpose of treating sexual assault survivors (see Foa & Rothbaum, 2001). CBT-based treatment approaches, as well as other promising models, are described below.

Stress Inoculation Therapy

Stress Inoculation Therapy, which can be utilized in group settings, places an intense focus on creating a toolbox of coping skills for clients to assess in the literature (Meichenbaum, 2007). Components include an interview phase (e.g., psychological testing, reading, self-monitoring), the normalization of fear and avoidance behav-

iors, skill acquisition including in vivo exposure to target rape-related phobias, and concludes with the practice of skill applications using role-playing, imagery, modeling, controlled breathing, and muscle relaxation (Veronen & Kilpatrick, 1983). Studies have found that for both individual and group therapy, individuals treated with SIT reported pre-/postimprovements in PTSD, hostility, tension, assertiveness, self-concept, and self-esteem as well as improvements in depression, fear, and anxiety (Foa, Rothbaum, Riggs, & Murdock, 1991; Resick, Jordan, Girelli, Hutter, & Marhoefer-Dvorak, 1988; Veronen & Kilpatrick, 1982, 1983).

Prolonged Exposure

Prolonged Exposure (PE) is consistently regarded as an efficacious treatment for PTSD (Foa, Keane, & Friedman, 2000). Whereas PE is utilized to treat PTSD resulting from various forms of trauma (see Eftekhari, Stines, & Zoellner, 2006), PE has also specifically been utilized to address rape-related PTSD (Foa et al., 1991). Numerous theories have been proposed to explain the mechanisms through which PE leads to reductions in trauma symptoms (Bouton, 1988, 1991; Brewin, 1996, 2001; Ehlers & Clark, 2000; Foa & Kozak, 1986). Broadly, PE uses imaginal and in vivo "flooding" techniques to treat anxiety and PTSD, with the goal of allowing survivors of trauma to construct a more organized trauma story through guidance on how to take control over how they understand and process their sexual assault (see Peterson, Foa, & Riggs, 2011). Treatment providers ask the survivor to essentially relive the sexual assault scene and describe it aloud as they reimagine the experience using present tense and vivid detail in their description (Jaycox, Zoellner, & Foa, 2002). PE also incorporates cognitive and coping skill components in order to correct faculty stimulus responses so that new meaning can be made of traumatic memories. Homework assignments sometimes include listening to the audio recording outside of the counseling appointment. To date, several studies have examined the efficacy of PE in ameliorating psychological distress among survivors. Studies support the efficacy of PE for reducing PTSD among trauma survivors in general (Foa et al., 2005; Rothbaum, Meadows, Resick, & Foy, 2000), as well as survivors of sexual assault in particular (Foa et al., 1991, 1999, 2005; Foa, Molnar, & Cashman, 1995; Foa & Rauch, 2004; Resick, Nishith, Weaver, Astin, & Feuer, 2002; Rothbaum et al., 2000).

Cognitive Processing Therapy

Cognitive processing therapy (CPT) was designed specifically for the treatment of psychological distress among survivors of sexual trauma (Resick & Schnicke, 1993). Drawing upon emotion processing theory (Foa & Kozak, 1986), CPT aims to successfully integrate trauma into preexisting schemas and allow patients to overcome previously unsuccessful attempts to accommodate personal trauma-related information. Psychoeducation, exposure, and cognitive techniques are primary treatment components.

CPT can be conducted with individuals or groups and has been manualized so that therapists can practice the treatment in a systematic manner. Specifically, CPT is typically a 12-step process that aids survivors in learning how to challenge and modify unhelpful beliefs related to their trauma experience (see Westwell, 1998; Wilson & Jones, 2010). The treatment process begins with writing assignments in which clients detail what the assault means to them. The therapist then facilitates a review of what these thoughts mean to the survivor. Then, after addressing their beliefs and perceptions of the trauma's unique implications on their life, the therapist engages the survivor in a discussion about safety, trust, intimacy, power/control, and esteem (Resick & Schnicke, 1993).

Several studies have evaluated the efficacy of CPT in promoting positive mental health outcomes among survivors of sexual assault. Specifically, CPT has been shown to improve PTSD, depression, guilt, hopelessness, self-blame, and social adjustment outcomes pre-/postintervention (Iverson, King, Cunningham, &

Resick, 2015; Resick et al., 2002; Sobel, Resick, & Rabalais, 2009;). CPT is effective in treating PTSD alongside various comorbid diagnoses (i.e., guilt's manifestation as a major depressive disorder) among sexual assault survivors (Chard, Resick, & Wertz, 1999; Nishith et al., 2005). Of note, cognitive–behavioral treatments—such as CPT—are also commonly utilized as evidence-based treatments for both depression and anxiety (see Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012, for a review), as well as substance abuse (McHugh, Hearon, & Otto, 2010).

Several studies have compared the efficacy of CPT and PE (Bedard-Gilligan et al., 2016; Nishith, Resick, & Griffin, 2002; Resick et al., 2002; Resick, Williams, Suvak, Monson, & Gradus, 2012; Wachen, Jimenez, Resick, & Patricia, 2014). Across these studies, data suggest that CPT and PE are relatively comparable in treating PTSD among rape survivors. For example, in a sample of 154 rape victims who received CPT or PE and were assessed pretreatment as well as posttreatment (9 months and 5–10 years), findings suggested that for PTSD both therapies have the potential to positively influence functioning outcomes long-term (Wachen et al., 2014).

Eye Movement Desensitization Reprocessing

Eye movement desensitization reprocessing (EMDR) is also grounded in exposure techniques (Shapiro & Solomon, 1995). Incorporating cognitive and exposure treatment practices, EMDR requires the survivor to describe the assault scene while the therapist moves their finger back and forth across the patient's line of vision. It is hypothesized that this dual-attention focused therapy facilitates trauma memory processing through the use of an internal and external stimulus (Posmontier, Dovydaitis, & Lipman, 2010). Studies have concluded that EMDR resulted in improvements in PTSD, depression, anxiety, and dissociation (Leiner, Kearns, Jackson, Astin, & Rothbaum, 2012; Lindsay, 1996; Regehr, Alaggia, Dennis, Pitts, & Saini, 2013). Whereas EMDR is also cited as a psychotherapeutic intervention by the American Psychological Association (2017) for treating clients with PTSD, there is continued debate regarding EMDR's mechanisms of action. For example, it is not known if the finger eye movement component is necessary as the trauma memory exposure itself may be the source of postmental health outcomes (Rothbaum, 1997). For example, one study found that when treating PTSD in adult female rape victims (n = 74), PE and EMDR did not differ in outcomes between baseline and 6-month follow-up (Rothbaum, Astin, & Marsteller, 2005).

Supportive Counseling

Supportive counseling (SC) is widely used in counseling settings (Artime & Buchholz, 2016; Vickerman & Margolin, 2009). Providing general unconditional support, supportive counseling relies on active listening, validation, and positive regard to facilitate positive health outcomes for survivors (Foa et al., 2006). The supportive counseling process is not manualized. SC's fluidity makes it possible for survivors to identify specific topics that they want to address and work through with their mental health professional. Specific treatment targets may not surface. While some studies have shown pre-/postimprovements in PTSD, anxiety, and fear (and sometimes depression), SC is still an underexplored treatment option. Comparative studies have concluded, however, that cognitive behavioral therapies are generally more effective than SC in reducing psychological sequelae (Foa et al., 2006; Foa & Rothbaum, 2001; Resick et al., 1988).

Solution-Focused Therapy

Solution-focused therapy (SFT) is another option for long-term psychological care of sexual assault survivors seeking treatment (Tambling, 2012). Brief in length and dependent on goal-set targets, SFT works to add or remove

a behavioral component of a problem interaction (Iveson, 2002). Amplifying the presence of solutions and the ability to develop tangible coping skills, the therapy parallels Buddhist mantra: acknowledging the past without letting it dictate the future or present (O'Hanlon, 1999). SFT's practices broadly aim to produce posttraumatic growth (e.g., better sense of self, life philosophy, relationships, spirituality; Frazier, Conlon, & Glaser, 2001; Tedeshi & Calhoun, 2004). Given the potential for sexual violence to influence a relationship (see Miller, Williams, & Bernstein, 1982), treatment may also focus on immediate sexual dysfunctions, impairments, and dissatisfactions, including reproductive pain, fear of sexual activity, arousal disorders, and inhibited sexual desires (see Becker, Skinner, Abel, & Cichon, 1984). Whereas numerous studies document the effectiveness of SFT in general (for reviews, see Corcoran & Pillai, 2009; Gingerich & Peterson, 2013; Kim, 2008), research is lacking to substantiate SFT as an approach to improving psychological outcomes among sexual assault survivors in particular.

Dialectical Behavioral Therapy

Dialectical behavior therapy (DBT) (Linehan, 1993) was originally manualized for treating patients diagnosed with borderline personality disorder (BPD) and involves the following four simultaneously functioning components: (1) individual therapy; (2) group therapy; (3) phone coaching; and (4) therapist consultation teams (see Landes, Garovoy, & Burkman, 2013). Treatment focuses on emotion regulation, as well as interpersonal, behavioral, cognitive, and self-regulation skills. While the body of research is small, the current literature suggests that DBT may be uniquely suited to address the dynamic psychosocial challenges postchildhood sexual abuse (for a review, see Decker & Naugle, 2008). Research is needed, however, to explore the efficacy of DBT for adult survivors of sexual trauma, specifically. Instead, some suggest that DBT skills-training may be useful to help survivors of sexual trauma cope with the distress that may be associated with participating in exposure therapy (Becker & Zayfert, 2001; Melia & Wagner, 2000; Wagner & Linehan, 2006).

Skills Training in Affective and Interpersonal Regulation (STAIR) Narrative Therapy

Skills Training in Affective and Interpersonal Regulation (STAIR) Narrative Therapy (Cloitre, Cohen, & Koenen, 2006) requires the patients to "tell their story" as a form of therapy. STAIR Narrative Therapy is a CBT approach comprised of two phases occurring over the course of sixteen 60-min sessions: (1) training in emotion regulation and interpersonal skills (8 sessions) and (2) additional skills training and prolonged imaginal exposure. Notably, this combination therapy in which skills-based intervention precedes trauma-focused work has been cited as a promising option when treating veterans who have experienced trauma (Cloitre, Jackson, & Schmidt, 2016). STAIR Narrative Therapy, however, has not been specifically evaluated as an approach for treating the sequelae of sexual victimization in adulthood.

Future Directions

Given the growth in evidence-based treatments for adult survivors of sexual trauma, researchers and health professionals now have numerous options for attending to the needs of survivors through the use of evidence-based treatments. While some care practices for adult survivors of sexual assault have been consistently evidenced as effective in treating specific diagnoses (particularly PTSD), the literature continues to highlight areas in which further research should be conducted. Below, we delineate gaps and limitations related to sexual violence research and the clinical practices/protocols.

Future Directions in Acute Care of Victim-Patients

Within an emergency department, clinicians who serve as members of an SART team must often act not only as healthcare providers, but also as agents of the justice system (Draughton, 2012; Mulla, 2014). In addition to caring for the victim-patient's health, SART teams and other comparable acute care collaborations not only are responsible for treating injury and providing PEP treatments, but also must also complete an array of forensic tasks. As this unique treatment process is not included in general medical training, some emergency medical providers may be unprepared to navigate the medical and legal issues that arise in the case of a sexual assault victim (Draughon, 2012). Emergency room providers are often the first people that survivors encounter postassault, it is critical that no blame should be imposed upon the victim-patient seeking care. Linden (2011) suggests that explicitly telling the victim-patient that they are not to blame, no matter what occurred prior to the sexual assault, can be useful to efforts to dispel or address feelings of guilt or embarrassment. To date, research has yet to explore how the personal attitudes and training of medical providers influence the quality of care provided to survivors of sexual violence in the emergency department. Acceptance of rape myths can impact how a person responds (i.e., positive social reaction/negative social reaction) to a survivor of sexual assault (Paul, Gray, Elhai, & Davis, 2009), and it would be valuable for researchers to explore how ascription to stereotypes regarding rape influences care among emergency department healthcare providers in the United States. Although false reports of rape are quite rare (Lisak, Gardinier, Nicksa, & Cote, 2010), it is feasible that some providers who hold a high level of ascription to rape myths may assume that a survivor is falsely reporting a rape, which may bias their clinical care. Given that responses to disclosure of sexual violence can influence the healing process following an assault (Orchowski & Gidycz, 2015), it is possible that training designed to promote positive responses to sexual assault disclosure within medical settings could be useful in supporting healing among survivors.

Hospital-specific policy makers may also consider how clinically induced distress may be mitigated through trauma-informed policies pertaining to the care of sexual assault survivors. For example, hospitals are often not equipped with enough gynecological beds, improvising through the use of bedpans to raise the buttocks for a pelvic examination (Girardin, 2017). The combination of creating physical spaces, as well as teams of certified health professionals (i.e., SART programs and SANE/SFE trainings) dedicated to treating sexual assault patients, may help to minimize these sorts of discomforts experienced in the hospital setting.

Work is also needed to disseminate policy and standards of care set by public health governing bodies to emergency department providers. For example, despite the CDC (2016) recommendations for providing HIV nPEP to victim-patients in the emergency department, there is a current lack of consensus regarding the circumstances under which HIV nPEP should be offered (Linden, 2011). Recent studies of SANE/FNE programs also suggest that HIV-related services are inconsistently provided to victim-patients in hospital settings (Scannell et al., 2018).

Future Directions in Psychological Treatments for Adult Survivors of Sexual Violence

There are also several limitations to current evaluations of long-term clinical treatments for sexual assault survivors. For example, more rigorous randomized control trials are needed to improve the depth of understanding of treatments that work for treating sexual assault survivors with multiple intersecting minority identities (see Regehr et al., 2013). Absent in the literature are treatments that have been evidenced as effective in treating sexual assault symptoms among men, women of color, the homeless, those physically or mentally disabled, incarcerated persons, members of the LGBT+ community, or racial and ethnic minorities. A better understanding of how intersectional identities

may impact sexual assault-induced sequelae is necessary in ensuring that clinicians are able to provide the most helpful care to patients, regardless of sociodemographic characteristics (Regehr et al., 2013; Sigurvinsdottir & Ullman, 2016). For example, it may be helpful to investigate why those with lower education levels, those who are younger in age, and those who have higher initial levels of angers tend to drop out of CPT and PE treatments more than their counterparts so to improve their ability to successfully complete the clinical process (Rizvi, Vogt, & Resick, 2009). Moreover, one study concluded that individual characteristics of patients affect their likelihood of completing a treatment (Keefe et al., 2018). Therefore, moderators such as childhood physical abuse, current relationship conflict, anger, and racial minority status should be considered when clinicians develop tailored treatment plans for their patients.

In addition, there is currently little research examining how best to treat the aftereffects of sexual violence among women with serious mental illness (SMI). Often, individuals diagnosed with psychosis or other forms of SMI are excluded from participating in randomized clinical trials evaluating the efficacy of clinical practices, leaving the suitability of most treatments untested among those with SMI (Goodman et al., 1997). As a result, there is currently an absence of clear, evidence-based treatment guidelines for addressing sexual trauma among individuals with SMI (see Mueser, Rosenberg, Goodman, & Trumbetta, 2002). Moving forward, research is needed to understand how treatment interventions may warrant adaptation to meet the specific needs of women with SMI who experience sexual violence (see Harris & Landis, 2016).

A noteworthy gap between research and practice concerns the use of supportive counseling as a psychotherapeutic technique. Cognitive behavioral therapies (e.g., CPT, PE, EMDR) have been manualized and are frequently examined in randomized controlled trials that highlight their effectiveness in treating sequelae (Regehr et al., 2013; Resnick, Acierno, Waldrop, et al., 2007). Nonetheless, a majority of therapists choose supportive counseling as their preferred treatment for survivors of sexual assault, especially in college counseling settings (Artime & Buchholz, 2016). The disparity between knowledge of evidence-based treatments—such as PE and CPT—and practitioners' day-to-day use of supportive therapies may be influenced by ethical concerns regarding exposure practices (see Olatunji, Deacon, & Abramowitz, 2009). To bridge the gap between research and practice, more information is needed as to why—despite evidence-based recommendations—supportive counseling continues to be widely utilized.

Conclusion

Whether providing acute care in an emergency department or treating the long-term adverse health effects of sexual assault through psychological intervention, professionals involved in sexual violence cases face the unique challenge of creating a safe and patient-centered space for those adults who have experienced intimate trauma. Although sexual violence prevention scholars are working to reduce the frequency of these types of violations in the United States, it is the responsibility of healthcare professionals to provide effective, trauma-informed care and treatment for survivors, and also work to enhance these practices for those who may experience harm in the future. It is our hope that this chapter provided insight into the types of evidence-based treatments both available and recommended to clinicians with a balanced discussion of limitations as well as opportunities for research, with the goal of enhancing care for adult victims of sexual trauma.

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