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Applied Research

The Psychological Consequences of Sexual Trauma

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

"Women's responses to childhood and adulthood sexual violence are complex and highly individualized. Some survivors experience severe and chronic psychological symptoms, whereas others experience little or no distress. The wide range of consequences may be attributed to assault characteristics, environmental conditions, survivor attributes, and availability of social support and resources. The use of different methodologies may also contribute to mixed findings across studies."

Applied Research papers synthesize and interpret current research on violence against women, offering a review of the literature and implications for policy and practice.

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The psychological consequences of sexual trauma among survivors have been widely studied, but research investigations continue, in part, because rates of violence against girls and women remain high. The National Violence Against Women Survey found that 18% of women reported experiencing a completed or attempted rape during their lifetime (Tjaden & Thoennes, 2000). More than half (54%) of the rape survivors that responded to the survey were younger than age 18 when they experienced their first attempted or completed rape. Ongoing research attention to mental health outcomes is also driven by evidence that survivors' responses are largely complex and unique to each individual (Briere & Jordan, 2004). Some individuals experience severe symptoms or long-term distress, whereas others do not (e.g., Kendall-Tackett, Williams, & Finkelhor, 1993). The diversity in outcomes may be attributed to characteristics of the violent acts, environmental conditions, survivor attributes, and availability of social support and resources. Another contributing factor is the use of different methodologies across research investigations. Although some individuals may be resilient to the negative effects of sexual trauma, it does not minimize the observation that for other women sexual victimization is the most devastating event they will experience.

This paper describes current research findings on the effects of childhood and adulthood sexual victimization on women's mental health. Existing data on understudied communities and risk factors for mental health problems are also presented. Childhood and adulthood sexual violence are discussed separately because, contrary to public opinion, sexual violence against children is fairly common and is frequently associated with psychological distress that continues into adulthood. There is also evidence that the mental health effects of childhood sexual victimization might be different from those due to adulthood victimization (e.g., Coid et al., 2003). This document does not cover other health outcomes, such as chronic medical conditions and reproductive and maternal health problems, because those outcomes make up a distinct body of literature

that requires a focused review in their own right. Having knowledge in this area is critical for all individuals working with survivors, including victim advocates, community health workers, and policy makers. First, it promotes continued empathy and support for survivors. Second, the knowledge may help diverse groups of service providers respond to current trends toward professionalization of the field of sexual violence. As state and federal funding for violence against women face budget cuts from year to year, organizations have had to move away from grassroots models to professional models (Patricia Yancey Martin, 2005). Professional models include the use of evaluation and analytic tools and other activities related to writing proposals and managing grants and contracts. This requires knowledge of the research literature and the language and conceptual models frequently used by scientists and professionals. This paper provides a review that will hopefully facilitate discussions of the psychological consequences of sexual victimization across different individuals and organizations that work with or for survivors.

Definitions

The terms *childhood sexual abuse* and *adulthood sexual violence* are based on definitions developed by the American Medical Association and the U.S. Centers for Disease Control and Prevention, respectively. According to the American Medical Association (1992), *childhood sexual abuse* consists of contact abuse ranging from fondling to rape and non-contact abuse, such as modeling inappropriate sexual behavior, forced involvement in child pornography, or exhibitionism. *Adulthood sexual violence* includes contact and non-contact acts performed without the survivor's consent since age 18. According to the U.S. Centers for Disease Control and Prevention (Basile & Saltzman, 2002), sexual violence is defined as completed or attempted contact between the penis and the vulva or the penis and the anus involving penetration; contact between the mouth and the penis, vulva, or anus; penetration of the anus or genital opening; and intentional touching of the genitalia, anus, groin, breast, inner thigh, or buttocks. Non-contact acts include voyeurism and verbal and behavioral sexual harassment. The acts are considered sexual violence if they are nonconsensual or committed against someone that is unable to provide consent (Basile & Saltzman, 2002).

There are many different terms for sexual violence. In this paper, *sexual trauma* is the main term that is used. Sexual trauma refers to one or multiple sexual violations that invoke significant distress. The term sexual trauma is recommended and used by many clinicians and advocates in response to observations that some survivors do not label their experiences as *rape* or *assault* due to familiarity with the perpetrator or the absence of force. Clinical observations have also suggested that *sexual trauma* may be a less stigmatizing term for some survivors and may promote healing by acknowledging the impact of the violent act on the individual's wellbeing. In contrast, most research investigations examine specific types of sexual violence (e.g., rape and sexual assault). It is recognized that the term sexual trauma compounds the acts of violence with survivors' responses. As a result, sexual trauma is used when presenting a clinical viewpoint and terms related to specific types of violations are used when conveying particular findings in the scientific literature.

Childhood Sexual Trauma

Psychological Consequences

Survivors of childhood sexual trauma are at high risk of posttraumatic stress disorder (PTSD). According to the American Psychiatric Association (1994), the diagnostic criteria for PTSD include exposure to a traumatic event that invokes intense fear, helplessness, or horror and a range of symptoms, such as 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. In a recent study, women who reported childhood sexual abuse were five times more likely to be diagnosed with PTSD compared to nonvictims (Coid et al., 2003). Another study showed that the lifetime rate of a PTSD diagnosis was over three times greater among women who were raped in childhood compared to nonvictimized women (Saunders et al., 1999).

Survivors are also more likely to suffer from depression, suicide, and other mental health problems. In one study, the rate of lifetime depression among childhood rape survivors was 52% compared to 27% among nonvictims (Saunders et al.,1999). A separate investigation showed that childhood sexual abuse was associated with an increased risk of a serious suicide even after accounting for the effects of previous psychological problems and a twin's history of suicidal behaviors (Stratham et al., 1998). Survivors of childhood sexual abuse have also been shown to be at greater risk of problem alcohol use (Galaif, Stein, Newcomb, & Bernstein, 2001) and eating disorders (Wonderlich et al., 2001) later in life.

Childhood sexual trauma may also affect certain developmental processes, such as the ability to develop and maintain relationships. For instance, clinical observations have revealed that some adult survivors of childhood sexual abuse report problems with low sexual interest and few close relationships. In other cases, some survivors display high-risk sexual behaviors (e.g., promiscuity) that may be attributed, in part, to modeling some of the behaviors shaped earlier in life by the perpetrator.

Distress experienced by adult survivors of childhood sexual abuse may also be related to their use of particular coping strategies (Fritsch & Warrier, 2004). Survivors may use different coping behaviors to protect themselves from negative feelings, thoughts, and internal conflict, but in some cases, the mechanisms may contribute to additional distress. For example, some survivors experience changes in consciousness and memory, producing a trance-like state or perceptions that one is living in a dream or a movie (APA, 1994). When these experiences are severe, abilities to work, socialize, or engage in other activities sometimes become impaired. Extreme experiences of victimization are also associated with symptoms of a personality disorder known as Borderline Personality Disorder. As defined by APA (1994), personality disorders are characterized by symptoms associated with maladaptive and inflexible personality traits. Borderline Personality Disorder is characterized by enduring patterns of instability in relationships, goals, values, and mood, nonfatal suicidal behavior and suicidal threats (i.e., parasuicidal behaviors), and other impulsive behaviors that may be harmful (e.g., substance abuse, unsafe sex). Research has shown that among the most severely impacted survivors of childhood sexual trauma, such as women in high security psychiatric hospitals, Borderline Personality Disorder is a common diagnosis (Warner & Wilkins, 2004).

The diagnosis of a Borderline Personality Disorder has been historically stigmatizing and controversial because it implies that the individual's personality is flawed and may not be altered or changed. Stigma surrounding this disorder is also due to observations that individuals with these symptoms are particularly difficult to treat and they often terminate treatment prematurely. Knowledge about this diagnosis, however, is vital to early detection and utilization of specialized therapeutic approaches. One of most promising treatments is Dialectical Behavior Therapy and it consists of individual therapy, skills group, and phone counseling (Linehan, 1993). Dialectical Behavior Therapy has been shown to be effective in lowering levels of parasuicidal and impulsive behaviors and alcohol use (van den Bosch, Koeter, Stijnen, Verheul, & vanden Brink, 2005).

Childhood sexual trauma is also associated with other personality disorders, including those that are distinguished by enduring patterns of distrust and suspiciousness (i.e., Paranoid Personality Disorder), grandiosity and need for admiration (i.e., Narcissistic Personality Disorder), social inhibition and feelings of inadequacy (i.e., Avoidant Personality Disorder), or submissive and clinging behavior (i.e., Dependent Personality Disorder, APA, 1994). A recent study, however, found that individuals with Borderline Personality Disorder reported higher rates of sexual abuse compared to individuals diagnosed with other personality disorders (Yen et al., 2002).

The literature on Borderline Personality Disorder among sexual trauma survivors has caused some researchers and clinicians to advocate for the use of a newer PTSD diagnosis: Complex PTSD. The diagnosis of Complex PTSD includes the behavior characteristics of Borderline Personality Disorder. This disorder is associated with experiencing an interpersonal stressor

and symptoms related to mood swings, changes in states of consciousness, physical symptoms without a medical diagnosis, and altered sense of self and others (Pelcovitz et al., 1997). In a recent study, women with a history of childhood sexual trauma met the diagnostic criteria for both Borderline Personality Disorder and Complex PTSD (McLean & Gallop, 2003). As a result, the researchers suggested that survivors might be better understood by a single diagnosis of Complex PTSD.

Understudied Communities

Although girls of all backgrounds are vulnerable to childhood sexual trauma, little is known about the psychological effects experienced by understudied communities. Communities that are frequently left out of research include racial, ethnic, religious, and sexual orientation minorities, women who are homeless, and those who are disabled. There is a growing body of literature with Latina survivors, but it has yet to be determined whether they experience worse or different consequences compared to other groups. One study showed that Latina childhood abuse survivors reported less intrusive PTSD symptoms than non-Latinas (Andres-Hyman, Cott, & Gold, 2004). Another investigation found that Latina survivors experienced more distress, including greater self-blame compared to Anglos (Katerndahl et al., 2005).

Findings with understudied populations need to be interpreted with caution. Differences may be partly or wholly explained by common characteristics of minority status in the U.S. including high levels of life stressors, limited educational and employment opportunities, and exposure to poverty. Discrimination and oppressive conditions may contribute to fewer physical and emotional resources among survivors of understudied communities, leading to increased vulnerabilities to mental health consequences. Group differences may also reflect barriers to participating in research and disclosing intimate experiences to strangers who use structured assessment tools. Such methods may lack sensitivity to cultures and communities that are frequently marginalized in society.

Risk Factors

Given the diversity of consequences, researchers have attempted to identify factors that may predict the severity and duration of psychological symptoms that some adult child abuse survivors, but not all, experience. To date, the findings are inconsistent. Whereas some studies have shown that distress levels are associated with the frequency and duration of victimization (Steel, Sanna, Hammond, Whipple, & Cross, 2004), other investigations indicated that qualities of the family environment, and not abuse characteristics, predicted adult outcomes (Fassler et al., 2005). The findings on the effects of family environment suggest that supportive assets may play an important role in explaining individual outcomes.

There has also been recent attention to the role of disclosure on adult psychological symptoms. One study found that survivors who did not disclose or delayed disclosure of childhood sexual trauma for more than one month had higher rates of PTSD and more major depressive episodes (Ruggiero et al., 2004). Reactions received by the survivor may also be linked to mental health outcomes. Maternal responses that are supportive and protective have been associated with improved mental health and functioning among survivors (Lovett, 2004). Supportive responses from partners also have positive influences on women's health and predict fewer symptoms (Jonzon & Lindblad, 2005).

Limitations of the Research

As mentioned earlier, some child survivors experience few psychological effects (e.g., Kendall-Tackett, Williams, & Finkelhor, 1993). There are several possible explanations why some child abuse survivors experience few, if any, psychological symptoms. One explanation is that severe distress may be greater when childhood sexual trauma occurs in the presence of adverse family characteristics, such as parental alcohol problems (Fergusson, Horwood, & Lynskey, 1996). Another explanation is that psychological consequences of childhood sexual trauma may be exacerbated among individuals that experience subsequent sexual victimizations, contributing to worse symptoms in adulthood (Coid et al., 2003). A review of research on repeat victimization concluded that women who experienced childhood sexual abuse were at heightened risk of adulthood victimization and those who were

revictimized reported greater mental health problems in adulthood (Messman and Long, 1996).

The topic of revictimization often raises strong sentiments and concerns about blaming the victim. It is noteworthy that some investigations have provided limited or no support for the victim's contribution to sexual revictimization (e.g., Siegel & Williams, 2003). And, although there is a substantial body of literature on survivor characteristics that increase vulnerability for later victimization (e.g., alcohol abuse, PTSD, interpersonal problems), many researchers are currently shifting their attention to perpetrators and the effects of societal and cultural responses to violence against women (Messman & Long, 2003).

Another explanation for inconsistent findings across studies on childhood sexual abuse is the use of different research methodologies, including the use of very different participants who are drawn from clinical, community, and student groups. Survivors who are surveyed in clinics may report higher levels of distress and greater impairment compared to those surveyed in the general community. Despite reasons for caution in interpreting the research, there is substantial evidence that, for many women, childhood sexual trauma increases vulnerabilities to mental health problems later in life.

Adulthood Sexual Trauma

Psychological Consequences

Women who are victimized in adulthood are vulnerable to short and long-term psychological consequences. Immediate distress may include shock, fear, anxiety, confusion, and social withdrawal (Herman, 1992). Survivors may also experience some PTSD symptoms shortly after a violent act has occurred, such as emotional detachment, flashbacks, and sleeping problems (Rothbaum, 1992). Many survivors experience a reduction in psychological symptoms within the first few months, but a small group of survivors report symptoms that persist for years (e.g., Kilpatrick &Resnick, 1993). Research has shown that symptom levels of victimized women, although they significantly improved over time, remained elevated for at least two years following a rape compared to women who have never been sexually traumatized (Frazier, 2003; Koss & Figueredo, 2004a,b).

The body of literature on long-terms outcomes of adulthood sexual trauma has predominately focused on PTSD. The reported rates of PTSD among rape survivors vary from approximately 30% to 65% depending on how and when the PTSD symptoms are assessed. The specific timing of an assessment is important because PTSD symptoms decrease on their own within the initial months following the assault. Some clinicians and researchers have criticized the use of PTSD as the primary diagnosis for sexual trauma survivors. One of the major arguments is that PTSD has received too much attention compared to other mental health outcomes and is ill fitting for serial and escalating forms of violence against women, including intimate partner violence (Mechanic, 2004). Psychological symptoms that may be overlooked in clinical practice include symptoms of depression, physical symptoms without the presence of medical conditions (i.e., Somatoform disorders), severe preoccupations with physical appearances (i.e., Body Dysmorphic disorders), disordered eating behaviors, sexual dysfunction, and extreme body piercing and tattooing (i.e., compulsory body mutilation). There is relatively little research conducted on these other psychological problems among survivors. Research on depression has produced mixed findings. Some researchers have found no association between depression and adulthood sexual victimization (Coid et al., 2003), whereas others have found high rates of depressive disorders among rape survivors (Dickinson et al. 1999). One investigation indicated associations between sexual victimization and parasuicidal behaviors and alcohol and illicit drug use; however, these consequences varied by specific type of sexual assault (i.e., rape versus other sexual assault; Coid et al., 2003).

Understudied Communities

Little is understood about the impact of adulthood sexual trauma among communities typically underrepresented in research. One existing study on ethnic differences showed that Latina rape survivors experienced more psychological distress and greater perceptions of

community victim blaming compared to non-Latina and African-American rape survivors (Lefley, Scott, Llabre, & Hicks, 1993). The implications of these findings are limited until they are replicated with additional study samples.

Risk Factors

Risk of developing mental health problems after adulthood rape is related, in part, to the severity of the assault and the presence of other negative life experiences. Assault characteristics associated with PTSD symptoms include threat to life and injury (Resnick et al., 1993) and substantial use of verbal and physical force (Bennice, Resick, Mechanic, & Astin, 2003). Divorce and exposure to adverse childhood environments (Elliott, Mok, & Briere, 2004) and histories of depression and alcohol abuse have also been shown to exacerbate the impact of adulthood sexual trauma (Acierno et al., 1999).

How survivors mentally process their experiences of sexual trauma is also related to mental health consequences (e.g., Halligan, Michael, Clark, & Ehlers, 2003). Koss and Figueredo (2004b) documented the influence of background characteristics on the severity of self-blaming thoughts, which predicted the degree of maladaptive beliefs that survivors used to understand and interpret ongoing life experiences. Maladaptive beliefs were a strong predictor of psychological distress than assault characteristics. Similarly, Frazier (2003) found that survivors' perceptions of past control (i.e., control over the assault), present control (i.e., control over recovery process), and future control (i.e., control over future victimizations) were related to post-trauma distress. Women who most strongly perceived that they had control over their recovery process were the least distressed.

Conclusion

Psychological consequences of sexual trauma in childhood and adulthood are diverse and highly individualized. There is no one response that is experienced by all survivors. The diversity of emotional outcomes is evident in the variability in severity (mild distressing to life threatening), timing (immediate to delayed impact), duration (short-term to long-term), and types of consequences (i.e., psychological symptoms, maladaptive behaviors). Whereas a large portion of the literature has focused on PTSD symptoms, survivors are also at risk of experiencing a range of other mental health problems, such as depression, suicidal thoughts and attempts, problem alcohol abuse, disordered eating behaviors, and sexual dysfunction. The research literature, however, includes studies with methodological limitations. In addition, various controversies have emerged, including arguments against the heavy focus on PTSD and the overemphasis of the survivor's role in responses to sexual trauma with relatively little recognition of role played by social support and societal and cultural factors.

These limitations and controversies highlight the need for future research and the development of strong collaborations across diverse areas, including research, practice, advocacy, and public policy. Maximizing efforts to reduce sexual violence requires combining resources and coordinating activities across different settings (e.g., research, healthcare, criminal justice). Successful collaborations rely on individuals having a basic foundation of knowledge and communicating with a common language and conceptual models of mental health. This is consistent whether mobilizing around issues related to preventing sexual victimization (i.e., primary prevention), minimizing psychological consequences (i.e., secondary prevention), or treating full-blown psychological symptoms and disorders (i.e., tertiary prevention). Of particular relevance to this paper is secondary prevention. Secondary prevention strategies consist of intervening as soon as possible and increasing positive social support to minimize the effects of the sexual trauma.

This review has several implications for advocates. It may be used to advocate for training more providers in specialized therapeutic approaches for sexual trauma. It may also support efforts to place pressure on the formal mental health system to work collaboratively with other public systems, including medical, legal, and law enforcement systems in order to minimize the likelihood of secondary victimizations and long-term distress. Another application is to supporting reforms that help

secure permanent funding for rape crisis centers and other specialized violence-related services, including specific prevention and intervention programs. Finally, continued education of the general public on mental health outcomes of sexual victimization is critical to improving reactions to disclosure, reducing stigma, and raising awareness of available services and resources for survivors.

The mental health impact of sexual trauma is clearly a serious public health problem for women. By acquiring a common foundation of knowledge and fostering collaborations, those in the field may increase access to support and resources, so that all women who experience the emotional aftermath of sexual trauma may follow a path of recovery that is healing and empowering.

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In Brief: The Psychological Consequences of Sexual Trauma

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Women's responses to childhood and adulthood sexual violence are complex and highly individualized. Some survivors experience severe and chronic psychological symptoms, whereas others experience little or no distress. The wide range of consequences may be attributed to assault characteristics, environmental conditions, survivor attributes, and availability of social support and resources. The use of different methodologies may also contribute to mixed findings across studies. In this paper, sexual trauma refers to one or multiple sexual violations that invoke significant distress. The term sexual trauma is used based on clinical observations that some survivors do not label their experiences as rape or assault due to familiarity with the perpetrator or the absence of force.

Childhood sexual trauma is associated with posttraumatic stress disorder (PTSD), depression, suicide, alcohol problems, and eating disorders. Survivors may also experience low sexual interest and relationship difficulties and engage in high-risk sexual behaviors and extreme coping strategies. In the most severe cases, women may experience symptoms of a personality disorder, including one that is distinguished by enduring patterns of instability and impulsivity (i.e., Borderline Personality Disorder). Limited data on risk factors suggests that family environment and supportive responses from family and intimate partners may improve mental health and functioning among survivors.

Adulthood sexual trauma is associated with short-term and long-term psychological consequences. Short-term effects include shock, fear, anxiety, confusion, and withdrawal. Many survivors experience a reduction in symptoms within a few months, whereas some women experience distress for years. Long- term outcomes include PTSD, depression, eating disorders, sexual dysfunction, alcohol and illicit drug use, nonfatal suicidal behavior and suicidal threats, physical symptoms in the absence of medical conditions, and severe preoccupations with physical appearances. Risks of developing mental health problems are related to assault severity, other negative life experiences, maladaptive beliefs, and perceptions of lack of control.

The current literature has identifiable gaps and controversies. Little is known about the impact of childhood and adulthood sexual victimization among women from understudied communities (e.g., racial, ethnic, religious, disability, sexual orientation, poor and homeless minorities). There is also an ongoing debate about the heavy reliance on PTSD as a primary diagnosis for survivors. Critics argue that the diagnosis supports a tendency to overemphasize the survivor's role in responses to sexual trauma with little recognition of the role of social support and societal and cultural factors. Addressing these limitations requires stronger collaborations between researchers, practitioners, advocates, health educators, and policy makers and utilization of a basic foundation of knowledge and common language of mental health.

Advocates may apply this information to promote specialized trainings for practitioners, support reforms that help secure funding for rape crisis centers and related services, and educate the general public to improve community responsiveness, reduce stigma, and increase awareness of available resources for survivors.

See the full Applied Research paper: Yuan, N.P., Koss, M.P., & Stone, M. (2006, March). *The Psychological Consequences of Sexual Trauma.* Harrisburg, PA: VAWnet, a project of the National Resource Center on Domestic Violence. Available at: http://www.vawnet.org

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