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# Counseling Sexual Assaulted Adolescents and Young Adults

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CERTIFICATE OF APPROVAL

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This is to certify that the Capstone Project of

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Abstract

Sexual assault affects men, women and children in the United States. Defining sexual assault and various forms of rape can help to formulate knowledge of the context of assaults that victims experience. There are certain populations that are at risk for sexual victimization. College aged individuals are at a higher risk for sexual assault than any other age group. There are four main risk factors for this age group that contribute to the vulnerability of assault. The impact of assault and rape on survivors can include emotional, physical and psychological issues. For clinicians, evidence -based treatments, understanding risk factors, and the context of assaults helps in treatment and recovery outcomes. Sexual minorities on college campuses are also vulnerable to assaults and may be at a higher risk due to minority stress and status. Prevention and education for this age group can help to advocate and reduce victimization that occurs within this demographic. Knowledge about the context of assaults, the populations that are at risk, and prevention and education can help aid in clinical care for those individuals that are victimized.

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## Introduction

Sexual violence including abuse, rape and assault can have negative psychological affects on it's victims that sometimes can last for years. According to statistics, one out of every six women has been sexually assaulted, estimated occurrence that a person will be assaulted is every two- minutes (Rainn, 2018). Even though these statistics can be staggering, there are still several assaults that go unreported. Counselors working with this population will need to have knowledge of the context of the problem that their clients face as well as evidence -based practices to work with recovery, healing, and prevention (Jackson-Cherry & Erford, 2014). To work effectively with survivors, defining sexual assault and rape helps to understand the severity and degree of the violence that victims experience. Psychological, emotional and physical symptoms will present in counseling, and an understanding of symptomology can help to identify those affected by sexual assault. Competent counselors should be knowledgeable on treatment and interventions to work with this population. The following literature review will address the definition of sexual assault, symptoms and theory- based practices for sexual assault in working with adolescent and young adult survivors. Considerations with sexual and racial minorities as victims of sexual assault will also be reviewed.

## Review of Literature

### Defining the Context of Sexual Assault: Various Forms and Rape

Survivors of a Sexual assault experience various forms and severity of sexual violence. According to Jackson-Cherry and Erford (2014, p 195), the U.S. Department of Justice define sexual assault as an attack or attempted attack involving unwanted sexual contact, either forcible or nonforcibly. Force, does not only imply physical pressure, but also emotional coercion, psychological force, and manipulation to coerce a victim into non-consensual sex. Forms of sexual contact or behavior that occur without consent or force includes attempted rape, fondling or touching, forcing a victim to perform sexual acts including oral sex or penetrating the perpetrator's body, and rape. Rape specifically includes sexual penetration without consent. Penetration of the vagina or anus with any body part or oral penetration of a sex organ of another person without consent (Rainn, 2018).

Rape is defined by four types; acquaintance rape, drug-facilitated, spousal, and statutory. In acquaintance rape, also known as date rape, the victim knows the perpetrator but does not have an intimate relationship with this person. Young women and college students are vulnerable to sexual assaults, especially acquaintance rape (RAINN, 2018). Drug facilitated rape is defined when drugs and/or alcohol are used to compromise an individual's ability to consent to sexual activity. The drugs and/or alcohol are used to inhibit a person's ability to resist the assault. Under the influence of drugs and alcohol, victims are not able to consent to the sexual activity and in many cases do not remember it. Three of the most common drugs used are Rohypnol also known as 'roofies', GHB (Gamma-Hydroxybutyric Acid), and Ketamine, which is a legal anesthetic mostly used on animals. All of these drugs given to the victim can cause blackouts, dizziness, loss of muscle control, confusion, lack of consciousness, and even death (Jackson-

Cherry & Erford, 2014). Spousal rape, also known as intimate partner violence, intimate partner rape, domestic violence, and marital rape involves the victim who is in an intimate relationship with the perpetrator. In spousal rape, one's partner uses force to sexually assault or rape. Spousal rape and assaults usually occur alongside other forms of abusive behavior in the relationship (RAINN, 2018). Statutory rape involves sex with a minor below the age of consent. Each state regulates and defines what the age of consent is. Children or minors are unable to consent and therefore statutory rape is punishable under those laws set by the state (Jackson-Cherry & Erford, 2014).

**Facts and Figures**

Sexual violence can affect men, women, and children. Sexual violence of men and women can occur at any age. It is estimated that a sexual assault occurs every 98 seconds in America according to data gathered RAINN (2018), through the National Crime Victimization Survey (NCVS). Although, these statistics are based on actual reported assaults, many other sexual violent acts go unreported. Within a year that averages out to around 213,000 people are victims of rape or sexual assault (Jackson-Cherry & Erford, 2014). Young people ages 18-24 years of age are at the highest risk of sexual assault at about 54% (see Appendix A) of all assaults committed. What is reported from the data gathered is that women and girls experience violence at a higher rate, with 1 out of every 6 women has been the victim of attempted or completed rape (RAINN, 2018).

Understanding and knowing who the perpetrators are can give insight into the context of the assault. By large, 7 out of 10 rapes are committed by someone known to the victim. Stranger assaults make up 28% of all perpetrators, and current or former spouse, boyfriend or girlfriend make up around 25% of all perpetrators. That leaves acquaintance rape or assault to be

an estimated 45% of all rapes and assaults committed by someone the victim knew (RAINN, 2018). Previous research suggests that men with a history of childhood sexual abuse may be more prone to perpetration of sexual violence in adulthood. One potential explanation for this phenomenon includes the idea that men with childhood sexual assault (CSA) histories have a desire to establish masculinity. It is suggested that in identifying with aggressors it is an urge to gain control (Wilhite, Mallard & Fromme, 2018). In a study conducted by Wilhite, et al. (2018), they examined alcohol levels, blackouts, and CSA in relation to perpetration of sexual coercion and violence. The data results indicated that participants with a history of both blackouts and CSA were at greater risks of sexual coercion perpetration. However, those participants who had a history of CSA but not a history of blackouts were most likely to perpetrate at higher levels of alcohol consumption. Previous research on perpetrators and alcohol suggest that perpetrators tend to hold a strong belief in that alcohol increases their sex drive and tend to consume alcohol prior to sexual acts more than other non-perpetrators (Wilhite, et al., 2018). These differences in the identity of the perpetrators help in understanding the differences in victimization experiences of sexual assaults. Knowledge of who the perpetrators are in relation to the victim and their experience can aid the clinician in the understanding of the assault as well as clinical care (Masters, et al., 2015).

There are certain populations that are at risk for assaults which are the military, spousal, LGBT, and college aged persons. The U.S. Department of Veterans Affairs (VA) defines military sexual trauma (MST) as repeated threatening sexual harassment or physical assault of a sexual nature. It is reported that 1 in 5 women and 1 in 500 men have had trauma from sexual assault in the services. Burgess, et al. (2013), report the unique nature in military assaults in that it occurs in the workplace which places victims to continue to work and live with their perpetrators. In this situation, victims may have to rely on their perpetrators, (if higher rank), for

approval before being referred for medical or psychological care, which adds to the distress and trauma. Furthermore, the Pentagon Reports (DOD, 2012 as cited in Burgess, 2013) an estimated 80-90% of sexual assaults go unreported. In Spousal sexual assault, the perpetrator has a relationship with the victim, including the role of intimate partner. Spousal sexual assault is usually combined with other forms of abusive behavior, and is also estimated to be underreported (RAINN, 2018). In spousal assaults, victims may experience multiple traumatic events and revictimization that adds to the severity and challenges to clinical care. For those that experience revictimization there is a three- times increase of depression and anxiety and a twelve-fold incident of Posttraumatic Stress Disorder (PTSD). By assessing for IVP clinicians can address the larger patterns of victimization that these clients experience (Masters, et al., 2015). The LGBT population is at risk for sexual assault, especially on campus. According to RAINN (2018), TGQN (transgender, genderqueer, nonconforming) individuals are 21% more likely to experience sexual assault compared to 18% non TGQN. Victimization rates on minorities are reported to be the same or higher than heterosexual assaults. Many risk factors can attribute to a higher risk including mental health issues and substance use (Ollen, et al., 2017). College students are a particular at risk, vulnerable population for sexual assault. As stated in the statistics by RAINN (2018), 18-34-year old's make up 54% of all sexual assault victims. College aged students are also more prevalent to acquaintance rape. Therefore, understanding the context, risk factors and severity of the assaults proves to be important factors to consider when treating victims of sexual assault in this particular demographic.

**Risk Factors that Contribute to Assault for College- Aged Victims**

There are four main factors that contribute to sexual assault for young women on campus which are intoxication to the point of incapacitation, being single, previous sexual victimization, and residing on campus (Jackson-Cherry & Erford, 2014).

Alcohol consumption as a major risk factor for sexual assault on campus has been firmly established by many researchers. Alcohol consumption is a part of campus life and researchers Wilhite, et al. (2018), suggest that hazardous style drinking is a factor that attributes to sexual violence. Hazardous drinking is described as shots of liquor, pregaming (drinking prior to an event or activity), and drinking games. These researchers investigated sexual victimization, blackouts and heavy drinking. The data gathered indicated that alcohol increased the risk of sexual assault by 4.4%, but those that had a history of blackouts this risk increased to 6%. Blackouts also cause other outcomes that can have negative social and emotional consequences such as injuries that are alcohol related, suicidal ideation, and doing something that was later regretted (Wilhite, et al., 2018).

Being single on campus can be a risk factor for sexual assault. Previous studies have determined that college students may have a difficult time identifying certain situations as sexual assault (Jackson-Cherry & Erford, 2015). Researchers Flack, et al. (2015) investigated college hookups in determining risky and potential sexual assaults. They define hookups as an intimate dyadic behavior. Hookups are seen as a single sexual encounter that may or may not entail further contact between the partners. Previous research has demonstrated that hooking up is associated with unwanted sex and can also include sexual assault or rape. In their study of female college students, the researchers Flack, et al. (2015), investigated different types of hookups to determine different risks associated with it. The data collected from the research revealed that hookups are related to sexual assault and heavy alcohol consumptions.

Revictimization is defined as sexual victimization that occurs in childhood and again in adulthood. Revictimization can include more than one perpetrator during separate events either in adolescents or adulthood (Masters, et al., 2015). College students who have been previously sexually victimized or have experienced childhood sexual trauma have a higher rate of being

revictimized. Longitudinal data suggests that experiencing a sexual assault by 13 years of age is a significant predictor of experiencing adult sexual assault (Angelone, et al., 2018). Individuals who have been previously victimized not only are at risk for revictimization, they also experience an increase in the psychological symptoms compared to individuals who do not have a history of victimization. The increase in symptoms can include an increase of three times in depression and anxiety symptoms and PTSD (Masters, et al., 2015).

Individuals who reside on campus are at a higher risk for sexual assaults and victimization. According to Angelone, et al. (2018), 20% of college students are victimized during undergraduate, and up to 80% report victimization occurring before the age of 25. It is suggested that the high prevalence of sexual assaults on campus can be attributed to new peer groups, newfound freedom, access to illegal drugs and alcohol and inexperience with sexual behavior. With the evidence provided by researchers including alcohol, age, being single and previous victimization clinician should be aware of how this risk factor can impact students. College students are at particular risk during certain times of the year. According to RAINN (2018), August, September, October, and November of the first semester are when 50% of all assaults occur on campus.

**Psychological, Emotional and Physical Effects of Sexual Assault**

The effects of sexual violence and sexual assault can lead to multiple negative symptoms of the psychological, emotional and physical domain. Understanding these effects can help to utilize effective counseling interventions and lead to more positive recovery. When victims experience the trauma of a sexual assault some develop posttraumatic stress disorder. According to the DSM-5 (American Psychiatric Association, 2013), the criteria for PTSD is exposure or threatened death, serious injury, or sexual violence. This can be directly experienced or

witnessing the event. Symptoms of PTSD include distressing or recurrent memories, recurrent or distressing dreams, flashbacks, and distorted cognitions and negative mood. These are but a few out of a cluster of symptoms that can develop. Many other psychological and emotional effects can develop in response of sexual assault which include depression, anxiety, increased alcohol consumption, and trauma. Maladaptive coping from these experiences can lead to substance use, eating disorders, or withdrawal from social environments (Cherry-Jackson & Erford, 2014). Physical effects can include pregnancy, sexual transmitted diseases and other somatic problems. such as pain with intercourse. Sexual trauma can also lead to sexual dysfunction in relationships or gynecological problems such as pain with intercourse (Tambling, 2012).

In a study done by Masters, et al. (2015), researchers identified three subgroups of sexual assault survivors based on their victimized experiences. The three subgroups were those that had sexual contact or attempted assault, incapacitated assault, and forceful severe assault. After empirically identifying the three subgroups, researchers examined whether or how the groups according to their victimization experiences differed in terms of psychological distress. The results of their study revealed different subgroups of sexual assault experience also had difference associations with negative outcomes (Masters, et al., 2015). It is not surprising therefore, that the more severe the trauma the higher the psychological distress. Masters, et al. (2015), research also indicated that though the psychological distress was higher for more severe assaults, that distress symptoms were also high or similar for those who were incapacitated or drinking during the assault.

For survivors, having to disclose the assault can add to the psychological distress that they are already experiencing. In a study done by DeCue, et al. (2017), those that do experience assault and develop psychological distress and PTSD may also experience shame, guilt and self-blame. The researchers hypothesized that shame was a strong predictor of PTSD symptoms and

it attributed to perceived negative reactions of disclosure to close acquaintances or negative social or cultural feedback. Social reactions to disclosure included victim blaming, being treated differently, and experiencing others' attempt to distract from the assault. The results of this study found that shame may account for why some sexual assault survivors experience significant symptoms and others do not and that not all survivors develop psychological distress symptomology (DeCue, et al., 2017). This research can help clinicians in treatment with survivors by developing an understanding on how shame correlates with PTSD and how it impacts disclosure issues.

Similar to the research of DeCue, et al. (2017), Peter-Hagen and Ullman (2015), investigated alcohol as a factor in assaults and the impact on recovery outcomes. They determined that alcohol related assaults resulted in more negative social reactions, self-blame and maladaptive coping which can increase PTSD symptoms. Their research also correlated with the results of Masters, et al. (2015), in that despite lower levels of violence in incapacitated assaults, women who were drinking at the time were more likely to develop diagnostic criteria for PTSD. This relation can be linked to the shame and self-blame that women may feel due to the alcohol use during the time of the assault (Peter-Hagen & Ullman, 2015).

**Evidence-Based Treatments**

Counseling survivors of sexual assault includes understanding the context of the assault, symptomology, and evidence- based treatments that are effective. If assaults are severe and violent in nature the first intervention will be the emergency room or a crisis center. Medical intervention can add to the distress, anxiety, and vulnerability of victims due to the nature of gathering evidence and the physical exam. Medical personnel will likely direct victims to crisis counseling where safety, stabilization, gathering information, connection with social support and

linking them with ongoing services (Jackson-Cherry & Erford, 2014). For many victims, especially those that were incapacitated during the assault may not seek recovery or counseling until later due to feelings of shame, self-blame, or perceived negative feedback. Peter-Haggen and Ullman (2018), report in their study of the longitudinal effects of sexual assaults that the characteristics of self-blame can be found to be related to worse recovery outcomes. The researchers distinguished between two forms of self -blame; behavioral and characterological. Behavioral self-blame attributions are situational in that the belief of one's action are due to the circumstances. Behavioral self- blame can be less detrimental to recovery and the researchers propose that perhaps victims feel they can avoid or protect themselves from this type of situation. Characterological self-blame attributions are dispositional beliefs about one's character or personality. Characterological self-blame can be extremely detrimental to the recovery process because the victim may believe that certain aspects of their personality or person would predispose them to victimization. The assault then, is a reflection of who they are or that the assault was deserved. This type of self-blame has stronger negative effects on the victim and makes recovery more difficult (Peter-Hagen & Ullman, 2018). A holistic view of counseling victims will incorporate recovery for psychological, emotional, physical, and mental healing in an individual's context of the issue.

Evidence based treatments and interventions provide a framework for working with victims of assault. Assessments at the beginning of the initial counseling provides the counselor with the necessary characteristics of the assault and symptomology of the victims (Masters, et al., 2015). The theory -based approaches that seem to be most efficacious to treatment of assault would be cognitive behavioral approaches. As Peter-Hagen and Ullman (2018), point out that working with victims who self-blame using cognitive behavioral techniques and interventions can help work towards the recovery process. Other theory- based approaches include trauma-

focused cognitive behavioral therapy, exposure therapy, and eye movement desensitization and reprocessing (EMDR). Psychoeducation about sexual assault as well as training programs for dealing with anxiety and stress or learning relaxation techniques can also add to the recovery process for victims. Group therapy help victims feel less isolated and supported as they process and work towards healing (Jackson-Cherry & Erford, 2014). For some treatment interventions specialized training for counselors is needed. Which perspective is most effective and why? This can depend on the counselor, the therapeutic relationship, and the context of the trauma of the victim. Russel and Davis (2007), examined twenty-five years of empirical research on treatment for sexual assault. The findings of the investigation confirm that cognitive behavioral approaches and exposure therapy are most effective in treatment of sexual assault. Other treatment models also showed significant improvement overall with victims. The initial anxiety following an assault has been correlated with increased risk for psychological distress and the researchers point out that early intervention can also have significant effect on long-term distress. The researchers also pointed out that though the negative effects of assault on sexual functioning are well documented, none of the studies measured the effect of treatment in this symptom cluster (Russel & Davis, 2007). Since many victims may not seek help directly after an assault, many may present to therapy much later for this concern.

**Multicultural Considerations**

Sexual minorities on campus are no exception to sexual violence and assault. According to researchers Ollen, et al. (2017), victimization rates for minority students on campus can be the same or higher than their heterosexual counterparts. One reason may be due to minority stress, which is the impact of socially marginalized groups experience from stress stigma due to minority status. The underlining assumptions is that minority stress is unique to a stigmatized group and is chronic and socially/culturally embedded (Meyers, 1995,2003, as cited in Ollen, et

al., 2018). In their investigation on minority sexual assault the researchers explored differences in perceptions of sexual assault, identified help-seeking barriers, and identified protective factors for this population. Under the minority stress framework, data collected suggest that minorities perceptions of sexual assault differ from heterosexuals in that they perceive sexual assaults to occur less frequently in their communities and that they have a lack of knowledge about consent. The risk factors that Ollen, et al. (2017), identified for sexual minorities were substance use, psychological health issues, unique stressors due to their marginalized identities, and heteronormative gender stereotypes. The researchers suggest that these risk factors occur at higher rates than heterosexual individuals (Ollen, et al., 2017). Alcohol use has been identified as a risk factor for sexual assault. Researchers have suggested that sexual minorities may have higher rates of alcohol use due to minority stress, adding to a higher risk factor for assaults.

Ollen, et al. (2017), found that minority stress also underlined barriers to seek help and counseling for students on campus. Their findings revealed that sexual minorities feared further marginalization, concern for tarnishing the reputation of their community, and difficulty navigating services due to heteronormative ideas about sex. The lack of confidence in providers' understanding of sexual minorities also contribute to help-seeking barriers. Other barriers included the burden of disclosing one's orientation and a lack of resources as perceived as safe and accepting.

Protective factors can help to educate and eliminate some of the help-seeking barriers and perceptions for sexual minorities. The protective factors that were reported by the students included a key element; communication. Communication can include that providers and counselors at the university level improve resources by making them more inclusive. Counselors can also increase awareness on campus of university policies that help in the understanding of the steps and process of reporting and educating assaults on campus. Along with

communication, campus counselors can help address issues of consent with sexual minority students through education (Ollen, et al., 2018)

**Prevention and Protective Factors of Sexual Assault**

Sexual assaults have seen a decline in recent years (see Appendix B). Although efforts have been put forth in reducing this crime it is estimated that there is still a 20-25% of violence on college campuses. Also included is the realization that there is still a large percentage of sexual assaults or violence that go unreported on campuses (Conley, et al., 2017). Sexual violence and violence against women worldwide have been occurring at widespread rates. Because of the epidemic problems of sexual assault pressure from the federal government to address these concerns on campuses across the United States have initiated mandates to the problem (Flack, et al., 2015). To improve prevention and programing mandates from Title IX and Campus Sexual Violence Elimination (SaVe) Act, college and university campuses are required to offer sexual violence prevention programing and support services to survivors. Some of these mandates include opportunities to request housing change for survivors, increasing campus security, resources and services for students and prevention programming on campuses (Conley, et al., 2017).

Previous research on sexual assault has documented both risk factors and protective factors that can lead to more effective programs and prevention. Researchers Conley, et al. (2017), sought to investigate and identify possible risk and protective factors that may inform education and prevention efforts across all college aged students. Risk factors identified in their research include alcohol consumption, previous CSA, and assessing for Potential Traumatic Event (PTE) that could lead to PTSD. Their investigation also included facets of early environment including parenting, devious behavior, and personality to investigate a correlation

to risk of assault. The results of their research correspond to other researchers in that alcohol and previous CSA are main risk factors. Their research also revealed another potential risk in that of personality. They assessed personality in traits of neuroticism, openness, extraversion, and conscientiousness. Their results indicated that men who were more open were at greater risks for broad SA's in college. This may be attributed that men are not socialized to fear and expect victimization as women do. The results for women coincide with past research that women who are more extraversion, had a lifetime of alcohol use, and experienced depression had a higher risk for potential SA's on campus. Suggestions made by these researchers include risk-reduction education and increasing protective factors such as social support and resources. Their suggestions coincide with Ollen, et al. (2017), in that both educating about risk factors and increasing protective factors on campus can help begin to reduce violence and crime.

## Conclusion

Sexual assault and violence affect women and men of any age and demographic. Sexual assault can have physical, psychological and emotional effects on survivors that can last for years. For clinicians, knowledge of the differences in assaults, the context, symptomology and evidence -based treatments is essential in competent clinical care in this area. Clinicians should be knowledgeable about the differences of assaults and rapes and those that are considered at-risk populations. Young people aged 7-24 years of age are in the highest risk (54%) for sexual assault and rape (RAINN, 2018). Understanding the risk factors that contribute to assaults and identifying protective factors helps in creating prevention and programing to reduce the threat of violence on campus and for this age group. The research in this literature review indicates both the risks of assaults and identifies those who may be more at risk. In understanding all the aspects of sexual assaults clinicians can be prepared for clinical care and advocacy.

## Author's Note

The opportunity to research and learn more about sexual assault and victimization has given me depth to the problem that so many individuals face. Sexual assault is a heinous crime that can have devasting effects on one's life. During the process of researching, writing, and learning about assault I have realized that so much of what the researchers have indicated is true and have been able to develop my clinical skills in this this area. The value that I take from this topic for my Capstone Project is the importance of advocacy and education. To eradicate this problem from society is of importance and continuing prevention measures on all levels in all demographic areas must continue.

I am grateful for the education that I received from Winona State University and want to thank the professors in the Counseling Education Department for their dedication and support through my education experience.

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# Appendix A

RAINN (2018), Retrieved from www.rainn.org

## Appendix B

RAINN (2018), Retrieved from www.rainn.org