Current Trends in Psychological Assessment and Treatment Approaches for Survivors of Sexual Trauma

Nicole P. Yuan, Mary P. Koss, and Mirto Stone

Female survivors of sexual trauma are vulnerable to a wide range of psychological consequences (see the VAWnet document entitled *The Psychological Consequences of Sexual Trauma*). Because some psychological symptoms may be long lasting and severe, treating them at the earliest point in time may reduce the duration and severity of distress. Therefore, this document provides a review and critique of current trends in mental health assessment and treatment for sexual trauma survivors with an emphasis on early intervention. Treatment approaches covered in this paper are restricted to psychotherapy. The body of literature on pharmacological approaches for symptoms common among survivors is sufficient for a separate document. Although trained professionals must administer most of the techniques, all individuals working with or for survivors may benefit from knowledge in this area.

The term *sexual trauma* is used in this paper to refer to distress resulting from experiencing one or more sexual violations. Clinical observations have revealed that some survivors do not label their experiences as *rape* or *assault* due to the absence of force or previous relationships with the perpetrator. For some individuals, the term sexual trauma more accurately describes their perceptions, highlighting the lasting impact of the event on their lives. Specific terms for sexual violence (e.g., *assault* and *abuse*) are used when research findings on specific types of violations are presented.

Psychological Assessment

When a woman discloses an experience of sexual victimization, it is important to explore areas of psychological distress, determine expectations for intervention, and consider available options. Topics that clinicians typically explore with a survivor include: characteristics of the trauma, psychological consequences, and pre-and post-trauma experiences. Information from each of these categories contributes to a better understanding of the complexity of the woman's response to the sexual violence and identifies target areas for clinical intervention.

Characteristics of the Sexual Trauma

One of the first areas to address is some exploration of what the survivor experienced. There is evidence that certain characteristics of the violent act may increase the likelihood that a survivor will experience negative mental health outcomes (e.g., Ozer, Best, Lipsey, & Weiss, 2003). These characteristics include relationship to the perpetrator, frequency and duration of the abuse, life threat, injury, and substantial use of force. There is a long understanding in the field, however, that survivors typically do not focus on the sexual details of the assault. In addition, clinical observations have shown that some survivors react negatively to extensive questioning about the event because of perceptions that they are being blamed for the victimization. The likelihood of a negative response might be particularly high during early stages of the recovery period and in a new relationship with the service provider.

Recent scholarship has evaluated the value of probing for detailed recall. There has been particular interest in the effects of structured disclosure activities, such as written and oral elaboration of the traumatic experiences, on survivors' mental health. One study was conducted with survivors experiencing posttraumatic stress disorder (PTSD), a psychological disorder (PTSD), a psychological disorder charaterized by symptons related to

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reoccurring recollections or dreams of the event, persistent avoidance of all things associated with the trauma, numbing and lack of responsiveness, and increased alertness to perceived threats (American Psychiatric Association, 1994). The researchers found that individuals who were asked to complete writing assignments on their traumatic experiences for three consecutive days reported relatively larger increases in health care visits and avoidance symptoms at the five-week follow-up compared to those who were asked to write about daily activities (Gidron, Peri, Connolly, & Shalev, 1996). Similarly, a study on writing about childhood abuse sexual experiences failed to document therapeutic benefits (e.g., Batten, Follette, Rasmussen Hall, & Palm, 2002). In light of these findings, it is arguable that extensive information gathering about the violent act should be avoided except when in the context of a long-term therapeutic relationship and combined with other therapeutic approaches, such as coping skills training (Gidron et al., 1996) to contain the high levels of emotional distress that may be triggered by recalling sexual trauma.

Psychological Consequences

Second to gaining some knowledge of the sexual trauma, identification of psychological distress and symptoms is the next most critical component of an assessment, contributing to referrals for specialized therapeutic services and the development of treatment plans. Current recommendations in the area of violence against women include conducting brief, but comprehensive, assessments of psychological functioning with the use of clinical interviews and/or psychological tests (Briere & Jordan, 2004). Clinicians routinely use interviews or tests to explore a range of symptoms typically reported by mental health clients as well as symptoms that are typical of trauma survivors (e.g., posttraumatic stress and dissociation). There are a number of brief screening tools that function as generic measures of psychological symptoms and require a minimal amount of time to administer and hand score (i.e., 5-10 minutes each). Some examples include the Brief Symptom Inventory (BSI; Derogatis, 1992), the Beck Depression Inventory (BDI-III; Beck, Steer, & Brown, 1996), the Beck Anxiety Inventory (BAI; Steer & Beck, 1997), and the Alcohol Use Disorders Identification Test (AUDIT; Saunders et al., 1993). The BSI is a 53-item measure that provides nine symptom scales (e.g., obsessive-compulsive, depression, phobic anxiety) and three global scales of distress. The widely used BDI is a 21-item survey that assesses the intensity of depression among distressed and non-distressed groups. The BAI is a 21-item measure that assesses the physiological and cognitive components of anxiety and addresses subjective, physical, and panic-related symptoms. The AUDIT is a 10-item questionnaire that determines problem alcohol use. All of these instruments are available in Spanish. The BSI is also available in French and German.

Clinicians also use existing standardized trauma-specific instruments. Two examples include the Posttraumatic Stress Diagnostic Scale (PSD; Foa, 1995) and the Trauma Symptom Inventory (TSI; Briere, 1995). The PSD is a 49-item instrument that determines the diagnosis of PTSD. The TSI consists of 100 items that measure posttraumatic stress and other trauma-related symptoms (e.g., depression, anger/irritability, sexual concerns). The TSI is available in Spanish and has been tested with Latino populations. The PSD is only available in English. Administration of all psychological tests is restricted to trained professionals. The level of training varies across instruments. Whereas some screening tools are available for use by physicians and other healthcare providers, such as the BDI and the BAI, most require advanced training in tests and measurements, a qualification most commonly fulfilled among clinical psychologists. The main advantage of using standardized tests in conjunction with diagnostic interviews is that they help clinicians achieve more objective assessments of what the survivor is actually experiencing, avoiding assumptions of what she should be experiencing (Briere & Jordan, 2004).

Pre-Trauma Experiences

Several studies suggest that to whom the sexual trauma happens is more important than the specific characteristics of the sexual assualt itself in determining the psychological aftermath (Koss & Figueredo, 2004). Therefore, clinicians often attempt

to explore pre-trauma and post-trauma events and experiences. Although researchers have developed surveys to assess these experiences, most clinicians use interview questions to help improve rapport with survivors. One area that is assessed is previous victimization, including physical, sexual, and emotional assault or abuse, and childhood adversity. Research has shown that some survivors experience multiple traumas in their lifetime and multiple traumas are associated with increased risk of psychological symptoms in adulthood (Messman & Long, 1996). In addition to abuse, other pre-trauma events that may exacerbate current symptoms include childhood neglect, parental alcoholism, divorce, marital separation, termination of a long-term relationship, separation from loved one, serious illness, accidents, injury, being burglarized or robbed, laid off from job, other serious problems at work, major financial problems, and legal problems or involvement with law enforcement (e.g., Gillespie, Whitfield, Williams, Heath, & Martin, 2004).

Clinicians also frequently assess pre-existing mental health difficulties and behavior problems. Pre-trauma functioning often highlights problem areas that are chronic and may increase in severity or contribute to shaping how the distress of sexual violence is experienced and expressed for a particular individual. Research has shown that some survivors have experienced psychosocial difficulties earlier in life. One study with adolescent sexual assault survivors found that the majority of them (59%) reported social or behavioral difficulties and a third (31%) reported mental health problems prior to the sexual assault (Kawsar, Anfield, Walters, McCabe, & Forster, 2004). Specifically, they reported problems associated with poor school attendance, learning difficulty, alcohol misuse, deliberate self-harm behaviors, depression, eating difficulties, and other behavior problems.

Post-Trauma Experiences

Because assessments are not usually conducted immediately following the assault, clinicians typically gather information about experiences and reactions that survivors have received since the sexual trauma occurred. One area of particular concern is survivors' experience disclosing their assault andseeking assistance from various community services, including police, prosecutors, doctors, and nurses. Survivors sometimes receive responses that leave them feeling blamed or doubted. Some individuals receive little or no help after reporting the assault. These negative interactions have been termed "secondary victimization" (Campbell & Raja, 1999). There is evidence of secondary victimization experiences among victims seeking help from medical and legal systems (e.g., Campbell & Raja, 2005; Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001). Although some survivors were satisfied with their criminal justice experiences, many more found it unfair and lacking in moral satisfaction. However, the evidence on whether participation in a trial increases PTSD symptoms is mixed (Koss, Bachar, Hopkins, & Carson, 2004).

Assessment of secondary victimization consists of identifying interactions with community systems, exploring exposure to victim-blaming attitudes, behaviors, and practices, and determining impact on the survivor. Examples of secondary victimization behaviors committed by the legal system include encouraging survivors not to report, telling the survivor that the case is not serious enough to pursue, and questioning the survivor about how she was dressed (Campbell & Raja, 2005). In medical settings, secondary victimization behaviors may consist of not explaining the risk of pregnancy or STDs from the assault, being rushed or inattentive with the survivor, and asking if drugs or alcohol were used by the survivor prior to the assault. Survivor's reactions may include feeling guilty, culpable if alcohol was involved, depressed, anxious, distrusting, and reluctant to seek additional help.

Treatment Approaches

Psychological impacts of sexual trauma are diverse and unique to each woman. No standard set of stages captures a typical recovery process. As a result, a one-size fits all treatment approach is inappropriate. Ideally, the selection of treatment strategies is dependent on the primary areas of

difficulty, the survivor's willingness to engage in a particular type of treatment, and strength of the the clinician-client relationship. The following section highlights some of the current trends in psychological treatments in practice and research, including early interventions, targeted strategies, and multimodal approaches. Most of these approaches embrace an ongoing movement to implement empirically based interventions. Empirically based therapies are treatments that have been proven to be effective on the basis of scientific investigations (American Psychological Association, 2002). The most stringent method of evaluation is a clinical trial characterized by random assignment of participants to treatment conditions and a non-treatment condition (i.e., control condition). The interventions are typically standardized with user manuals that instruct clinicians to implement a strict protocol of treatment components over a fixed number of sessions. Treatment outcomes are usually assessed across multiple time points.

It is noteworthy that efforts to promote wide spread implementation of empirically based treatments have raised a number of issues and controversies (Paul, 2004). One concern is the quality of the scientific data and interpretation and application of the evidence. Some individuals argue that the data are subjective and ever changing (Gonzales, Ringeisen, & Chambers, 2002). For instance, experts argue that clinical significance (i.e., meaningful to the patient) is more important than statistical significance, but the former is rarely documented in the literature (Seligman, 1995). Another challenge is how to transfer the tightly controlled procedures of experiments to real world clinical settings (Paul, 2004). Many mental health agencies lack the structure and resources needed to implement the therapies in the highly rigid manner that their effectiveness was evaluated in clinical trials. They also lack an ideal decision-making process to determine the fit between the evidence, target population, and practice settings (Gonzales et al., 2002). Another concern expressed by clinicians is that if healthcare systems limit reimbursement to empirically based therapies, survivors may be faced with fewer treatment options. This is a particular problem for those that may benefit from less validated and non-manual based approaches. It also may add barriers for women living in rural areas with limited access to professionals trained in empirically based interventions. These limitations characterize many of the therapeutic approaches that are presented in the following discussion.

Early Intervention

One current trend is to conduct interventions with survivors at the earliest possible time point. An example of an early intervention is a one-session intervention administered to rape survivors prior to a hospital forensic exam (Resnick, Acierno, Kilpatrick, & Holmes, 2005). Support for early interventions is based on the assumption that reduction of early symptoms may reduce the likelihood of long-term effects. Research in this area has produced mixed findings. Some studies have shown that early interventions alleviate PTSD symptoms in the short-term (e.g., Foa, Hearst-Ikeda, & Perry, 1995; Resnick et al., 2005), whereas other studies have failed to document short-term and long-term effects on psychological symptoms (e.g., Foa, Zoellner, Feeny, Meadows, & Jaycox, 2000). These inconsistent findings may reflect methodological differences or weaknesses among the studies. The lack of short-term effects may also reflect the fact that recovery appears to be particularly rapid in the first three months with or without professional intervention (e.g., Kilpatrick & Resnick, 1993). The absence of long-term effects may be partly due to the tendency of some symptoms to decrease over time (e.g., Frazier, 2003).

Even though some studies have failed to show significant differences in measured symptoms, early interventions may still provide benefits for survivors. Positive outcomes might include increased ability to access additional resources and greater satisfaction with services. Early interventions might also help mobilize a positive support network for the survivor and reduce exposure to negative interactions earlier in the recovery process. Researchers have found that positive support is particularly helpful in recovery, whereas negative support proves to be harmful (Filipas & Ullman, 2001). These types of important

benefits are often not assessed in clinical trials.

A major drawback of early intervention approaches is they are dependent on individuals identifying themselves as sexual assault survivors. It is well known that many survivors do not report or seek treatment immediately following an assault. Data from the National Women's Study indicated that only one in five women reported an adult rape to police or other authorities (Resnick, et al., 2000). Among those who received medical attention, only about half of them disclosed to medical providers that they had been sexually assaulted. Survivors who request treatment for physical or psychological complaints, but do not disclose the sexual trauma, may miss an opportunity to receive specialized services. The success of early intervention approaches is dependent, in part, on removing barriers to reporting and developing community systems that openly promote validating and appropriate responses to sexual trauma survivors by those who receive disclosures, including services providers, families, and friends.

Targeted Approaches

Another trend in treatments for sexual trauma survivors is the implementation of therapies that focus on specific categories of psychological symptoms and particular theoretical frameworks. One of the most tested therapies in the scientific literature is cognitive-behavioral treatment for PTSD among rape survivors. Cognitive-behavioral interventions typically consist of exposure techniques and cognitive restructuring exercises (Jaycox, Zoellner, & Foa, 2002). Exposure techniques include guiding the individual to experience memories of the trauma and fearful or difficult life experiences that have developed in the aftermath of sexual trauma. Cognitive restructuring activities aim to reduce distress by having the individual identify, evaluate, and modify negative thoughts. Some trauma survivors experience extensive self-blame and shame that drastically upsets their views of the world and themselves (Jaycox, Zoellner, & Foa, 2002; Koss & Figuredo, 2004). To date, both community-based studies (e.g., McDonagh et al., 2005) and case studies (e.g., Jaycox, Zoellner, & Foa, 2002) have shown that cognitive-behavioral treatments are effective for alleviating PTSD symptoms among female sexual assault survivors.

There is less agreement on the use of cognitive behavioral therapies for treating PTSD among survivors who have characteristics of Borderline Personality Disorder (BPD), such as patterns of instability in relationships, goals, values, and mood, and nonfatal suicidal behavior and suicidal threats. Some researchers have presented evidence that survivors with BPD characteristics benefit from cognitive-behavioral treatment for chronic PTSD (e.g., Feeny, Zoellner, & Foa, 2002), whereas others have argued that personality disorders are most effectively addressed using alternate interventions, such as emotion regulation skills building (e.g., Cloitre, Koenen, Cohen, & Han, 2002), at least as a preliminary step.

Although cognitive-behavioral techniques have been shown to be effective with various trauma-related consequences, there are also alternate theoretical approaches for addressing the same problems. For instance, there is evidence that nightmares can be effectively treated with behavioral techniques, such as scripting new non-distressing dreams (i.e., imagery rehearsal therapy; Krakow et al., 2001), as well as by classic dream analysis as observed in clinical practice. Psychodynamic approaches have been recommended for other particular problems, such as impaired and instable close relationships (Siegel & Solomon, 2003) and have been implemented and tested in combination with cognitive-behavioral strategies. One example is the eye movement desensitization and reprocessing (EMDR), developed by Shapiro (1989). EMDR has been shown to help survivors access and process traumatic memories to obtain positive outcomes (Shapiro, 2001).

Many of these targeted approaches, including exposure techniques and cognitive processing activities, are adaptable for a group format (e.g., Resick & Schnicke, 1992). They are typically combined with other group interventions, such as assertion training, coping skills, relationship building, and supportive and self-esteem enhancing techniques. Studies on the effectiveness of group psychotherapy for sexual assault survivors have shown improvements in post-traumatic stress symptoms and depression (Resick & Schnicke, 1992) and fears and intrusions (Roth, Dye, & Lebowitz, 1988). Among survivors of childhood

sexual abuse, a recent review of treatment studies found that survivors who participated in either individual and/or group psychotherapy showed decreases in psychological distress, depression, and trauma-specific symptoms. Neither individual nor group psychotherapy was more effective than the other (Martsolf & Drauker, 2005).

Multimodal Approaches

Given that some sexual trauma survivors experience a variety of psychological difficulties, strictly-focused therapies may not always be adequate (Briere & Jordan, 2004). Targeted techniques may lead clinicians to minimize or overlook co-occurring problem areas, such as depression or alcohol abuse, that impact the overall effectiveness of the treatment and increase the likelihood of future negative consequences if other problem areas are ignored. The application of only one theoretical approach may also contribute to poorer outcomes by failing to address different layers of impaired functioning. Among certain survivors, especially women who have experienced multiple traumas, a single-method, and single-orientation approach may underestimate the complex, dynamic qualities of their responses. In response to these limitations, there is a trend supporting the use of multimodal interventions. Multimodel approaches target a number of different problems or symptoms even across areas that are as diverse as PTSD and substance abuse (Briere & Jordan, 2004). Although clinical observations support their effectiveness, few studies have examined the effectiveness of multimodel interventions. Implementation of this approach in mental health settings is not always feasible due to the requirements of longer treatment duration (Briere & Jordan, 2004) and professional training in multiple intervention and theoretical frameworks.

Discussion and Conclusion

Ideal approaches for assessment and treatment for sexual trauma survivors are comprehensive and multi-faceted in techniques and theoretical frameworks. They are also flexible and adaptable to the unique needs of each survivor. Many providers and agencies, however, do not have the time, resources, or training to fully implement and individualize many strategies in the current literature. At best, they are able to achieve the closest approximation of comprehensiveassessment and treatment plans within resource constraints. In light of these real world limitations, future improvement of the quality and accessibility of mental health services for survivors rests largely on combining resources and developing strong collaborations among researchers, clinicians, advocates, and policy makers.

The partnership between academic and community settings needs strengthening. Although there are a growing number of resources that translate scientific findings for non-academics, an open dialogue and cross training between researchers and sexual violence prevention workers has yet to reach its full potential. The transmission of information is often one-way from the scientific community and offered through relatively inaccessible methods, such as publications in professional journals. Development and evaluation of new assessment tools and intervention strategies need to be better informed by service providers with direct contact with survivors. There also need to be greater opportunities for clinicians, advocates, and policy makers to contribute to the translation of existing research findings and planning of future studies to increase the likelihood that research will influence community services and legislation.

Another collaboration to be enhanced is between sexual assault coalitions and organizations and behavioral and public health systems. Efforts to promote mental health screenings and utilization of psychological services among the general public often occur independently from activities promoting the needs of sexual trauma survivors. Greater integration of violence against women and health promotion fields would help reduce the stigma associated with victimization and related mental health consequences. Possible intersections include adding a violence screening component to national mental health screening days and other public mental health events (e.g., health fairs, conferences).

The future of mental health care for sexual trauma survivor also rests on providing educational

resources to advocates and policy makers to support their efforts for increased resources for treatment services and evaluation. Funds are needed for treatment outcome research with understudied populations and investigations of new assessment and treatment approaches as they are developed. Advocates may also direct attention to obtaining stable resources for specialized services and better coverage for mental health services by health insurance companies, major employers, and state assistance programs. As revealed in this review, effective treatments for sexual trauma survivors currently exist. The focus is now on building bridges across research, clinical practice, advocacy, and policy arenas, so that more survivors have access to effective services at their most critical point of need.

Authors of this document:
Nicole P. Yuan, Ph.D.
Assistant Professor
Mel and Enid Zuckerman College of Public Health
University of Arizona
nyuan@email.arizona.edu

Mary P. Koss, Ph.D.
Professor
Mel and Enid Zuckerman College of Public Health
University of Arizona
mpk@u.arizona.edu

Mirto Stone, Ph.D.
Senior Therapist
Southern Arizona Center for Sexual Assault
mstone@sacasa.org

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In Brief:
Current Trends in Psychological Assessment and Treatment Approaches for Survivors of Sexual Trauma

Female survivors of sexual trauma are vulnerable to a wide range of psychological consequences. Because some psychological symptoms may be long lasting and severe, treating them at the earliest point in time may reduce the duration and severity of distress. Ideal approaches for assessment and treatment for sexual trauma survivors are comprehensive, multi-faceted theoretical frameworks and techniques that are individualized to the needs of each survivor. Although trained professionals must administer most of the techniques, all individuals working with or for survivors may utilize knowledge in this area to improve the overall quality and accessibility of mental health services for women.

Psychological assessments contribute to referrals for specialized therapeutic services and the development of treatment plans. Important areas for exploration include some aspects of the assault, psychological distress and symptoms, and pre-trauma and post-trauma experiences. Although certain assault characteristics may shed light on the likelihood of mental health outcomes, extensive information gathering about the event should be generally avoided. Forced recollection of specific details has been shown to trigger or exacerbate emotional distress among some survivors. Brief screening tools and trauma-specific instruments are frequently used to obtain an objective assessment of specific groups of symptoms (e.g., depression, anxiety, alcohol problems, and posttraumatic stress). Pre-trauma experiences that may shape how the distress of sexual victimization is experienced and expressed include previous victimization, history of mental health difficulties, and stressful life events. Post-trauma experiences of interest include negative interactions with family and peers, medical professionals, law enforcement, and prosecutors.

A one-size fits all treatment approach does not exist. Ideally, the selection of treatment strategies is dependent on the primary areas of difficulty, the survivor's willingness to engage in a particular type of treatment, and strength of the clinician-client relationship. Current trends in psychological treatments include early interventions, targeted strategies, and multimodal approaches. Early interventions have produced mixed findings, but potential benefits may include the mobilization of a positive support network and reduced exposure to negative interactions early in the recovery process. Targeted therapies consisting of cognitive-behavioral interventions for PTSD have been shown to be effective in individual and group formats. Multimodal approaches are recommended for survivors with a multiple psychological issues, such as women who also experience depression or problem alcohol use.

Implementation of these recommended assessment and treatment approaches largely rests on greater opportunities for open dialogue and cross training among researchers, practitioners, advocates, and policymakers. This includes enhanced integration of violence against women and health promotion fields. By strengthening collaborations and addressing the stigma associated with sexual violence and mental health problems, more survivors may have access to services at their most critical point of need.