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Psychological First Aid in Sexual Assault Cases

Cinsel Saldırı Olgularında Psikolojik İlk Yardım

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Abstract

Sexual assaults often targeting women, co-occur with other forms of violence, may cause physical injuries and psychological harm in victims. A significant number of sexual assault victims do not make legal notifications and those who do exceed the critical time required for collecting evidence. According to the literature, this is related to myths about sexual violence, stigmatization, not perceiving non-consensual sexual behavior as violence in intimate relationships, and the trauma reminding effect of forensic examination. Uncertainties about how to plan the life after a legal notification is another factor that affects the victim's help-seeking behavior. The aim, timing, and stages of psychological first aid addressed in this review. Psychological first aid aims to address the safety needs and negative feelings of the victim and to inform about the availability of resources when they feel ready to seek help in the short term. It helps to reduce the psychological trauma of the victim in the long run. The intervention consists of establishing a relationship with the victim, identifying problems, dealing with feelings, discovering alternatives, developing an action plan and follow-up. Psychological first aid not only ensures the collecting evidence by providing healthcare worker-victim cooperation but also the preparation of the victim's safety plan and reduce the emotional trauma.

Keywords: Sexual violence, first-aid, crisis intervention, posttraumatic stress disorders, rape

Öz

Cinsel saldırılar sıklıkla kadınları hedef almakta, diğer şiddet formları ile birlikte görülmekte, mağdurlarda fiziksel yaralanmalara ve psikolojik örselenmeye yol açabilmektedir. Cinsel saldırı mağdurlarının önemli bir kısmı adli bildirim yapmamakta, bildirim yapanlar ise delillerin toplanması için gereken kritik süreyi aşmaktadır. Alanyazında bu durumun cinsel şiddetle ilgili yanlış inanışlar, damgalanma, yakın ilişki içinde rıza dışı cinsel ilişkilerin şiddet olarak algılanmaması ve adli muayenenin travmayı hatırlatıcı etkisi ile ilişkili olduğu belirtilmiştir. Adli bildirim sonrasında hayatını nasıl planlayacağıyla ilgili bilinmezlikler mağdurun yardım arama davranışını etkileyen bir başka faktördür. Bu derlemede cinsel saldırı durumunda psikolojik ilkyardımın amacı, zamanlaması ve müdahalenin aşamaları ele alınmıştır. Psikolojik ilkyardım kısa vadede mağdurun güvenlik ihtiyacı ve olumsuz duygularını ele almayı, yardım almaya hazır hissettiğinde ulaşabileceği kaynakların varlığıyla ilgili bilgilendirmeyi hedeflemektedir. Uzun vadede ise mağdurdaki psikolojik örselenmeyi azaltmaya yardımcı olmaktadır. Müdahale mağdurla ilişkinin kurulması, problemlerin tanımlanması, duyguların ele alınması, alternatiflerin keşfedilmesi, eylem planının geliştirilmesi ve takip aşamalarından oluşmaktadır. Psikolojik ilk yardım sadece sağlık çalışanı- hasta kooperasyonunu sağlayarak delillerin sağlıklı bir şekilde toplanmasını sağlamakla kalmaz aynı zamanda mağdurun güvenlik planının hazırlanmasına ve duygusal örselenmesinin azaltmasına da katkı sağlamaktadır.

Anahtar sözcükler: Cinsel şiddet, ilk yardım, kriz müdahalesi, travma sonrası stres bozukluğu, tecavüz

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REGARDLESS of the relationship with the survivor, any non-consensual sexual or verbal act by any person in any setting, including home or work, is considered sexual violence [World Health Organization (WHO) 2002]. These acts, ranging from verbal harassment to rape, may occur in situations that the survivor cannot consent because of being under the influence of alcohol or drugs and may include not only physical coercion but also psychological violence (Krug et al. 2002). Sexual violence co-occurs with other forms of violence, and men can also be the survivors (Alsaker et al. 2012, Vu et al. 2014). However, survivors tend to hesitate to seek help due to personal or cultural reasons (Masho and Alvanzo 2009). World Health Organization (WHO 2020) announced that sexual violence has a short and long-term impact on women's physical, mental, sexual, and reproductive health. Yet, the ability to understand and prevent these impacts due to low reporting rates and lack of follow-up services is limited (Holmes et al. 1998).

While reports presented male cases, community-based studies generally reported women as survivors and men as perpetrators who were often acquainted with the survivors. The prevalence of sexual violence was reported as 22% for women and 3.8% for men in Elliott et al. (2004). Tjaden and Thonnes (2006) reported that every one in six women is exposed to lifetime sexual violence while this rate was every one in 33 for men. According to a WHO (2013) report titled the "Global Status Report of Violence Prevention," one in three women globally is exposed to physical or sexual violence at least once. In a community-based study conducted with university students in Turkey, 44.8% of participants reported that they experienced sexual violence, including touching (Kayı et al. 2000). In other studies conducted in Turkey, 12% of the perpetrators were the husband or partner of the survivors (Yüksel-Kaptanoğlu et al. 2015), and perpetrators were acquaintances in two of three cases who were consulted to the hospital by legal authorities (Tetik et al. 2019).

Sexual violence frequently co-occurs with other forms of violence. A six-year cohort study revealed that 26.1% of women experienced two forms while 14.8% experienced all three forms of violence among women who experienced physical, sexual, or psychological violence (Leithner et al. 2009). Palmer et al. (2004) reported that 46% of women who consulted a hospital for forensic examination 72 hours after sexual assault had extra-genital injuries. Thereby, sexual violence is considered either an indicator of the presence of other forms or an increase in the severity of violence (Coker et al. 2000).

Sexual violence causes psychological traumas in addition to physical injuries. 61.3% of sexual violence survivors who consulted the Council of Forensic Medicine in Turkey met the criteria of post-traumatic stress disorder (PTSD) (Gölge et al. 2014). A review study findings revealed that 13%-51% of survivors had depression symptoms, 23%-44% had suicidal ideation, and 2%-19% had suicide attempts (Campbell et al. 2009). Although these psychological problems are expected to decrease within a few months after the incident, having emotional difficulties in two years is not considered rare (Koss and Figueredo 2004).

Sexual assaults may occur at an unexpected time when there is nobody around to ask for help. The survivors may not have the ability to avoid the assault due to the perpetrator's threats of harm or intoxication (Galliano et al. 1993, Fırat and Erk 2019). They may feel

helpless, lose power and control, and face death (Welch and Mason 2007). The survivors have often experienced the assault alone and might face questions regarding their roles in the incident, unlike other traumatic experiences (Gölge et al. 2000). As the crime scene is the survivor's own body, it can be hard to leave the traumatic experience behind.

A considerable number of survivors of sexual assault do not report (Langton et al. 2012, Morgan and Kena, 2018). This is related to factors such as feelings of shame and guilt, being afraid of family members hearing, fear of retaliation by the perpetrator (Feldhaus et al. 2000, Wolf et al. 2003, Sable et al. 2006); and not perceiving non-consensual sex as sexual violence in the intimate relationships (Rossi et al. 1974). Another factor associated with low reporting rates is the evocation of traumatic memories through the exposure to the questioning and thorough forensic examination (Barutçu et al. 1999, Tillman et al. 2010, Demirer et al. 2013). Therefore, establishing sexual violence crisis centers that respond to the needs of survivors and standardize the service provided is substantial. The development of unique service models for survivors was among the national aims in the National Action Plan on Combating Violence against Women in the period between 2016 and 2020, prepared by the Ministry of Family and Social Policies in Turkey (Aile ve Sosyal Politikalar Bakanlığı 2016). The psychological first aid model for sexual assault survivors might be applied to a crisis center, as presented in this review.

Psychological debriefing versus psychological first aid

Psychological debriefing is defined as a psychological intervention method that aims to prevent long-term distress and the development of PTSD after a traumatic event [American Psychological Association, (APA) 2021]. This one-session intervention is applied by professionals working in the field within three days of the traumatic event and aims to normalize the traumatic event (Bisson et al. 2000).

The roots of psychological debriefing and psychological first aid (PFA) began to lay with the research aimed at returning soldiers who experienced war trauma to the battlefield as quickly as possible during and after World War I. The first step of psychological debriefing is taken by General Samuel Marshall, who realized that the soldiers experienced emotional relief using historical group debriefing when he was in the American army during World War II (Dyk et al. 2010). Following this model, Mitchell (1983) proposed the critical incidents stress model in seven steps as the psychological debriefing model. These seven steps include talking about the questions of where, when, and how, sharing thoughts and feelings about the event, assessment of PTSD symptoms, providing psychoeducation about normal reactions to such event, and referral of individuals, if needed, to long-term psychological support (Everly et al. 2000). Although the model has been in use for a long time to prevent PTSD development, it has become controversial for two decades that it does not affect the development or decrease of PTSD symptoms (Kenardy 2000, Rose et al. 2002). Meta-analytic studies revealed that psychological debriefing applied to encourage individuals to talk about the event's details may cause an increase in the individuals' stress levels (Arendt et al. 2001, Sijbrandij et al. 2006, Wei et al. 2010). According to WHO (2012), psychological

debriefing should not be used as an intervention method for individuals who have recently experienced a traumatic event and presented this as a strong recommendation based on studies conducted until 2009.

Similar to psychological debriefing, PFA is an intervention method for individuals exposed to a traumatic event after the incident. According to a definition of WHO (2016), PFA is accepted as the basic and supportive assistance for distressed individuals. This assistance includes identifying needs and concerns, helping them feel calm, listening when they are willing to talk, and referral to service to provide their needs. Psychological first aid differs from psychological debriefings, such as not asking individuals to analyze what happened or a detailed discussion of the distressing event.

Objectives of the psychological first aid

The primary objective of PFA is to provide the individuals who need a safe, calm, and hopeful place, enable social, physical, and emotional support by promoting to connect with others, and reduce the feeling of losing control. According to WHO (2011), providing psychological first aid by respecting individuals' socio-cultural values, age, gender, and privacy in the guide prepared for field workers in 33 languages in 2011.

Sexual assaults harm the physical integrity of survivors and affect their just-world beliefs (Janoff-Bulman and Morgan 1994, Harris and Valentiner 2002). Realizing to be vulnerable to dangers affects survivors' cognitive appraisals, such as self-control and self-esteem (Resick 1993, Perilloux et al. 2012). The change of survivors' pre-assault perceptions harms their psychological adjustments, which indicate a crisis. At this point, PFA promotes survivors to feel that the threat is over and that they are safe now, and it provides a safety plan on what to do after reporting. Psychological first aid aims to assist survivors in meeting their basic needs rather than determining the mental health status of the survivor (Ruzek et al. 2007).

Studies showed that PFA reduces PTSD symptoms characterized by insomnia, nervousness, sudden outbursts of anger, or feelings of guilt. Chivers-Wilson (2006) reported that the rate of PTSD in individuals who are survivors of sexual assault is much higher (50%) than in the general population (7.8%), which is explained by irregularities in the axis of HPA (hypothalamic -pituitary-adrenal), which handles stress response regulation. Dworkin and Schumacher (2018) explored the role of PFA in PTSD development after exposure to sexual assault. Their findings have shown that perceived PFA is positively associated to lesser PTSD symptom development. Thus, adequately provided PFA is a source of support for the sexual assault survivors.

Timing of the psychological first aid

Studies showed that survivors may not be open to therapeutic alliance just after the traumatic experience as they would be in shock (Wessely et al. 2000, Sijbrandij et al. 2006); yet, WHO (2011), in the Guidance for Field Workers advice to assist survivors in the first contact. The services that survivors receive help in are often rape crisis centers and hospitals consulted for forensic examination. However, the survivors may be afraid of the forensic examination

process because of the reminder effect of the assault or fear of pain (Barutçu et al. 1999). For example, in the study of Yılmaz et al. (2011), 70.3% of the cases applied for examination 72 hours or more after the assault. However, the optimal time for forensic examination is the first 72 hours after the assault to collect as much DNA evidence as possible (Linden 2011).

Steps of the psychological first aid

Although many crisis intervention models are presented in the literature, the general approach in all models is that the first thing to do is to determine the individuals' physical, psychological, social needs, and resources (Roberts 2002). We applied the seven-steps crisis intervention model proposed by Roberts (2001) for the cases of sexual assault.

Step 1. Assessment of lethality

The first step is assessing the threat to the individual at that moment. In the case of sexual assault, assessment of the lethality is whether the assault was systematic or one-time and whether there is an ongoing thread. This is because the first step of crisis intervention is to cease the crisis at first.

Step 2. Establishing rapport

Establishing rapport is a key factor in all clinical practices. In crises, individuals need to be understood and supported. The professional should take care of going at the pace of the individual experiencing the crisis while using techniques, such as attentive listening, reflection, and open-ended questions during the interview process. Only in the presence of a good rapport would the crisis intervention be effective. Thus, all individuals in interaction with the survivor, including the law enforcers and healthcare professionals, should act accordingly.

Individuals internalize the myths and judge themselves with these myths in cases such as sexual assault. The professionals interacting with the survivor after the assault (law enforcers, healthcare professionals, judges, prosecutors, etc.) are not exempt from these myths. Gölge et al. (1999) reported that 40% of forensic experts, 38% of prosecutor and judges, and 66% of law enforcers have thoughts that women's appearance and behaviors provoke sexual assaults, good women would not experience sexual assault, and most accusations of sexual assault are false. The survivors in such a situation would like to hear from others that they are not responsible for the assault, and there is no need for them to feel guilty or ashamed. The interacting professional must be in this manner toward the survivor.

Step 3. Identifying problems

This step includes determining the physical, social, and psychological harm to the survivor. The medical examination conducted by the healthcare professional comprises detection of injuries, sexually transmitted diseases, and pregnancy.

As stated above, the survivors may be unwilling or even reject the forensic

examination as they experienced the assault on their bodies. Barutçu et al. (1999) reported that 89% of the survivors stated that the forensic examination was their first gynecological examination. Therefore, the healthcare professionals should explain why this examination is necessary and ask for consent before starting to reduce the perceived psychological harm. Asking for consent in each step of the examination is not only a legal obligation but also gives survivors a sense of control. Also, problem identification includes determining the perpetrator(s), conditions of the assault, and barriers to seeking help. In case of repeated sexual assaults, problem identification may be more detailed because repeated exposure to trauma may change emotion regulation (Levy-Gigi et al. 2014). Josse (2010) reported that sexual assaults cause changes in the survivors' perception of themselves and society.

The evidence collection process by a trained professional can take up to six hours. Physical evidence is more likely to be found at the examination within 72 hours post-assault (Maguire et al. 2009). Laboratory investigation focuses on tests for STD and pregnancy (Workowski et al. 2015). A pregnancy test must be applied for women of reproductive age, and emergency postcoital contraception should be recommended (Glasier 1997). In the treatment process, fractures and injuries should be treated as a priority, and then the focus should be on STD (including hepatitis B and HIV) and pregnancy (Linden et al. 2017). Individuals must be informed about emergency contraceptives and medical abortion at an early stage in case of pregnancy. Vaginal, anal, and oral traumas, and not using a condom are risk factors for STD (Gostin et al. 1994). Survivors must be informed about prophylactic treatments in case of STD (Kutlu and Seringen 2010). Empiric treatment must be provided for the survivor, and she must be vaccinated (hepatitis B and HPV) in STD. If the survivor has already been pregnant during the assault, the gynecologist should hospitalize the woman and follow up the fetus during the hospitalization.

Step 4. Dealing with feelings

Defining the feelings in reaction to the event and interpreting these feelings in the guidance with the counselor is crucial. Feelings of shock, fear, shame, disgust, and uncertainty in the short term and depending on the severity of the assault, suicidal ideation, depression, anxiety, impairment in sexual functions, and PTSD in the long-term may be observed (Hanson 1990, Mackey et al. 1992, Resick 1993, Koss et al. 2003, Demiralp and Sarıkoç 2016). Yet, there are cases reported as not having any psychological symptoms in the short or long term (Eyüpoğlu 2008). Defining, interpreting, and normalizing feelings in the interview with the survivors is essential. It is also necessary to talk about what the survivor has felt since in case of systematic assault. Helplessness may manifest in the form of ignoring feelings in such assaults (Fang et al. 2020).

Step 5. Exploring alternatives

The crisis arises due to the inability to find an effective alternative to the adverse conditions. In sexual assaults, particularly for the systematic assaults, a sense of hopelessness and

desperation may affect help-seeking behavior. Working on finding alternatives that may prevent the assaults in the future would maximize the sense of control and minimize the despair.

Step 6. Developing an action plan

Developing an action plan constitutes one of the active responses in crises. In sexual assaults, uncertainties about planning life after reporting affect help-seeking behavior. Providing safe and trustworthy sources for the survivor who has lost trust after that traumatic experience is essential (Aşırdizer 2006). For survivors, the action plan is called a safety plan. The safety plan should be unique to the individual and may include providing a place in a shelter if necessary and the phone numbers to call in an emergency. During the interview, with whom the survivor accompanies, where will the survivor go after the forensic examination, whether the survivor's house is safe, what will the survivor do in a possibly dangerous situation must be questioned. Sharing the address and telephone information of the institutions from where they can receive assistance may prevent further harm.

Step 7. Follow-up

This step includes checking the psychological and physical needs of the survivor and referral to long-term therapy in necessity. Rothbaum et al. (1992) reported that 90% of survivors had PTSD symptoms in two weeks, while almost half of those showed these symptoms in three months after the assault. Studies presented EMDR (Rothbaum et al. 2005) and trauma-focused cognitive behavioral therapy (Bisson and Andrew 2007) as effective therapeutic methods in reducing the trauma symptoms. Furthermore, trauma-focused group therapy has a significant effect on reducing PTSD symptoms (Sloan et al. 2013, Castillo et al. 2016, Schwartze et al. 2017). The mechanism of psychotherapy methods is not the topic of this article, but all three approaches involving emotion regulation related to traumatic memories.

The functionality of the safety plan and the availability of the sources are parts of the follow-up step. Including family members in the process as social support may maintain the psychological and physical well-being of the survivor. Yet, this should be decided by a professional only if it is necessary and appropriate; otherwise, as Bokszczanin (2008) warned, overprotective and childish behavior by family members toward the survivor may prompt PTSD symptom development.

The other essential part is the gynecological follow-up of the survivor. As specified in the U.S. Centers for Disease Prevention and Control guideline, if the survivor has not got treatment for STD, she must be called in a week to follow the tests. In this control, the survivor must have a pregnancy test, even though she already had it negative. Those who reject prophylactic treatment must retest for gonorrhea, chlamydia, trichomoniasis, and bacterial vaginosis a week later post-assault. Testing is indicated for those who develop intermediate symptoms and those who request a test. The survivor must be assessed for STD two weeks later, retested for pregnancy, HIV, HCV, syphilis, and administered the second dose of the vaccination six weeks after the assault. The survivor should be recalled

for retest for HIV, HCV, and syphilis after three months, for HIV, and the last vaccine doses after six months (Workowski et al. 2015, Vrees 2017). Individuals must avoid sexual intercourse until the end of prophylactic treatment and use condoms until the serological test results. Lastly, if the survivor is pregnant, she must be encouraged to have regular visits to the gynecologist.

Conclusion

The Turkish government has decided to establish crisis centers for survivors, including a forensic examination and psychological support. Such services for taking testimony and the forensic examination for children who are survivors of sexual abuse and for adults and their children who experienced or are in danger of domestic violence are available. The objective of PFA is to empower and support the survivor emotionally. The establishment of these centers and the implementation of PFA in these centers may prevent the survivors from being exposed to secondary trauma. Besides, considering that the survivor is often the only person who can identify the perpetrator, the emotional empowerment of the survivor will allow the manifestation of justice.

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