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Recognition and Management of Sexual Violence in Psychiatry Outpatient Clinics

Psikiyatri Polikliniklerinde Cinsel Şiddetin Tanınması ve Yönetilmesi

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ABSTRACT

Sexual violence is defined as the act of forcing an individual to engage in sexual intercourse or perform sexual acts without their consent, whether by a partner or someone else. Victims often face considerable barriers to reporting these incidents, frequently due to prevalent myths surrounding sexual violence. Consequently, many victims end up seeking help in psychiatry outpatient clinics, where they encounter healthcare professionals. It is crucial for these settings to integrate routine inquiries about sexual violence into their protocols, ensuring that all patients are assessed in a consistent and sensitive manner. The primary goal of this review article is to underline the critical need for psychiatry outpatient clinics to acknowledge and address sexual violence effectively. This involves establishing clear guidelines for mental health professionals on how to routinely question patients about sexual violence, which will help in identifying those at risk more effectively. Furthermore, the review seeks to highlight the importance of identifying and addressing the psychological risk factors that may predispose individuals to become perpetrators of sexual violence. Understanding these factors can lead to better preventive strategies and therapeutic interventions tailored to the needs of this specific group. Additionally, the necessity of providing victims with immediate psychological support, known as psychological first aid, following an incident. is emphasized, This form of early intervention is vital for reducing the impact of trauma and assisting in the recovery process. By focusing on these key areas, the article aims to enhance the overall response to sexual violence within psychiatric settings, ensuring that victims receive the comprehensive support and care they need.
Keywords: Sexual violence, perpetrator, victim, sexual abuse, mental disorder

ÖZ

Cinsel şiddet, bir kişinin partneri veya bir başkası tarafından rızası olmaksızın cinsel ilişkiye girmeye veya cinsel eylemlerde bulunmaya zorlanması olarak tanımlanmaktadır. Mağdurlar, çoğunlukla cinsel şiddeti çevreleyen yaygın mitler nedeniyle, bu olayları bildirme konusunda önemli engellerle karşılaşmaktadır. Dolayısıyla pek çok mağdur, sağlık çalışanlarıyla karşılaştıkları psikiyatri polikliniklerinde yardım arayışına girmektedir. Bu ortamların, cinsel şiddetle ilgili rutin sorgulamaları protokollerine dahil etmeleri ve tüm hastaların tutarlı ve hassas bir şekilde değerlendirilmesini sağlamaları çok önemlidir. Bu gözden geçirme makalesinin temel amacı, psikiyatri polikliniklerinin cinsel şiddeti etkili bir şekilde kabul etmesi ve ele almasının kritik bir ihtiyaç olduğunun altını çizmektir. Bu, ruh sağlığı uzmanları için hastaları cinsel şiddet konusunda rutin olarak nasıl sorgulayacaklarına dair net kılavuzlar oluşturmayı içerir; böylelikle risk altındaki kişilerin daha etkili bir şekilde tespit edilmesine yardımcı olunacaktır. İnceleme ayrıca, bireyleri cinsel şiddet faili olmaya yatkın hale getirebilecek psikolojik risk faktörlerinin belirlenmesinin ve ele alınmasının önemini vurgulamayı amaçlamaktadır. Bu faktörlerin anlaşılması, bu özel grubun ihtiyaçlarına göre uyarlanmış daha iyi önleyici stratejilere ve terapötik müdahalelere yol açabilir. Ayrıca, bir olayın ardından mağdurlara psikolojik ilk yardım olarak bilinen acil psikolojik destek sağlanmasının gerekliliği vurgulanmıştır. Bu erken müdahale biçimi, travmanın etkisini azaltmak ve iyileşme sürecine yardımcı olmak için hayati önem taşımaktadır. Makale, bu önemli alanlara odaklanarak, psikiyatrik ortamlarda cinsel şiddete yönelik genel müdahaleyi geliştirmeyi ve mağdurların ihtiyaç duydukları kapsamlı destek ve bakımı almalarını sağlamayı amaçlamaktadır.
Anahtar sözcükler: Cinsel şiddet, fail, mağdur, cinsel istismar, ruhsal bozukluk

Introduction

World Health Organization (WHO) defines sexual violence as follows: Sexual violence is any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting (WHO 2021). According to the report organized by the World Health Organization, one out of every three women in the world is exposed to physical or sexual violence at least once in her life (WHO 2013). In a recent meta-analysis study, the percentage of sexual violence among women worldwide was found to be 29% (Li et al. 2023).

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Unfortunately, this violence is mostly encountered within families. 6% of women aged 15 years and over experience non-partner sexual violence at least once in their lifetime (WHO 2021). Although most domestic violence and abuse studies focus on physical violence, sexual violence can also be perpetrated by spouses. However, studies generally do not examine the relationship between the victim of sexual violence and the perpetrator (Trevillion et al. 2012). Partner sexual violence is defined as "the person being physically forced to have sexual intercourse against his/her will by his/her partner, having sexual intercourse because he/she is afraid of what his/her partner can potentially do, and/or having to do something sexual that he/she finds humiliating". Non-partner sexual violence, on the other hand, is defined as "forced to perform any sexual act without her/his consent, by someone other than the spouse/partner when she/he is 15 years of age or older"(WHO 2013).

Due to certain myths, victims of sexual violence can be overlooked in psychiatry outpatient clinics. Myths about sexual violence are widespread globally, such as the belief that women who use alcohol or drugs want to be raped, the misconception that women provoke rape through their revealing outfits and/or behavior, and the notion that rape is a crime of passion. These myths are serve to diminish the responsibility of the perpetrators, stigmatize and blame the victims. As a result, many victims opt not to report their experiences or label what happened to them as acts of sexual violence (Dartnall and Jewkes 2013).

Domestic or intimate partner violence and sexual violence are epidemics that remain hidden in healthcare settings. intimate partner violence and sexual violence are worldwide problems and have historically been disregarded. In the last few years, intimate partner violence and sexual violence against women have received increasing attention and recognition as global health issues (WHO 2016). It has been determined that the rate of anxiety, depression, substance abuse, post-traumatic stress disorder and suicide attempts is higher in the victims (WHO 2013). Many social institutions need to establish a common discipline in the fight against intimate partner violence and sexual violence (United Nations 2014). In many countries, social media movements have played a pivotal role in encouraging other victims to share their experiences. For example, global social media feminist movements such as #MeToo, #YesAllWomen, and #BeenRapedNeverReported have highlighted the prevalence and consequences of sexual harassment and sexual violence (Mendes et al. 2018). These movements such as #Metoo against sexual violence have not only raised awareness of the issue, but have also provided a safe space for the victims to speak out and caused some reactions and repercussions for the perpetrator (Hegarty and Tarzia 2019). For instance, an analysis published in the New York Times revealed that over 200 men lost their jobs due to workplace sexual harassment, and a significant number of them being replaced by female employees (New York Times 2018). On the contrary, social media movements related to domestic violence may not be the most effective way to promote the change in health systems, there is a crucial need for activations that will increase notification and inquiry related to this issue in health.

Although there are overlaps between domestic violence and sexual violence, it is not correct to consider sexual violence only as a part of domestic violence. Because by doing this we would not accept certain nuances of sexual violence perpetrated by an intimate partner or do not consider sexual violence perpetrated by strangers (Hegarty et al. 2016). It is unclear how interventions can be implemented for different victims of sexual violence (Regehr et al. 2013).

Domestic sexual violence often goes unreported by the victim, overlooked by practitioners, neglected by witnesses, and unfortunately ignored for an extended period. Sometimes it can be very difficult to define and address sexual violence in cases of domestic sexual violence that have been identified (Hegarty and Tarzia 2019). Mental health services for adult survivors of sexual violence are also often insufficient . Studies conducted in Brazil, Sweden and the United Kingdom have reported that between 12% and 43% of victims of sexual violence disclose their experiences to healthcare professionals (De Oliveira et al. 2012, Khalifeh et al. 2015, Ormon et al. 2016). In India, it has been reported that 60% of women who have been experienced sexual violence and sought mental health services do not disclose their experiences to anyone. Reasons for non-disclosure include fear of blamed, concerns about further violence from the perpetrator, and the belief that abuse is a common experience for women (Chandra et al. 2003). According to one study, the process following routine questioning and the inability to document evidence of the perpetrator's disclosure hinder these women from seeking civil and legal remedies (Bacchus et al. 2010). Many victims lack motivation and refuse support through official institutions. Various factors contribute to non-disclosure, including economic concerns, fear of heightened violence from the perpetrator (if all types of violence are combined), stigma, humiliation, disbelief, and concern about the victimization of their children (Rose et al. 2011). Counselors or physicians generally do not question domestic sexual violence because they do not traumatize the patient, time constraints, or a lack of understanding of their responsibilities. WHO (2013) recommended that all healthcare professionals receive training in primary care for

intimate partner violence and sexual violence. It recommends listening to victims' concerns, identifying their needs, enhancing safety and providing support.

This review article aims to contribute to the literature by offering guidance to healthcare professionals on the recognition, questioning and managing instances of sexual violence among patients seeking treatment at psychiatric outpatient clinics. Our aim in this review is emphasizing the importance of recognizing sexual violence in psychiatry outpatient clinics, determining the rules that mental health professionals should pay attention to routine questioning, identifying and treating the psychological risk factors of the perpetrators, and providing support by providing psychological first aid to the victims.

Recognizing Victims of Sexual Violence in Mental Health Services

Almost no research has been conducted to define sexual violence and to investigate the barriers to recognition of sexual violence in institutions providing mental health services related to sexual violence. A small qualitative study conducted in Australia revealed that staff members reported personal discomfort with addressing the issue and felt inadequate to respond to disclosures due to inadequate training and guidance (McLindon and Harms 2011). Despite the high prevalence of domestic violence and abuse among mental health service users, a review conducted in 2010 found that only 10-30% of victims of domestic violence and abuse were identified by international mental health professionals. In addition, all women who have experienced physical violence have also been subjected to some form of psychological violence, and many have suffered sexual abuse at the hands of their husbands (Howard et al. 2010).

There are screening tests such as Women Abuse Screen Tool (WAST, Canada), Abuse Assessment Screen (AAS, USA) and Humiliation, Afraid, Rape and Kick (HARK, UK) that have been developed to identify instances of sexual violence. These tests have beenfound to exhibit stronger psychometric values compared to other assessments validated against appropriate reference standards (Arkins et al. 2016).Sexual Coercion in Intimate Relationships Scale (SCIRS) developed by Shackelford and Goetz in 2004, is designed to measure partner sexual violence. Recently, a reliability and validity study of Turkish version of the Sexual Coercion in Intimate Relationships Scale was conducted (Guvenc et al. 2022).

There is considerably less evidence the screening of sexual violence compared to intimate partner violence. Although scales of exposure to sexual violence are available, there is limited evidence regarding their utility in healthcare settings (Thompson 2006). There are many barriers to preventing mental health professionals from screening or asking patients about intimate partner violence or sexual violence. A study conducted in 2016 reviewed 35 studies and reported low routine screening rates ranging from 10% to 20% (Alvarez et al. 2017).

In the research conducted by Oram et al. (2017), a potential association between sexual violence and mental disorders is postulated. Nevertheless, this investigation does not make a clear distinction between violence perpetrated by intimate partners and violence inflicted by individuals who are not in a spousal relationship. While individual risk factors for sexual violence are likely to vary depending on the context of abuse, sexual violence is more likely to occur among young people, women, individuals with mental illness, those facing economic challenges, and people who have experienced childhood sexual abuse and substance use disorders (Krug et al. 2002, Casteel et al. 2008).

Identification of Perpetrators of Sexual Violence in Mental Health Services

There is insufficient evidence regarding the identification of sexual violence perpetrators, particularly those involved in domestic violence and abuse, within mental health services. At the same time, it is emphasized that in a qualitative study targeting mental health professionals, there is a lack of specific research focused on domestic violence and abuse. While many mental health professionals inquire about violence concerning women, there is often a failure to gather information regarding the post- separation stage, where the risk of violence may be heightened. More clarity in information sharing is needed due to the current risk assessment being insufficient to question (Oram et al. 2016).

Relationship between Sexual Violence and Mental Health

Research has demonstrated that individuals with mental health issues are at an increased risk of encountering domestic violence relative to those without mental disorders. Additionally, evidence suggests that people diagnosed with bipolar disorder are eight times more likely to endure spousal violence than individuals who do

not have mental illnesses (Grant and Goldstein 2011). Furthermore, there is an established link between sexual violence and addiction to alcohol and other substances (Jonas et al. 2011).

A recent meta-analysis showed that more than half of women who suffer sexual violence experience symptoms of post-traumatic stress disorder (PTSD), but only about one-third of them consider seeking help (Li et al. 2023). Studies indicate that the incidence of PTSD among survivors of sexual violence is substantially higher (50%) compared to the general population (7.8%) (Chivers-Wilson 2006). Research has also demonstrated that early psychological interventions, when viewed positively by the survivor, can significantly reduce the likelihood of PTSD symptoms developing (Dworkin and Schumacher 2018). Furthermore, a study found that 61.3% of sexual assault survivors referred to the Forensic Medicine Institute in Turkey for evaluation showed symptoms consistent with PTSD (Gölge et al. 2013). In a recent systematic review and meta-analysis, evidence was found for an association between a lifetime history of sexual victimization and perinatal depression (Lombardi et al. 2023).

Research has revealed a substantial prevalence of sexual violence history among individuals who frequently seek secondary health services. A study reported a concerning prevalence of sexual violence, reaching 61% among 129 female patients. Disturbingly, over half of those who were victims of rape or attempted rape indicated that they had attempted suicide as a direct consequence of their traumatic experiences.Another study reported that 13-51% of sexual violence victims showed signs of depression, 23-44% had suicidal ideation, and 2-19% attempted suicide (Campbell et al. 2009).

Women with severe mental illness are six times more likely to experience lifetime sexual violence than women in the general population (Khalifeh et al. 2016). At the same time, it was determined that the risk of mental disorders and comorbidities increased in women who were exposed to more than one type of abuse (Jones et al. 2001, Echeburúa et al. 2003, Romito et al. 2005). Additionally, it is important to note that women who are exposed to sexual violence may present with different psychological symptoms as well as sexuality-related symptoms (Barbara et al. 2022).

Sexual Violence by Persons with Mental Disorders

Mental disorders are associated with the risk of perpetrating violence, and at the international level, mental health policy focuses on assessing the risk of violence against others. At the same time, few studies have been conducted on domestic violence and the extent of risk of abuse or sexual violence perpetration, rather than violence in general. Therefore, information on the prevalence and risk factors of such abuses is limited. In a meta-analysis study, that systematically examined cross-sectional psychiatric comorbidity and population questionnaires, correlations were found between mental disorders and domestic violence and crime of abuse in both men and women (Oram et al. 2014).

A cross-sectional study involving multiple countries has found that severe depressive symptoms may elevate the risk of physical, sexual, and emotional abuse within domestic settings (Fulu et al. 2013). Additionally, research indicates that in England and Wales, 14% of those who committed intimate partner violence and 23% of individuals responsible for family homicides had sought mental health services in the year before committing the crime (Knight et al. 2016). Långström and Grann (2007) reported a relatively increased risk of psychiatric hospitalization and severe mental illness in sexual violence perpetrators. In addition, severe mental disorders may be associated with potential risk factors for sexual violence (aggression, poor social skills, cognitive impairment, alcohol and substance abuse).

What Can Mental Health Professionals Do About Sexual Violence?

Studies have emphasized the need to change the infrastructure of health systems and community services in order to address violence against women (Colombini et al. 2012, García-Moreno et al. 2015). Primary protection includes raising awareness by mental health professionals about sexual violence against women and children and challenging cultural norms in society. Secondary protection consists of interventions necessary to reduce the impact and harm of violence that has already occurred (Semrau et al. 2015).

International guidelines, including WHO and the UK's National Institute for Health and Care Excellence (NICE), recommend that mental health professionals facilitate the emergence of domestic violence and abuse. They emphasize the need for comprehensive clinical evaluation and the importance of providing victims with support and safety measures. It is also stated that mental disorders arising as a result of any domestic violence and abuse should be treated (WHO 2013, NICE 2014).

While the topic of universal screening for domestic violence and abuse in healthcare settings, such as primary care or emergency services, remains a subject of debate, clinical guidelines suggest that routine inquiries should be conducted in mental health services due to the heightened likelihood of individuals seeking mental health support being victims of violence (Feder et al. 2009). Nevertheless, the lack of conclusive evidence in the literature regarding the efficacy of routine questioning may contribute to hesitancy in implementing such practices. Another obstacle in the process of questioning is the emotional challenge experienced by healthcare professionals, both for themselves and their clients. Since the results will vary according to the nature of the reaction to disclosure, the guidelines state that the inquiry should be conducted by personnel trained in managing this process and in accordance with the protocols. The guidelines recommend that mental health professionals routinely ask questions about domestic violence and abuse and sexual violence experienced in childhood and adulthood as part of clinical assessment and ongoing care. However, it is very important that this routine questioningbe carried out safely. Before starting routine questioning, healthcare professionals should also be prepared in advance how to react (Stewart et al. 2013, NICE 2014, WHO 2016).

It is very important that a relative such as family or friend is not in the interview room while sexual violence is being questioned, and it is very important to create the opportunity to meet with the patient alone. Access to an independent interpreter should be provided if the patient speaks a different language. The client is making a disclosure, and therefore the therapist must be sensitive, compassionate, and non-judgmental. It is essential for the therapist to know where to start asking questions and the way they ask questions. It is necessary to respect the client's sense of self, to have an informative and practically supportive approach to their concerns (WHO 2013). At the same time, the health professional should be aware of their own psychological barriers. These barriers could result in:

1. Pity and contempt for the victim,
2. Defamation of the harasser,
3. Neglecting the role of the clinician or researcher (Chapman and Monk 2015).

Interventions for Victims of Sexual Violence

Evidence regarding psychological interventions for victims of sexual violence is inconsistent. A systematic review of 20 low-quality studies found some evidence of the effectiveness of eye movement desensitization and reprocessing (EMDR) and trauma-focused Cognitive Behavioral Therapy (CBT) on PTSD, depression, and other psychological problems commonly experienced by women who have been sexually assaulted (Vickerman and Margolin 2009). A Cochrane review of 70 studies (4761 participants) involving psychological interventions for PTSD found evidence that trauma-focused CBT and EMDR therapy are superior to non-trauma-focused CBT (Bisson et al. 2013). Recent literature emphasizes the necessity of a women-focused, multidisciplinary approach to approaching victims of sexual violence, including gynecologists, psychologists, sexologists, forensic medicine doctors and lawyers, along with psychiatrists (Barbara et al.2022).

Psychological First Aid in Sexual Violence

Victims of sexual violence not only endure vulnerability but also suffer losses in various aspects of their lives, such as control, self-esteem, and trust. The objective of providing psychological first aid is to establish a sense of safety and security for the victim. Additionally, psychological first aid assists in the development of a safety plan to help the victim navigate their life after reporting the incident to the authorities. In the short term, psychological first aid aims to fulfill the victim's need for safety, address negative emotions, and inform them about available resources when they feel ready to seek assistance. The long-term goal is to mitigate psychological trauma, allowing the victim to experience a greater sense of safety, serenity, and hopefulness towards the future (Tetik et al. 2021).

In the guide prepared by the World Health Organization for field workers in 33 languages, it is emphasized that psychological first aid should be provided in accordance with the age, gender and socio-cultural values of the individual and with due care for privacy (WHO 2011). Psychological first aid aims to meet the basic needs with guidance rather than detecting whether the mental health of the victim is impaired or not (Ruzek et al. 2007).

For domestic violence and sexual violence, WHO recommends the LIVES approach. The LIVES approach consists of 5 steps:

1. Listen: Empathetic and non-judgmental listening is required.

2. Inquire about needs: Psychological, physical health, safety, support-needs and concerns are asked.
3. Validate patients' experiences: At this stage it is important to show that you believe and understand it.
4. Enhance safety: How to protect against further damage is discussed.
5. Support: In the last step, a continuous support plan is made.

Interventions against Perpetrators of Sexual Violence

There is no evidence of the effectiveness and relevance of programs for perpetrators of domestic violence and abuse with psychiatric illness, and applications to these programs are very low (Kelly and Westmarland 2015). This also applies to perpetrators of sexual violence. Interventions targeting modifiable risk factors (administration of antipsychotics for persecutory delusions, treatment of alcohol and substance abuse, or initiation of medication for anger control problems) present in the perpetrator are expected to significantly reduce physical and sexual violence (Capaldi et al. 2012). Substance abuse, and especially excessive alcohol consumption, contribute to domestic physical violence, harassment and sexual violence. Therefore, it may be beneficial for mental health professionals to support the reduction of dangerous alcohol intake levels (Capaldi et al. 2012).

Identifying and treating perpetrators can play a crucial role inpreventing future violence and improving the mental health of victims. Risk assessment should include a focus on domestic violence and risk of abuse, sexual violence against former and current partners and family members.

Conclusion

Mental health professionals play an important role in protecting against gender-based violence, especially against women, and primary, secondary and tertiary measures can be taken to reduce the risk of violence against women. Protecting and supporting children who witness violence against women can also reduce the likelihood of these children becoming victims or perpetrators of violence against women and reduce the risk of violence against women for future generations. Increasing access to mental health services is an important secondary and tertiary preventive measure. Despite evidence indicating that psychiatric illnesses increase the risk of domestic violence and exposure to abuse, and that domestic violence and abuse increase the risk of mental disorders, healthcare treatments remain inaccesibleto the majority of people worldwide (Demyttenaere et al. 2004, Semrau et al. 2015).

It is crucial for mental health workers to undergo sufficient training to effectively listen to the issues faced by victims of sexual violence, assess their needs, and provide appropriate psychosocial support. Psychological early intervention plays a crucial role in mitigating the adverse psychosocial effects of trauma, particularly considering the high prevalence of mental illnesses among women who have experienced sexual violence or multiple forms of abuse. In the event of mental disorders, prompt identification and treatment are essential. Additionally, addressing sexual violence requires the identification and treatment of the perpetrators. Existing studies highlight the necessity for structural changes within healthcare systems and community services in the ongoing battle against violence targeting women.

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