Trauma in Rapes and Assaults

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This entry describes that psychological trauma in rapes and assaults is a serious public health issue.

Keywords: trauma ; rape

1. Nature of Traumatic Experiences

Traumatic assaults on the subjects that people are tasked with treating consist of physical or sexual violence; either with a mainly utilitarian goal (theft) or a perverse one (an assault with no other aim than itself); either in a professional context (armed assault, altercation at a shop counter, or behind a bus wheel) or a civil one ("suburban uprising"); either in an international setting (war) or a societal one (violent political confrontation); either on isolated subjects (rape) or on groups (hostages); and they can be further complicated by facts of another nature (traumatic loss and/or separation). As there is an intersubjectivity between a victim and an aggressor, these events stand out from other potentially traumatic situations, such as natural disasters for instance, in which traumatised subjects do not feel that they have been objectified by an aggressor through a sadistic relationship.

Psychological traumas predominantly involve children and adolescents; moreover, they mainly consist in physical and sexual maltreatment [1]. In the *Medico-Judicial Unit Center for Sexual Violence Victims* in Tours, about three-quarters of the patients are underage. A national survey was conducted among several thousand adolescents representing the general population, in collaboration with Marie Choquet's "*Adolescent Health*" group (INSERM U472). It revealed that almost one out of five adolescents had experienced physical or sexual assaults, and that although the number of sexual assaults probably does not exceed that of physical assaults, most of the time their psychological consequences do considerably exceed those of physical assaults [2].

Indeed, not all of the various situations which are likely to generate traumas have the same intensity levels in their consequences, just as not all subjects have the same resistance levels. Moreover, the context or sequence in which the trauma occurs influences its psychopathological evolution. In particular, on top of the usual psychotraumatic clinical consequences, the chronic reiteration of trauma creates other specific clinical manifestations of its own. Therefore, suffering from a car accident but then being warmly supported by family or friends is not the same as suffering from war abuse for several years [3]; similarly, the wound caused by a single rape event endured by a thirty-year-old is not the same as the one caused by incest endured from one's own father every day from six to sixteen years old [4]. With that in mind, knowing the differences between boys and girls regarding rapes and assaults is important. Boys who have been subjected to sexual assaults represent no less than a quarter of victims. These boys' psychological distress is hardly less severe than that of girls. Moreover, distress expressed via deviant behaviours, which are a behavioural surfeit to psychological distress, are much more prevalent in boys than in girls [5].

Ultimately, like Edna Foa [6], we introduce rape as the first cause of psychological trauma, at least in peacetime, and maybe even in times of war, as rapes by mercenaries are as old as time. Our statement is based firstly on the numerous occurrences of this potentially traumatic wound; almost two million women have experienced rape in France, according to the INSERM team from Bicêtre [7], confirmed by the *Comité Français d'Education pour la Santé* [8]. It is also based on the fact that this event is highly trauma-inducing [1]. Indeed, re-experiencing traumatic syndrome chronically persists in most cases, and even more so if the rape was incestuous [3][4]. In fact, among psychiatric inpatients, when subjects suffer from a trauma history, most of the time it is a sexual one [9].

2. Trauma Clinics

Several psychotraumatic syndromes appear after experiencing rapes or assaults [10]. They each have a distinct semiology and independent evolution. We isolated three of them [9][10]: *dissociative and phobic traumatic syndrome, re-experiencing traumatic syndrome,* and *borderline-like traumatic syndrome*. They are generally triggered all at the same time or in close

succession. Re-experiencing traumatic syndrome is profound; however, by many accounts, the other two are much more worrying, particularly in relation to children and adolescents, because they generate severe disorders in their psychological development [11].

Dissociative and phobic traumatic syndrome represents the way subjects defend themselves during the traumatic event and then attempt to treat both their identity wound and their re-experiences, respectively, by fragmenting their memory and psyche and by avoiding the world. What we call “dissociation” is a phenomenon that is both intra-psychological and somato-psychological [12]. Intra-psychological dissociation includes amnesia phenomena (about the traumatic event, or not), depersonalisation phenomena (for instance, with out-of-body experiences), derealisation phenomena (for instance, the feeling that they are watching their life as if it were a film on television), identity fragmentation phenomena (at worst, feeling like two different people), and automatisation phenomena (in particular, when running away from home). On various levels, these are responses to the pain of subjects who were unprepared for the emergence of a world-representation that contradicted the one they had until then. Somato-psychological dissociation in European psychiatric tradition, for example, a non-epileptic seizure or anaesthesia, means conversion. This responds to the pain that was also felt in the body, which used to be considered safe but has been proven not to be. It counteracts somatic re-experiencing [13]. **Table 1** shows the strong link between traumatic experiences and psychological dissociations, conversions, and phobias. As for phobias, let us point out the most specific one, agoraphobia, and the least specific one, social anxiety disorder. Indeed, social anxiety disorders may come from traumatic consequences, as well as from complications due to a temperamentally low ability to avoid hostile situations. We sometimes notice that while the *re-experiencing syndrome* has disappeared, the only disorder that still remains consists of psychogenic amnesia or panic disorder with agoraphobia [14]. These results concur with the most recent theorisations of panic attacks. Indeed, in order to understand the first attack’s trigger, specialists need to include an environmental wound along with the other involved factors [15].

Table 1. Links between constituted (*) psychiatric disorders and persistent traumatic re-experiencing—a prospective study of raped subjects over six months.

Traumatic Re-Experiencing			
	Still Re-Experiencing	**No Re-Experiencing**	**Comparison**
	at Six Months	**at Six Months**	**of Both Groups**
	%	**%**	***p***
Psychological dissociation	**84**	**38**	**<0.0001**
Conversions	**75**	**42**	**<0.01**
Agoraphobia	**70**	**20**	**<0.0001**
Simple phobia	**56**	**25**	**<0.02**
Social phobia	**49**	**29**	**ns.**
Panic disorder	**18**	**0**	**<0.03**
Depressions	**53**	**8**	**<0.001**
Sexual identity disorder	**41**	**4**	**<0.001**
Alcohol consumption excess	**29**	**8**	**<0.05**
Drug use	**14**	**8**	**ns**
Obsessional disorder	**12**	**0**	**ns**
Generalised anxiety	**7**	**17**	**ns**
Psychosis or bipolar disorder	**7**	**13**	**ns**
Anorexia or bulimia	**20**	**8**	**ns**

(*) The only results taken into account in this table are those of disorders that appeared precociously and persisted in one way or another during the six months duration [10].

Dissociative and phobic traumatic syndrome is the first traumatic syndrome to appear after the traumatic event takes place. It can become chronic. In that case, everything seems to indicate that experimenting with this defence mechanism during the traumatic event leads to using the same mechanisms with a much higher frequency later, during other hostile

but non-trauma-inducing events, when other people could have reacted, for example, with depression symptoms. Its persistence must come as a warning that *re-experiencing syndrome* may be present for a long period of time [10].

The clinical features of *re-experiencing traumatic syndrome* include reminiscences, nightmares, and trigger associations which set off a re-experience of the pain tied to the traumatic experience, or even the illusion of the traumatic experience itself. They are the most specific and sensitive out of all post-trauma symptom groups [1]. The American classification of mental disorders states that this syndrome is a necessary criterion for PTSD diagnosis but that it is not enough on its own. However, in practice, when we observe the presence of painful assault re-experiences, the other two symptom groups required for this category are rarely absent. Physically or sexually maltreated subjects prominently undergo painful re-experiences [3]. The diagnosis still applies to the majority of raped subjects one year after the traumatic event took place [16][14], and this chronologically constitutes one of the first therapeutic challenges at stake. Re-experiencing happens when an elementary sensory representation is recalled (for example, the image of the rapist's eyes) through memories, nightmares, or trigger-associations (for example, a white car for someone who was assaulted inside a white car). It represents the traumatic event in its entirety and activates the emotions tied to it. Therefore, re-experiencing indicates a disordered representation of the past.

In spite of how frequent it is among traumatised people (one out of two people are affected), highlighting their depression symptoms could lead to assumptions that treating such patients is not any more difficult than treating isolated depression. However, let us point out that the British psychiatry professor Sir David Goldberg, who dedicated his entire life to studying depression vulnerability factors, has no hesitation in claiming that sexual assaults are the first aetiological factors of depression [17].

Borderline-like traumatic syndrome can manifest in more psychological ways or more behavioural ways, depending on the cases or the moments in time. At first, "identity instability" is expressed on a psychological level and as a narcissistic depression (bad self-esteem, shame, guilt, abandonment disorder, feelings of emptiness, and the loss of vitality and identity) which can be so severe that it could evoke melancholy if its traumatic aetiology is not identified. The alteration of psychological development often complicates the identity disorder afterwards, sometimes quickly, particularly among children and adolescents. Indeed, an identity rebuilding process appears, with paranoid omnipotence fits or acting-out behaviours of various kinds. These well-documented borderline personality characteristics are rather typical of traumatic interactions between individuals [18][19]. This intersubjectivity, which promotes alienating identifications (to the aggressor among other things) and masochism often associated with traumatophilia, results in the alteration of relationships to other people and to the world. This disorder happens all the more frequently depending on how chronic and severe the trauma was. Thus, in **Table 2**, borderline-like characteristics are over-represented in incestuous rapes compared to non-incestuous rapes, in particular when it comes to bad self-esteem, abandonment disorder, feelings of emptiness, and a loss of vitality [4]. One should keep in mind that among those most severely traumatised, this syndrome is often the last one to keep resisting therapeutic measures, long after re-experiences have disappeared. This syndrome affects the subject's expectations and ideals; therefore, it is unsurprising that out of the three syndromes, this one proves to be the most detrimental for children and adolescents. *Borderline-like traumatic syndrome* is a pathology that damages the representation of the future.

Table 2. Illustration of the increased suffering of rape victims in cases of incest, through borderline-like psychological or behavioural features (*).

Rapes		
	Incestuous	**Non-Incestuous**
Frequent abandonment fear	**64%**	**57%**
Idealising of friends	**28%**	**44%**
Bad self-esteem	**68%**	**37%**
Running away from home impulsively	**33%**	**21%**
Suicide attempts	**33%**	**26%**
Emotional disorder of depressive nature	**49%**	**31%**
Lingering feeling of emptiness	**76%**	**56%**
Violence-inducing fits of anger	**54%**	**42%**

Rapes		
	Incestuous	Non-Incestuous
Dissociative incidents	84%	60%
At least five out of nine characteristics	58%	38%
Average number of characteristics	4.8	3.7

(*) The only results taken into account in this table are those of disorders that appeared precociously and persisted in one way or another during the six months duration [4].

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