PTSD 101
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COURSE TRANSCRIPT FOR:
Sexual Assault & PTSD: Information, Screening & Treatment
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Slide 1: Sexual Assault and PTSD: Information, Screening and Treatment

My name is Dr. Dawne Vogt and I am here with Dr. Candice Monson. And we're going to be talking today about sexual assault and PTSD, information, screening, and treatment. And this talk that we're going to be giving was authored by Lisa Welch, myself, Dr. Candace Monson, and Dr. Patricia Resick. And we're here at the Women's Health Sciences Division in the National Center for PTSD.

Slide 2: Goal

So our goal is that after viewing this course you will be more knowledgeable about sexual assault including specifically what it is, who's most at risk, what some of the health consequences are for survivors, issues around screening at the VA, and various treatment options.

Slide 3: Specific Objectives

The specific objectives of this course include that the provider will be able to define sexual assault and identify populations most at risk, the provider will have a better understanding of the consequences of sexual assault, the provider will be able to identify unique issues related to sexual assault among veterans, the provider will be more knowledgeable regarding screening for sexual assault at the VA, and the provider will be able to identify major treatments for sexual assault related PTSD.

Slide 4: Sexual assault is a major, often life threatening, traumatic event.

Slide 5: Sexual Assault

For the purposes of this presentation we're going to define sexual assault as any sort of sexual activity between at least two adults in which at least one of the people is involved against his or her will. Importantly physical force may or may not be used.

Slide 6: Forms and Sexual Assault

There are several forms of sexual assault. Forms of sexual assault include vaginal, oral or anal sex or penetration with an object or rape, and unwanted touching or grabbing in a sexual manner.

Slide 7: Reporting of Sexual Assault

Reported cases of sexual assault appear to be only a trace of actual events. In fact research findings suggest though only approximately thirty-two percent of sexual assaults are reported to the police. And underreporting may occur for a variety of reasons including the possibility that the victims are acquainted with their attackers and may not consider the event an assault. Victims may also fear retaliation from perpetrators. And victims may fear that they will not be believed by police.

Slide 8: Every <u>five minutes</u> a rape is reported to the authorities in the U.S.

Slide 9: Incidence of Rape

Regarding the incidence of rape in a twelve month period it is estimated that three hundred and two thousand, one hundred women and ninety-two thousand seven hundred men experience an event they label as rape. Approximately seventeen percent to twenty-four percent of women experience rape in their lifetime. And three percent of men experience rape in their lifetime. Among college women twenty percent indicate that they've experienced a rape and fifteen percent of female college students indicate having experienced a rape since the age of fifteen.

Slide 10: Who are the Perpetrators?

Who are the perpetrators? In a recent study seventy-six percent of adult women who were sexually assaulted were attacked by someone they knew, either husbands, partners, dates, etcetera.

Slide 11: Risk Factors for Sexual Assault

There are a number of risk factors for sexual assault. For example female gender is a risk factor. Eighty-seven percent of rape survivors are women. Younger age is also a risk factor. Fifty-four percent of rapes occur to victims under age eighteen and twenty-two percent before the age of twelve. Minority, race, and ethnicity is also a risk factor. Among American Indian and Alaskan Native women thirty-four percent report being raped. Nineteen percent of African American women and eighteen percent of Caucasian women report rape as well.

Another risk factor for sexual assault is exposure to previous sexual assault. Women who have been assaulted prior to age eighteen are twice as likely to be assaulted as an adult.

Slide 12: Consequences of Sexual Assault

There are a number of consequences of sexual assault. There are physical health problems that are associated with sexual assault and these include injuries related to the assault, sexually transmitted diseases, unwanted pregnancies, and sexual dysfunction. In addition survivors of sexual assault engage in more health risk behavior. For example they are more likely to smoke, less likely to wear seatbelts, are at an increased risk for obesity, and are more likely to engage in risky sex behavior.

Slide 13: Consequences of Sexual Assault (cont.)

Additional consequences of sexual assault include interpersonal difficulties. Survivors of sexual assault often report anxiety or distrust in interpersonal relationships and fear of groups or strangers. Survivors of sexual assault are also at increased risk for alcohol and drug use. Finally survivors of sexual assault report poor mental health. Mental health problems include posttraumatic stress disorder or PTSD, depression, anger, shame, and guilt, suicide attempts, and poor psychological well-being more generally.

Slide 14: The most frequently observed disorder resulting from sexual trauma is PTSD

However the most frequently observed disorder resulting from sexual assault is PTSD or posttraumatic stress disorder.

Slide 15: Posttraumatic Stress Disorder

A month after a traumatic event posttraumatic stress disorder or PTSD can be diagnosed if the victim has pronounced symptoms from each of three categories, re-experiencing, avoidance, and emotional numbing and hyperarousal. Re-experiencing symptoms include intrusive or distressing memories, thoughts or dreams related to the traumatic event. Avoidance and emotional numbing include avoidance of event related thoughts, feelings, activities, or places and difficulty expressing emotions and being close to others. Hyperarousal symptoms include difficulty relaxing, concentrating, falling or staying asleep and irritability or angry outbursts.

Slide 16: Sexual Assault and PTSD

It is important to note that psychological distress following a sexual assault is normal. Ninety-four percent of rape survivors meet symptom criteria for PTSD during the first week following a sexual assault and forty-seven percent still meet PTSD criteria after three months.

Slide 17: Sexual Assault and PTSD

However if rape related PTSD symptoms persist past the third month, victims are less likely to fully recover thereafter. And if rape related PTSD criteria is not met after three months, improvements are typically seen throughout the first year.

Slide 18: Factors that Increase Risk for PTSD Following Rape

There are a number of factors that increase risk for PTSD following rape. One risk factor is if the victim knows the perpetrator. Another risk factor is if the victim experiences of detachment or dissociation during the assault. Another risk factor is negative self views after the assault, in addition greater life threat during the assault or more severe victimization and finally negative reactions from family members and friends.

Slide 19: What is Military Sexual Assault (MSA)?

A special form of sexual assault is called "Military Sexual Assault" and this is sexual assault that occurs in the military setting. It is important to note that victims and perpetrators can be both male and female.

Slide 20: How is MSA Different from other Types of Sexual Assault?

Military sexual assault is different from other types of sexual assault. For example military sexual assault occurs in a setting where the victim lives and works and as a consequence the victim may rely on the perpetrator for basic needs, possible that career goals will be disrupted, and the victim may experience increased feelings of powerlessness associated with experiencing a sexual assault in the work setting. Anecdotal evidence suggests that military sexual assault may be underreported because of fear that the report will be ignored, the survivor will be blamed for the assault, and there will be negative implications for a career.

Slide 21: Prevalence of MSA

With respect to the prevalence of military sexual assault in 1995 the Department of Defense conducted a study of active duty military members. And findings from this study indicated that in the previous year military sexual assault had affected six percent of women and one percent of men.

Slide 22: Consequences of MSA

In a study of female VA healthcare users conducted in 1997 findings indicated that twenty-three percent reported military sexual assault at some point during their military service. In addition military sexual assault was related to a number of health outcomes among them mental health problems including PTSD, depression, and anxiety, gastrointestinal and pulmonary problems, chronic fatigue, vision, and hearing problems and dissatisfaction with sex life.

Slide 23: Sexual Assault and PTSD among Returning Iraq and Afghanistan War Veterans

Sexual assault is also an issue among returning Iraq and Afghanistan war veterans. Reports of sexual harassment and assault perpetrated by fellow military personnel, military leaders, allies and foreigners have surfaced in the media. And this may be particularly detrimental because military members may be coping with additional deployment stressors that increase the risk for negative health consequences. For example lack of social support, family stress, and exposure to combat and other war zone stressors.

Slide 24: Screening for Military Sexual Trauma

The VA has screening for military sexual trauma and the term military sexual trauma is used to refer to both sexual harassment and assault experienced during military service. The VA mandates universal screening for military sexual trauma. There's a number of important elements of the screening process and these include establishing a comfortable climate for

disclosure, deciding on how the screening will be conducted, for example as part of taking a social history or on an intake form, introducing the line of questioning in a non-judgmental manner, and asking behaviorally based questions. For example, "Did someone ever use force or the threat of force to have sexual contact with you against your will?"

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Slide 25: Screening for Military Sexual Trauma in the VA (cont.)

The response to disclosure of military sexual trauma should include a number of factors. First validation and empathy for the sexual trauma survivor, education about post-trauma reactions, assessment of current health and safety status, and assessment of support available to the individual. All patients with a sexual trauma history should be offered the option of a mental health referral.

Slide 26: Screening for Military Sexual Trauma in the VA (cont.)

When making a referral it is important that the clinician know first how to present the referral in a way that will maximize its acceptability to the patient. It's important to normalize the experience and offer options. And second where to send the consult. Some options include the local VA's military sexual trauma coordinator, the women that are in program manager, and the mental health service. For additional information about screening for military sexual trauma in the VA please see the military sexual trauma quick reference guide that is available through the Employee Education System.

Slide 27: Treatment of Sexual Assault-Related PTSD

I'm going to now turn this over to Dr. Candice Monson who will talk about treatment of sexual assault related PTSD.

Candice Monson: So when thinking about treating sexual assault related PTSD most all interventions include some basic principals. One of the first of those principals is addressing immediately any health or safety concerns. So for example it wouldn't be appropriate to pursue a form of PTSD treatment while someone who is in a currently violent relationship. You would want to make sure that the person was safe in their relationship and safe in their daily living to be able to pursue any treatment. Or if they were for example self-harming or self-injurious it would be important to address those issues before doing any trauma specific therapy.

All of the evidence based therapies for PTSD typically include some education that talks to the survivor about posttraumatic reactions and normalizing these reactions, very typical to consider one's role for example in an assault, what they possible could have done different. All, all of those reactions, which are normal in terms of the reaction to a traumatic event.

It's also important for any provider to provide the victim with validation. To normalize their distress, to indicate that that's normal, that they understand that they are hurting from this traumatic experience.

Another principal is to provide support for their current coping strategies, what they might be doing well in their day to day life to take care of themselves while also introducing new coping skills. And the therapies that we're going to talk about in more detail are those therapies that typically explore affective or emotional reactions as well as cognition, the way that someone thinks about what has happened to them, exposure therapy, meaning exposing the individual to their traumatic memories with the notion of making them less anxious about those memories

and/or the use of cognitive restructuring or going about challenging the individual's way of perceiving and making meaning of what has happened to them.

Slide 28: Cognitive Behavior Therapies

The cognitive behavior therapies have probably received the most empirical support for their advocacy in treating sexual assault related PTSD. And exposure based treatments more specifically have been typically a treatment of choice because of that evidence that they have accumulated.

One particular form of exposure based therapy is prolonged exposure which was developed by Dr. Edna Foa and Dr. Barbara Rothbaum and in this particular form of exposure therapy they provide ten sessions of a therapy with sessions devoted to imaginal exposure or exposure to specific scenes or images that the individual has about their memory of the traumatic experience. Also an effort to allow the person to further process what has happened to them in that traumatic situation. The interventions also include in vivo exposure or in real life exposure meaning that the individual is facing those things in the environment that are particularly anxiety provoking to them. And it's important to choose particularly safe experiences that might remind them of the traumatic event so that they can learn mastery and realize that those experiences will not necessarily result in further distress.

There's also an effort to teach the client to use breathing retraining so as to help them slow their breathing and decrease their anxiety while they are facing the traumatic memory of those experiences.

Prolonged exposure also includes homework assignments and this is true of most all of the cognitive behavior therapies. And those homework assignments include listening to a tape, an audio tape of the imaginal exposure that they have done in session where they recount the traumatic event with as much detail as possible expressing their emotions and allowing themselves to sit with those emotions until their distress dissipates. Also homework assignments related to in vivo exposures or exposures in their life. And the breathing retraining practice.

Slide 29: Cognitive Behavior Therapies (cont.)

Another cognitive behavior therapy that has received empirical support is cognitive processing therapy developed by Dr. Patricia Resick originally applied to sexual assault victims and since applied to other trauma populations. This therapy is very much based on an information processing model of PTSD, which relies mostly on how individuals make meaning of events that have happened to them. How they incorporate those traumatic experiences into their beliefs about themselves, about the world and about others.

CPT includes elements of exposure therapy as well as cognitive therapy. The exposure therapy is mostly through having the patient write accounts of the traumatic event or events and reading those accounts to themselves and in session with the therapist.

The later part of the therapy is much more focused on the maladaptive cognitions that the individual may have. For example some trauma survivors may make sense of their traumatic event by blaming themselves. So in some way shape or form they should have seen the sexual assault coming. They should have been able to protect themselves. They shouldn't have had a sexual reaction, all of those different beliefs that they may have as a result of the event. And with the therapist the cognitive processing therapy focus on trying to help the individual figure

out ways that they have been thinking about the event that has kept them stuck, that has not allowed them to recover from the event because of the way that they have perceived the event.

Slide 30: Cognitive Behavior Therapies (cont.)

Another class of cognitive behavioral therapies are focused on anxiety management. So not necessarily on the traumatic event itself and taking the individual back to those traumatic memories with the goal of habituation or making meaning of those events but rather to try to manage the anxiety and distress that's associated with having had a traumatic experience. And stress inoculation training is an example of these anxiety management protocols that has received empirical support. Stress inoculation training or S-I-T or SIT has three phases. The first phase is focused on psychoeducation, teaching the client about the fear conditioning response or how they've learned that certain cues are associated with particular memories. And in the face of those cues and fearful responses teaching them relaxation techniques that can help manage the anxiety or the stress that's associated with those cues.

The second phase of SIT is really focused on skill building and controlling fear reactions with exercises. So using relaxation training to allow the person to relax in the face of their distress or breathing re-training so that they can calm themselves physiologically and not have the level of arousal that they have to the cues and internal responses.

The final phase of the therapy is really focused on trying to get the client to use the skills that they've learned in the skill building phase and apply that outside of the session so that it's generalized to their everyday life and can use the strategies that they've learned not just to manage their anxiety related to trauma cues and trauma reactions but to the day to day stressors of life and anxiety that come with living.

Slide 31: Cognitive Behavior Therapies (cont.)

There are also cognitive behavioral therapies that are focused only on using cognitive therapy or cognitive restructuring techniques that are really usually of two types. One is focused on the client's interpretation of the trauma. So in this case more trauma focused and similar to cognitive processing therapy in that the focus is trying to figure out how the individual has made sense or construed the event, their role in it, the perpetrator's role in it, and to try to disentangle that so that they can have a more accurate interpretation of the event and more relief from their symptoms. So that's a more trauma focused form of cognitive therapy.

There are also cognitive therapies that are being developed that are focused on trying to manage the person's anxiety reaction. So not necessarily focused on the trauma itself but rather how are they making sense of their day to day life, construing situations that are more current day life examples and restructuring those cognitions so that the person is less distressed but not necessarily focused on their traumatic experience.

These cognitive therapies are largely based on Aaron Beck's original cognitive model of depression which was later applied to anxiety and its disorders and focused on using Socratic questioning with the client or questioning that's designed to lead the client down the primrose path of making a better understanding of those particular events or their traumatic experiences. These therapies also often use worksheets or logs, ---thought records--- in the person's day to day life so that they can track their automatic thoughts that they may have in reaction to events and trace how those thoughts are related to their emotions and their behaviors.

Slide 32: Other Treatments

There are other treatments that are being developed or have been tested to treat the symptoms of PTSD and other posttraumatic reactions. Most all of the classes of pharmacological agents have been tested. The anti-depressants and specifically the SSRI's have received the most empirical support. However I think it's important to point out that when people have looked across all of these studies and compared them to psychotherapy trials it appears that the talk therapies or the psychotherapies for posttraumatic stress disorder seem to be more efficacious in treating the symptoms of PTSD. And there are invariably the issues of discontinuing medications and the relapse of PTSD symptoms once the medication has been discontinued.

Eye movement desensitization reprocessing or EMDR has also been tested in the treatment of posttraumatic stress disorder. And the evidence suggests that EMDR is as efficacious as the other psychotherapies in treating posttraumatic disorder. However there has been some controversy about what the active ingredients are of EMDR and specifically whether or not it is necessary that the patient have the particular eye movement that is created in EMDR to create the symptom changes that come as a result of EMDR. It maybe that EMDR is essentially an exposure therapy where the patient is presented with traumatic memories and sit with those traumatic memories until they have left anxiety in facing them and not necessarily about the eye movements per se.

Family or couples therapy has been more recently applied to the treatment of PTSD and that has taken a couple of different forms, both in the way of psychoeducation and providing a psychological explanation of posttraumatic stress disorder for others, significant others, both partners and children, also support groups that are designed to support those significant others in their living with the individual and trying to help and support their recovery from posttraumatic stress disorder. There have also been a few efforts to development family and couples therapies specifically for PTSD that include family members and the person identified with PTSD in those interventions and thinking more systemically about the effects of PTSD and how social support and families and relationships can help in the recovery process for an individual who has PTSD.

There are other treatments that are being developed to treat comorbidities that often go along with posttraumatic stress disorders such as drug abuse or alcohol abuse, dependence. Seeking safety is an example of this type of combined treatment. Seeking safety was developed by Dr. Lisa Najavits and is largely a present focused treatment that is designed with the theme of seeking safety both in terms of how one copes with their PTSD symptoms and also works to achieve and maintain sobriety.

There are also efforts to combine different pharmacotherapies across different classes of pharmacotherapies as well as to mix those pharmacotherapies with the evidence based therapies such as cognitive behavioral therapy both in terms of managing symptoms while doing the more exposure, trauma exposure based therapies as well as certain pharmacological agents that may be helpful in enhancing extinction and learning when applying the evidence based psychotherapies.

Slide 33: Additional Information

For additional information about posttraumatic stress disorder, its [meaning] and treatment we encourage you to visit the National Center for PTSD website which is located at

www.ncptsd.va.gov as well as the National Violence Against Women Prevention Center at the website listed below. And finally at the Rape Abuse and Incest Network at www.rainn.org