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Physical and Sexual Abuse of Adults Violence is an important public health concern in the United States. The majority of Americans will fall victim to a violent crime during their lifetime. Besides mortality, violence creates a heavy toll in medical costs, disability, and psychiatric sequelae. Assault can be viewed in the context of two variables. The first involves who is being assaulted, and the second is where the assault occurs. With these parameters assault can be classified into several categories, the most common being violent crimes (aggravated and simple assault, robbery), rape, domestic violence, workplace violence, and torture. The prevalence of the different types of assaults is most often reported by two different data collection systems: (1) the Federal Bureau of Investigation’s Uniform Crime Report (UCR), which collects reported crime information from local law enforcement agencies and (2) the Bureau of Justice Statistics’ National Crime Victimization Survey (NCVS), which generates estimates of the likelihood of victimization from different types of assaults. VIOLENT CRIME Violent crime is defined as murder and nonnegligent manslaughter, forcible rape, robbery, and aggravated assault. These categories exclude simple assault, which is defined as an assault not involving a weapon and in which the victim was not seriously harmed. Simple assault has also been defined as stalking, intimidating, coercing, or hazing. Prevalence In 2011, the UCR reported over 1.2 million violent crimes occurred within the United States. Aggravated assault accounted for approximately 750,000 of this total, and robberies accounted for approximately 350,000. Ten-year trends show a decrease of 16 percent in violent crime since 2002. Aggravated assault was the most reported violent crime (62 percent), followed by robbery (29 percent), forcible rape (7 percent), and murder (1 percent). Also in 2011, firearms were found to be used in 21 percent of aggravated assaults and 41 percent of robberies. Risk Factors Gender and age play large roles in the rate of risk for assaults of all types. Males between the ages of 15 and 34 years are more likely to be assaulted than females and are 11 times more likely to be assaulted by strangers than by someone they know.

Research suggests that race is an important factor as well, with African Americans being at greater risk of violence and having a death rate that is four or five times higher than age-matched whites during aggravated assaults. The NCVS found that males and females in households earning less than $15,000 in annual income were twice as likely to be robbed and 1.5 times as likely to suffer a physical assault. Homelessness has also been shown to be a factor in increased physical assaults. Finally, substance abuse has been shown in multiple studies to increase the risk of victimization. RAPE Rape is the forceful coercion of an unwilling victim to engage in a sexual act, usually sexual intercourse, although anal intercourse and fellatio can also be acts of rape. The legal definition of rape varies from state to state. Some states strictly define rape, whereas other states describe any sex crime as varying degrees of sexual misconduct or sexual assault. Rape can occur between married partners and between persons of the same sex. Forced acts of fellatio and anal penetration, although they frequently accompany rape, are legally considered sodomy. In some states the definition of rape has been changed to substitute the word person for female. In most states, male rape is legally defined as sodomy. Like other violent crimes, sexual assault is declining; however, every 2 minutes someone in the United States is sexually assaulted. Although much of the population believes in the stereotype of the culprit being a stranger, research has shown that only about 26 percent of all rapes are committed by a stranger. Prevalence Unfortunately, accurate statistics are difficult to obtain because of underreporting and unacknowledgment. The Rape, Abuse, and Incest National Network (RAINN) estimates that over half of rapes go unreported. Although in the United States, rapes have fallen in number since 1993, currently there is an average of 207,754 rapes and sexual assaults per year. RAINN estimates that 1 in 6 US women and 1 in 33 US men are victims of sexual assault. In addition to being underreported, there are many rapes that go unacknowledged by the victim, who often refer to the assault in more benign terms such as a misunderstanding, despite the fact that it meets the legal definition of rape. Research has reported that this percentage is substantial; more than 50 percent of sexual assaults may go unacknowledged and, thus, unreported. Research has further revealed that victims who fail to acknowledge having been raped usually believe that rape involves two strangers and greater force, as opposed to the views of those who acknowledge their having been sexually assaulted. Statistics show that most men who commit rapes are between 25 and 44 years of age; 51 percent are white and tend to rape white victims, 47 percent are black and tend to rape black victims, and the remaining 2 percent come from all other races. Alcohol is involved in 34 percent of all forcible rapes. Homosexual rape is much more frequent

among men than among women and occurs frequently in closed institutions such as prisons and maximum security hospitals. Risk Factors Although women are usually the victim of rape and sexual assault, greater than 10 percent of victims are estimated to be men. Furthermore, most experts believe that men underreport more than women. Nevertheless, young women have four times the risk of any group of becoming a victim of sexual assault. Persons who are raped can be of any age. Cases have been reported in which the victims were as young as 15 months and as old as 82 years. However, 80 percent of all rape victims are under the age of 30 years and the Bureau of Justice statistics indicate that women age 16 to 24 years are at the greatest risk for rape in the United States. Having been a victim of childhood abuse or previous assault increases the likelihood of further assault of all types. Most rapes are premeditated; about half are committed by strangers and half by men known, to varying degrees, by the victims. The Violence Against Women Act has had an important role to play in reducing rape and other types of violence (Table 26-1). Table 26-1 Violence Against Women Act (VAWA)

Perpetrators In general, rape is considered a crime of power and aggression, not one of sexuality. Male rapist can be categorized into separate groups: sexual sadists, who are aroused by the pain of their victims; exploitive predators, who use their victims as objects for their gratification in an impulsive way; inadequate men, who believe that no woman would voluntarily sleep with them and who are obsessed with fantasies about sex; and men for whom rape is a displaced expression of anger and rage. Seven percent of all rapes are perpetrated by close relatives of the victim; 10 percent of rapes involve more than one attacker. Rape often accompanies another crime. Rapists always threaten victims, with fists, a knife, or a gun, and frequently harm them in nonsexual ways as well. Victims can be beaten, wounded, and killed. In cases of male or homosexual rape, the dynamics are identical to those of heterosexual rape. The crime enables the rapist to discharge aggression and to aggrandize himself. The victim is usually smaller than the rapist, is always perceived as

passive and unmanly (weaker), and is used as an object. A rapist selecting male victims may be heterosexual, bisexual, or homosexual. The most common act is anal penetration of the victim; the second most common is fellatio. SEXUAL COERCION Sexual coercion is a term used for incidents in which a person dominates another by force or compels the other person to perform a sexual act. STALKING Stalking is defined as a pattern of harassing or menacing behavior coupled with a threat to do harm. The first antistalking law was passed in 1990 in California. Now most states prohibit stalking, although some will not intervene unless an act of violence has occurred. In states with stalking laws, the person can be arrested on the basis of a pattern of harassment and can be charged with either a misdemeanor or felony. Some stalkers continue the activity for years; others, for only a few months. The court may mandate that stalkers undergo counseling sessions. The best means of deterrent is to report all stalkers to law enforcement agencies. Most stalkers are men, but women who stalk are just as likely as men to attack their victims violently. SEXUAL HARASSMENT Sexual harassment refers to sexual advances, requests for sexual favors, or verbal or physical conduct of a sexual nature—all of which are unwelcomed by the victim. In more than 95 percent of cases the perpetrator is a man and the victim is a woman. If a man is being harassed, it is almost always by another man. A woman sexually harassing a man is an extremely rare event. The victim of harassment reacts to the experience in various ways. Some blame themselves and become depressed; others become anxious and angry. In general, harassment most commonly occurs in the workplace, and many organizations have developed procedures to deal with the problem. All too often, however, the victim is unwilling to step forward and lodge a complaint because of fear of retribution, of being humiliated, of being accused of lying, or ultimately of being fired from the job. The types of behaviors that make up sexual harassment are broad. They include abusive language, requests for sexual favors, sexual jokes, staring, ogling, and giving massages, among others. To reduce harassment, organizations may distribute educational material. Employees are obligated to investigate every complaint, which most often are addressed to the Equal Employment Opportunity Commission. Appropriate organizational responses range from a written warning to firing the offender. DOMESTIC VIOLENCE Domestic violence (also known as spouse abuse) is defined as physical assault within the

home in which one spouse is repeatedly assaulted by the other. It has been estimated that domestic violence occurs in one of every four families in the United States. Often domestic violence is broken down into two categories: “high-severity abuse,” which includes being threatened or hurt with a weapon, burned, choked, hit, or kicked, resulting in broken bones and head or internal

injuries; and “low-severity abuse,” which includes being slapped, hit, or kicked without injury, but also could include bruising, minor cuts, and sprains. Unfortunately, domestic violence does not end when a woman becomes pregnant. In fact, the surgeon general’s office has identified pregnancy as a high-risk period for battering; 15 to 25 percent of pregnant women are physically abused while pregnant, and the abuse often results in birth defects. In addition, pregnant and recently pregnant women are more likely to die from homicide than any other cause. Some husband-beating wives have also been reported. Husbands complain of fear of ridicule if they expose the problem; they fear charges of counterassault and often feel unable to leave the situation because of financial difficulties. Husband abuse also been reported when a frail, elderly man is married to a much younger woman. Prevalence Estimates of the prevalence of domestic violence in the United States vary widely, and many studies include psychological or emotional abuse. Worldwide estimates state that one in every three women has experienced some form of physical or sexual abuse from a domestic partner. One study based on several internal medicine practices found that approximately 6 percent of women had experienced domestic violence in the year prior to presentation. It was found that of the women currently experiencing abuse, 49 percent experience high-severity abuse and 51 percent experience low-severity abuse. Risk Factors Domestic violence occurs in families of every racial and religious background and in all socioeconomic strata. Any person in an intimate relationship can be at risk. It is most frequently found in families with problems of substance abuse, particularly alcohol and crack abuse. Another risk factor is a history of childhood abuse. About 50 percent of battered wives grew up in violent homes and their most common trait is dependence. Abusive men are also likely to have come from violent homes where they witnessed wife beating or were abused themselves as children. Women face risks when they leave an abusive husband; they have a 75 percent greater chance of being killed by their batterers than women who stay. New York State prepared a physician reference card to alert and guide doctors about domestic violence (Table 26-2). Table 26-2 Physician Reference Card

Perpetrators The perpetrators of domestic violence come from all races and socioeconomic levels. However, having been a victim of abuse or witnessing abuse in the home increases the risk of someone becoming an abuser. Alcohol abuse is usually involved in most offenses. The act of abuse itself is reinforcing; once a man has beaten his wife, he is likely to do so again. Many abusers are noted to be charming in public but cruel to their intimates. Abusive husbands tend to be immature, dependent, and nonassertive and to suffer from strong feelings of inadequacy. The husband’s aggression is bullying behavior designed to humiliate their wives and to build up their own low self-esteem. Impatient, impulsive, abusive husbands physically displace aggression provoked by others onto their wives. The abuse most likely occurs when a man feels threatened or frustrated at home, at work, or with his peers. The dynamics include identification with an aggressor (father, boss), testing behavior (“Will she stay with me, no matter how I treat her?”), distorted desires to express manhood, and dehumanization of women. As with rape, aggression is deemed permissible when a woman is perceived as property. When an abused wife tries to leave her husband, he often becomes doubly intimidating and threatens to “get” her. If the woman has small children to care for, her problem is compounded. The abusive husband wages a conscious campaign to isolate his wife and make her feel worthless. Some men feel remorse and guilt after an episode of violent behavior and so become particularly loving. If this behavior gives the wife hope, she remains until the next inevitable cycle of violence.

WORKPLACE VIOLENCE Acts of violence at work are defined as simple assault, aggravated assault, robbery, rape/sexual abuse, and homicide. Prevalence Workplace violence accounts for approximately 15 percent of all violent crimes in the United States. According to the NCVS, in 2009 there were approximately 572,000 acts of violence committed against persons at work. During the same time, over 500 workrelated homicides occurred. Approximately 78 percent of workplace assaults did not involve weapons, and 80 percent of workplace homicides involved firearms. With some variation, violent crime in the workplace has decline approximately 35 percent since 2002. Risk Factors Gender and race are important risk factors in workplace violence. The workplace violence rate for women has decreased approximately 43 percent since 2002, while the rate for men has decreased approximately 30 percent. Approximately two thirds of all workplace assaults (excluding rape/sexual assault) are committed against men. Workplace crime rates are higher among whites than other races. An important component of workplace violence is the relationship between the risk of violence and the type of occupation. The NCVS found that police officers are at the highest risk for victimization (78 per 1,000) and constituted 9 percent of all workplace assaults. Other high-risk occupations include security guard (65 per 1,000), correction officer (33 per 1,000), bartender (80 per 1,000), technical/industrial schoolteacher (55 per 1,000), mental health custodial worker (38 per 1,000), gas station attendant (30 per 1,000), and mental health professionals (17 per 1,000). Perpetrators There are several distinct characteristics among offenders, of which gender is the most pronounced. As reported by victims, four fifths of all violent workplace crime is committed by men, and this is regardless of the victim’s gender. The race of the offenders is most often white, followed by black, and most of the attacks are interracial. Unlike domestic violence, workplace violence is more often perpetrated by strangers or casual acquaintances than by known intimates. Mental health and teaching are the only fields in which attacks occur more often at the hands of a known perpetrator than by a stranger. SEQUELAE OF VIOLENCE AND ASSAULT Survivors of violence have varied reactions, but they are similar to those exposed to other types of trauma. Furthermore, the severity of the sequelae varies with the

individual. However, multiple studies have shown that many of the people who experience violence have decreased physical and mental health, resulting in higher utilization of health care services. The most common reported sequelae after sexual assault in women are posttraumatic stress disorder (PTSD), mood disorders, substance abuse, eating disorders, and sexual disorders. One of the most protective factors in ameliorating the development of PTSD is social support. Furthermore, the lack of social support and the perception of being treated differently can be quite detrimental to the survivor, causing an increase in PTSD symptoms. Domestic violence has been associated with depression, anxiety, low self-esteem, substance abuse, sexual dysfunction, functional gastrointestinal disorder, headaches, chronic pain, and multiple somatic symptoms. Physical symptoms associated with current abuse include loss of appetite; frequent or serious bruises; nightmares; vaginal discharge; eating binges or self-induced vomiting; diarrhea; broken bones; sprains or serious cuts; pain in the pelvic or genital area; fainting; abdominal pain; breast pain; frequent or severe headaches; difficulty passing urine; chest pain; problems with sleeping; shortness of breath; and constipation. Many studies have shown that survivors of domestic violence attempt suicide more frequently than those who have not experienced violence. Substance abuse seems to be a significant factor for both the survivor and the batterer. It is both a risk factor for abuse and a consequence of it. The relationship between childhood abuse and adult abuse is complex. Childhood abuse is a risk factor for abuse as an adult, and childhood abuse increases both physical and mental health sequelae of adult abuse. Survivors of sexual assault or

domestic violence who are older and without a history of childhood abuse have fewer symptoms TREATMENT ISSUES Initial Evaluation Many victims of assault initially present to a medical doctor for treatment of their injuries. In emergency departments, patients may often be treated for their injuries without the assault being recognized or addressed. Consequently, it is important to consider any concerning injuries as being a potential stigmata of assault. The patient may initially be avoidant when asked about the cause of injuries that appear related to assault. This may be further complicated by the need to complete specific tasks (i.e., rape kit, photo documentation, reporting of legal concerns) that require the patient to describe and relive the recent assault. It is paramount to build rapport with the patient while continuing to complete a thorough evaluation. To facilitate this process, it is important to reduce the victim's stress and anxiety regarding discussion of the event. The initial evaluation process should be explained to the patient before beginning. Allowing the patient some say in dictating the pace and content of the interview is preferable to having a patient feel a lack of control over the process. The crime may represent a time when the patient lacked control, and similar feelings in the initial

interview can lead to a triggering of traumatic or anxious responses. Finally, the physician should remain attuned to nonverbal patient responses that signify discomfort and conduct the interview accordingly. Furthermore, when a patient discloses domestic violence, this should be documented in his or her chart for future follow-up and possible future legal documentation. Safety After an assault, it is imperative that a safety assessment be performed on the victim. The patient needs to be evaluated for suicidal and homicidal ideation as it pertains to the recent assault. The patient's safety from further assault also needs to be addressed, especially in a setting in which the perpetrator was a loved one or known acquaintance. Finally, the patient needs to be screened for severe psychological symptoms that would cause difficulty in self-care. These would include acute mood deterioration or affective instability, self-destructive behaviors, dissociative symptoms, or psychosis. If the evaluation shows that any of these areas are inadequate to ensure patient safety, then a plan needs to be developed. This plan should provide for the patient's physical safety and give the patient a place to sleep, recuperate, and eat. Hospitalization In the event that the patient's safety cannot be guaranteed, hospitalization of the assault victim may be necessary. Common indications for hospitalization include (1) severe medical injuries, (2) suicidality or homicidality, (3) dissociative or psychotic symptoms, (4) mood instability or affective dysregulation, (5) self-destructive behaviors, and (6) a continued serious threat to the patient's life or well-being. If the victim is admitted to the hospital, then an individualized multidisciplinary treatment plan should be developed. Safety, milieu therapy, mood stabilization, and medication evaluation are the primary treatment modalities provided in the hospital and reflect the short-stay nature of most psychiatric facilities. Because the assault victim will likely need longer treatment than what can be provided in the hospital, it is important that there is a coordinated inpatient-to-outpatient transition, which psychiatric, medical, and social work issues all being address prior to discharge. Legal Issues A physician evaluating an assault victim needs to adhere to mandatory reporting requirements for the state in which he or she is practicing. Mandatory reporting of child abuse, abuse of developmentally disabled children, and abuse of the elderly exist in all 50 states. In cases of assault secondary to domestic violence, states do not usually require mandatory reporting. However, many states do require physicians to report serious injuries due to acts of criminal violence. Thus, in the setting of injury secondary to domestic violence, this can sometimes be considered a de facto mandatory reporting situation.

Psychotherapy Treatment After the patient’s safety has been ensured and the initial evaluation is complete, there are a variety of psychological interventions that can be initiated. Cognitive-behavioral approaches are the most researched techniques demonstrating efficacy. Exposure therapy is a variant of cognitive-behavioral therapy (CBT) that has been shown to help victims emotionally process the assault by decreasing their fear to memories or cues of the event. There is evidence in the literature that brief early CBT may accelerate recovery in victims manifesting acute PTSD. Eye movement desensitization and reprocessing (EMDR) is another alternative treatment for the processing of distressing memories. These individual psychotherapies may be augmented with group psychotherapy, art therapy, dance and movement therapy, music therapy, and bodyoriented approaches if they prove beneficial to the patient. Psychopharmacological Treatment Although medication is not recommended in the acute treatment of all assault victims, it may be beneficial in certain circumstances. The clinician may decide to medicate a patient with incapacitating anxiety, extreme aggression toward themselves or others, or dissociation or psychoses immediately after the assault. The patient’s safety and the safety of those around the patient will help to decide the need for pharmacologic intervention. Most medication treatment will be initiated much later after the assault as the patient develops symptoms of PTSD, depression, anxiety, obsessive-compulsive disorder, or psychosis. Although medication may be useful in symptom management, they should not be viewed as a replacement for psychotherapy aimed at trauma symptom resolution. REFERENCES Arnetz JE, Aranyos D, Ager J, Upfal MJ. Development and application of a population-based system for workplace violence surveillance in hospitals. Am J Ind Med. 2011;54:925. Baltrushes N, Karnik NS. Victims of military sexual trauma—you see them, too. J Fam Pract. 2013;62(3):120–125. Cannell MB, Manini T, Spence-Almaguer E, Maldonado-Molina M, Andresen EM. U.S. Population Estimates and Correlates of Sexual Abuse of Community-Dwelling Older Adults. J Elder Abuse Negl. 2014. [Epub ahead of print] Chesney-Lind M, Pasko L. The Female Offender: Girls, Women, and Crime. 3rd ed. Thousand Oak, CA: Sage; 2013. Chiu GR, Lutfey KE, Litman HJ, Link CL, Hall SA, McKinlay JB. Prevalence and overlap of childhood and adult physical, sexual, and emotional abuse: A descriptive analysis of results from the Boston Area Community Health (BACH) survey. Violence Vict. 2013;28(3):381–402. Cramer RJ, McNiel DE, Holley SR, Shumway M, Boccellari A. Mental health in violent crime victims: Does sexual orientation matter? Law Hum Behav. 2012;36(2):87. Dutton DG, Karakanta C. Depression as a risk marker for aggression: A critical review. Aggress Violent Behav. 2013;18(2):310–319. Harrell, Erika. Workplace Violence, 1993–2009: National Crime Victimization Survey and the Census of Fatal Occupational Injuries. Washington, DC: Bureau of Justice Statistics; 2011.

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