outlook
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Sexual assault and alcohol use: Where should intervention begin?

By Sue Robb

Abstract

Sexual assault nurse examiners and other advocates who provide specialized care to victims of sexual assault recognize the role that alcohol plays in sexual assault. Conservative estimates indicate that approximately 50% of sexual assaults occur under the influence of alcohol, making the issue of alcohol use a significant vulnerability issue. The question has been raised in current literature about the feasibility of addressing the problem of alcohol abuse in the emergency department (ED) during the sexual assault exam. Although the opportunity exists for an intervention due to the dedicated nature of the SANE programming, is the ED an appropriate venue for such an intervention? The potential for discussion on voluntary alcohol consumption being perceived as victim blaming and concerns with what can be cognitively processed during the acute phase of crisis requires closer scrutiny before intervention models are established.

Alcohol is the number one drug used to facilitate sexual assault (Ledray, 2008; Madea & Mußhoff, 2009). It serves to facilitate victimization, perpetration, re-victimization and a tendency for ongoing alcohol abuse (Abbey, McAuslan, Zawacki, Clinton, & Buck, 2001; Benson, Gohm, & Gross, 2007; Gidycz et al., 2007; Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997; Kilpatrick et al., 2003; Miranda, Meyerson, Long, Marx, & Simpson, 2002). As many sexual assaults go unreported, a conservative estimate of sexual assault prevalence suggests that 25% of adolescent or adult American women have experienced sexual assault (Abbey, Zawacki, Buck, Clinton, & McAuslan, 2001). Of these known sexual assaults, approximately one-half of the victims report that they were drinking alcohol at the time of the assault (Abbey, McAuslan, et al., 2001), and research has indicated that heavy episodic drinking is the greatest risk factor for alcohol-related sexual assault (Mohler-Kuo, Dowdall, Koss, & Wechsler, 2004).

Sexual assault nurse examiners (SANEs) clearly recognize the contribution of alcohol in creating an environment of vulnerability for the victims of sexual assault. Despite our understanding that alcohol use can function as both a risk factor and consequence of sexual assault (Benson et al., 2007; Kaysen, Neighbors, Martell, Fossos, & Larimer, 2006; Kilpatrick et al., 1997; McCauley et al., 2008) and that once victimized there is a greater chance for revictimization (Gidycz et al., 2007; Turchik, Probst, Irvin, Chau & Gidycz, 2009), these risks are typically not addressed by those who first respond to the sexual assault (Cole & Logan, 2008). Vulnerability is clearly an important issue. However, this aspect of emotional care is allocated to other sexual assault advocates and support services through SANE referrals or recommendations at discharge. Unfortunately, most victims do not follow through on the supportive services that they need, (Boykins & Mynatt, 2007; Ledray, 2008; Nesvold, Friis, & Ormstad, 2008). Therefore, the time spent one-on-one with the SANE in the ED may be the only intervention that the victim receives. At this point, what can realistically be done to address the issue of alcohol and vulnerability for sexual assault?

Alcohol and sexual assault is a vulnerability issue that is well understood, but poorly addressed. As Ledray (2008) suggests, SANEs are in an excellent position to address alcohol-induced vulnerability, but the fear of having concern construed as blaming the victim has prevented an effective approach for dealing with this issue. Cole and Logan (2008) suggest that the way to address the issue of substance abuse in the immediate aftermath of sexual assault is controversial, and with legitimate concern. Self-blame is more likely to occur when victims have been under the influence of alcohol and believe that they have contributed to the assault (Abbey, 2002). It has also been found that alcohol use is perceived by others as contributing to responsibility for the assault by the victim (Sims, Noel, & Maisto, 2007). Therefore, while maintaining an emphasis on avoiding revictimizing by suggesting blame, what information is central to the issue that can be retained at a single point of intervention, and what can be cognitively processed by the victim at this point of crisis?

Alcohol's influence on sexual assault

The fact that alcohol consumption and sexual assault co-occur frequently suggests some type of causal pathway. Abbey (2002) poses several attitudinal and situational factors that interact with alcohol consumption as explanations for the relationship between alcohol and sexual assault, particularly in the realm of acquaintance sexual assault. Abbey (2002) has identified

alcohol's influence on sexual assault as involving personal beliefs and expectancies about alcohol, deficits in cognitive processing and motor control, and peer group norms that encourage drinking.

Alcohol beliefs and expectancies

Alcohol expectancies strongly influence the use of alcohol and have been associated with sexual victimization (Corbin, Bernat, Calhoun, McNair, & Seals, 2001). The expectation that alcohol will diminish sexual inhibition and positively enhance a social or sexual experience (positive alcohol outcome expectancy) often leads to increased drinking in potentially sexual situations and, for some, may also provide an "excuse" for sexual risk-taking behaviour that would otherwise not be acceptable (Pumphrey-Gordon & Gross, 2007). Corbin and colleagues (2001) have found that women who hold positive alcohol outcome expectancies are more vulnerable to sexual victimization. They are less likely to attend appropriately to harm or threat cues that are incongruent with their positive expectancies. They are more vulnerable to yield to sexual coercion and tend to offer less resistant refusal responses to unwanted sexual advances. This behaviour may suggest that women who hold strong beliefs about the influence of alcohol may feel that they have little power to alter the course of the social/sexual interactions and succumb to unwanted sexual contact (Pumphrey-Gordon & Gross).

Whereas beliefs and expectations associated with alcohol consumption increase the risk of vulnerability to the victim, they also have a causal influence on the perpetrators of sexual assault. Expectations of alcohol's effects (feeling more powerful or more sexual), stereotypical beliefs about women who drink, and perceiving alcohol a sexual signal, may be factors that encourage men to interpret a spurned sexual advance as an invitation to become increasing more persistent (Abbey, 2002). For the perpetrator, the consumption of alcohol may be construed as a viable excuse for sexual assault (Abbey, 2002). However, perpetrators of sexual assault are legally and morally responsible for sexual assault regardless of levels of intoxication or beliefs that they were somehow "led on". In Canada, self-induced intoxication cannot be used as a viable defence for perpetration of sexual assault (Minister of Justice, 2010).

Deficits in cognitive processing and motor control

Alcohol consumption impairs cognitive processes and facilitates the misperception of ambiguous messages, ones that may convey sexual intent or subtle cues of threat (Steele & Josephs, 1990). Steele and Josephs have labelled this phenomenon "alcohol myopia," or "short sighted-information processing" (p. 922). Essentially, alcohol prevents the drinker from responding normally to incoming cues by narrowing the range of cues that can be processed, as well as impeding one's ability to extract the meaning from the perceived cues. It also interferes with one's ability to plan and implement an effective escape strategy (Abbey, 2002). In a social situation, a woman is less able to perceive the presence of threat in a message or situation that may lead to a forced sexual contact or sexual assault (Abbey, Clinton-Sherrod, McAuslan, Zawacki & Buck, 2003). According to Abbey (2002), alcohol myopia may lead women to take risks that they ordinarily might not. While in the process of having fun or wanting to be liked, they are less likely to attend to personal safety issues. Alcohol myopia also influences the perpetrator, who may misinterpret friendly or benign female responses as sexual responsiveness, and even a clear verbal or physical rebuff may be construed as a message for a more persistent pursuit (Abbey, 2002).

Alcohol also interferes with motor function, thereby limiting a woman's ability to resist a sexual assault (Abbey, 2002). The notion that sober victims are more able to escape or resist is supported by studies showing that attempted sexual assaults, rather than completed sexual assaults, are more common among sober individuals (Abbey, 2002; Testa, Vanzile-Tamsen, & Livingston, 2004; Ullman & Brecklin, 2000). Sadly, not being able to adequately resist a sexual assault is often seen by women as a failure on their part to be in control of the situation, which contributes significantly to the self-blame associated with sexual assault (Abbey, 2002; Sims et al., 2007).

Peer group norms and binge drinking

Another factor that influences an individual's consumption of alcohol may be peer group norms. Alcohol consumption can be shaped by how an individual perceives the drinking patterns of valued peers, and the misperception that peers are drinking heavily or binge drinking encourages others to engage in similar behaviour (Ham & Hope, 2003; Wechsler & Kuo, 2000). Heavy drinking, particularly binge drinking (four to five drinks in a row), is recognized as a significant problem among college youth (McCauley & Calhoun, 2008; Wechsler, Lee, Kuo, & Lee, 2000) and is a strong risk factor for sexual assault (Mohler-Kuo et al., 2004). Although several mechanisms may influence this alcohol-assault relationship, such as increased exposure to more sexually risky environments and association with heavily drinking men who may be aggressive toward women, it has been found that women who drink heavily have a tendency to underestimate their vulnerability to be a victim of sexual assault. Contributions to this vulnerability may also include a lower risk perception, less need for resistance and a diminished ability to resist (McCauley & Calhoun, 2008).

Despite this awareness of alcohol's contribution to sexual assault, and an increased emphasis on sexual assault prevention programs, particularly at the college level, the effects of these programs on the overall rate of victimization remains unclear. Recent findings suggest that the prevalence of sexual assault has not significantly changed (Casey & Lindhorst, 2009; Casey & Nurius, 2006), and may have increased (Casey & Nurius,

2006). Interestingly, of those studies that reported program efficacy in reducing sexual assault in college women, findings did suggest that programs were not effective for those with a prior history of sexual assault (Rothman & Silverman, 2007; Yeater & O'Donohue, 1999). Similarly, Marx, Calhoun, Wilson and Meyerson (2001) found that prevention programs might not be effective in influencing levels of risk recognition for those previously victimized. Unfortunately, individuals who present to SANEs in the ED are just that group of women who, by virtue of the current assault, have now become that challenging group where the efficacy of education has shown to be questionable. Given this, what can one hope to achieve in the ED? We do know that there has been a significant body of research focusing on brief alcohol-related interventions in acute care and emergency settings that suggest promising outcomes with respect to both alcohol reduction and high-risk behaviour (Barnett et al., 2004; D'Onofrio, Pantalon, Degutis, Fiellin, & O'Connor, 2005; Lau-Barraco & Dunn, 2008; Monti et al., 2007; Monti et al., 1999; Sommers et al., 2006; Sommers & Riback, 2008). These interventions are client-centred, and emphasize empathy, exposing discrepancy in alcohol-related expectancies and supporting self-efficacy for change (Monti et al., 2007). It has been suggested that these types of interventions in the ED capitalize on a "teachable moment" due to recency of the event, the emotional state and probable ambivalence toward alcohol given the current negative consequence of its use (Monti et al., 1999). However, can one assume the same "teachable moment" potential in the instance of sexual assault? Alcohol-related high-risk behaviour with salient negative consequences connotes a degree of blame or responsibility. Alcohol-related sexual assault is about vulnerability and victimization and not blame or responsibility. Addressing the use of alcohol at initial contact, however well intentioned, may be construed as a negative or judgmental reaction by care providers (Ahrens, 2006). This serves to reinforce the victim's perception of self-blame by implying some degree of responsibility for their victimization (Sims et al., 2007; Ullman, Townsend, Filipas, & Starzynski, 2007). Cole and Logan (2008) also suggest that any emphasis on the victim's actions, such as alcohol consumption, may be construed as blaming, particularly at the time of crisis. Thus, even though those who have been sexually assaulted are at an increased risk of developing substance abuse problems (Kilpatrick et al., 1997), or may be at risk of victimization again due to present drinking practices, it may not be not advisable to address issues in the immediate aftermath of a sexual assault.

Conversely, some victims of sexual assault present with self-blame associated with alcohol consumption as a possible influence on the assault, and are looking toward support providers to help them overcome these feelings of self-blame and culpability. Addressing the issue of alcohol use and vulnerability, while clearly communicating that a victim's use of alcohol does not absolve the perpetrator of responsibility for his actions, may help to reduce a victim's self-blame (Cole & Logan, 2008). Pennebaker (1990) suggests that talking about issues where there may be self-blame, rather than ignoring them may facilitate victim recovery, as long as the discussions are framed in a non-judgmental manner. Ahrens (2006) similarly found that when support providers were unable or unwilling to counter disclosures of alcohol-related self-blame, or were inadequate in their responses, victims chose to internalize blame and not seek further help. With self-blame being a possible link to revictimization (Miller, Markman, & Handley, 2007), and Post Traumatic Stress Disorder (PTSD) (Ullman et al., 2007) the responsibility to assuage these feelings is noteworthy.

How, then, to best address this issue of alcohol and sexual assault? Victims present to the ER in what is known as the acute phase, characterized by shock, numbing and disbelief, and it is advised that during this crisis stage, most victims are not ready to engage in interactions that require sustained attention or intense involvement (Kress, Trippany & Nolan, 2003). Thus, engaging in discussion on the interactions of alcohol's influence on sexual assault, as outlined by Abbey (2002), would likely be beyond the victim's processing capability. Furthermore, an in-depth critique of studies on the efficacy of sexual assault programs suggests that there is little valid evidence of the efficacy of a "one shot" educational process, particularly with high-risk individuals such as those with substance use issues, or that behavioural changes, if any, can be maintained (Yeater & O'Donohoe, 1999). We also know that efficacy in revictimization prevention programs requires multiple risk-reduction information exposures, so that victims can cognitively process and retain information (Macy, 2007; Yeater & O'Donohue, 2002). This suggests that a single-point education process to address characteristics that could otherwise be amenable to change, such as alcohol expectancies and beliefs and binge drinking, would be insufficient.

The role of education in the ED, if applicable, should be very simplistic, as there may only be moments at the end of an arduous process where there is an opportunity to move beyond the primary SANE goals of treating medically and collecting evidence. Undoubtedly, the need to address vulnerability is important. However, care must be taken not to overemphasize the victim's capacity to avoid revictimization, as this places undue responsibility on victims for their experience (Macy, 2007) and, as suggested by Yeater and O'Donohoe (1999), may even contribute to feelings of loss of self-efficacy or hopelessness toward future experiences. For those victims who are assuming some responsibility for the assault due to the consumption of alcohol, it is essential that SANE capitalize on this receptivity or "teachable moment" to assuage these feelings. It should be made clear that alcohol consumption by either the victim or the perpetrator cannot justify the socially inappropriate action of sexual assault. However, the influence of alcohol in diminishing one's ability to accurately perceive cues of threat and to effectively resist an assault should be mentioned. This information does not evaluate the victim's drinking behaviours, but does provide information that may later influence either alcohol consumption or the creation of a social safety plan, as a means to reduce vulnerability. Another non-judgmental method of imparting the perils of alcohol and sexual assault may be by

teaching from the perspective of the perpetrator. The effect of alcohol-related sexual beliefs, stereotypes about drinking women, the misinterpretation of sexual intent and inability to interpret signals of rejection may create an awareness by women of the mindset of the sexual predators, encouraging better choices for risk reduction.

Conclusion

Although the attitudinal and situational factors that interact with alcohol consumption to increase the likelihood of sexual assault are amenable to change, in general, it would appear that a brief ED intervention provides a limited opportunity to implement this change (Yeater & O'Donohoe, 1999; Yeater & O'Donohue, 2002). Also, as alcohol is only one risk factor among many that contribute to revictimization (Macy, 2007), such as age, Caucasian race, attending college, on/off campus, use of drugs while intoxicated, belonging to a sorority, peer norms and social environment (Mohler-Kuo et al., 2004), an ED intervention may have no discernible impact on the victim. Because of the many pathways that contribute to sexual assault, a downstream approach such as an ED intervention should only be one of many efforts to address sexual assault prevention. Sexual assault prevention programs typically introduced at the college level should be implemented at middle school, where attitudes and beliefs are forming and peer group norms are being established (Abbey, 2002). Also, as evidence suggests that the etiology of sexual aggression emerges from multiple contexts, including individual, peer and community risks, an ecological prevention model strategy may be a more promising approach to sexual assault prevention (Casey & Lindhorst, 2009). At the point of crisis, however, for those health professionals such as SANE who are addressing prevention of further victimization, appropriate care involves a delicate balance between seizing an opportunity to briefly introduce issues of alcohol-related vulnerability against the risk of contributing to self-blame. As suggested, without an expressed indication of self-blame or responsibility for the sexual assault by the victim, addressing alcohol-related vulnerability may be tenuous and possibly harmful. What appears significant to the process of prevention is multiple information exposure that can only be achieved by rigorous follow-up and counselling once the initial crisis has passed. As indicated previously, poor follow-through on referrals or recommendations upon discharge is an ongoing problem that contributes to the issue of alcohol and vulnerability (Boykins & Mynatt, 2007; Ledray, 2008; Nesvold et al., 2008). Perhaps the role of SANE should not end at the ED, rather should encompass a program that includes facility-based follow-up on accessible referrals and ongoing counselling.

About the author

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