

# The Acute Treatment of Sexually Abused Patients: An Evolving Profession

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The crime of sexual assault and rape was documented already in ancient times. This is one of the most prevalent violent crimes, yet only in recent times has it become the object of significant public attention. Medical care, both for the physical and psychological injuries, needs to be based on knowledge and experience, which is scarce. Sexual abuse is defined as any sexual act or behavior that is imposed on a woman, man, or child, without their consent. In most cases, it is a sexualized form of violence, consciously designed to terrify. Sexual abuse is not the result of uncontrollable sexual impulses or libido. It is a crime intended to humiliate and control the victim. However, the definition of rape is not simple. It depends on where it happens, the age of those involved, the gravity of violence involvement, the type of sex involved, and other specific related issues. The first recorded law against this crime was in 1275 in Europe, which made it an offence to have sex (with or without consent) with a “maiden within age” – under the age of 12 years. In the Bible, in Deuteronomy (22: 28–29), it is written that the rapist (although not clearly defined) may be compelled to marry the unmarried woman instead of receiving the civil penalty only upon her father’s consent (an ancient social arrangement

that does not take into consideration that this solution forces the victim to spend her life with the man who initially raped her). The prevailing societal understanding that most rapes are committed by sexual perverts, or by men who cannot control their sexual urges, has been repeatedly refuted.

The intrusiveness of rape results in both physical and psychological damage to the victim. Rape is rated as one of the most severe traumas because it is not a natural disaster or an act of God, but a monstrous phenomenon that emerges from the propensity to evil in human nature. Such a grave act shakes a person’s fundamental understanding and basic notions of personal safety, and leads to both long- and short-term physiological and emotional disturbances. As we learn from two articles in this issue of *IMAJ* [1,2], sexual assault and rape are prevalent in different societies. According to United Nations sources in Botswana, the police report more than 90 rape cases per 100,000 population per year. Sweden is just behind with over 60. In the United States, 232 rapes are recorded by the police every day. The impact of sexual assault on society is immense. It is estimated that 70,000 male prisoners in the U.S. are raped annually.

Approximately half of all psychiatric patients were victims of sexual abuse during childhood, but there are many other expressions of a gradual deterioration in general health that occurs after experiencing rape or sexual abuse. These include chronic stomach ache, recurrent pelvic infections, eating disorders, repeated visits to the emergency room, and avoidance

of and aversion to being examined by a doctor. Descriptions of this phenomenon are increasingly common in the medical literature. Every sexual attack has its unique characteristics and the seriousness of the damage is determined by the severity of the attack, the level of violence and the nature of the attack, whether the attacker was a relative or a stranger, whether the attack was singular or one of a series of abusive incidents, and by individual differences between the victims.

The World Health Organization has recognized this dismal situation both because of the prevalence of the phenomenon and because of its medical implications. In Israel, the Ministry of Health and the Authority for the Promotion of Women’s Health have also adopted the understanding that sexual assault and rape constitute a health problem in every respect. They realize that turning a blind eye and refusing to acknowledge the scourge of sexual assault effectively discourages women and men from seeking needed medical attention and emotional assistance.

Clinical studies show that the initial post-rape contact is a critical factor in the victim’s rehabilitative potential [3,4]. The primary objective of treatment is to allow victims to take back control of their lives. At the end of 2000, a treatment center for victims of sexual assault was established in Israel at the Wolfson Medical Center in Holon, a small town close to Tel Aviv [1]. The center is the first of its kind in Israel, based on the philosophy that the victim and his or her needs are central, and hence all those involved – police, forensic medical personnel, social worker, doctor and

nurse – must converge in one place to provide the victim with the best possible care. The center at Wolfson is well situated near the Institute of Forensic Medicine and collaborates closely with its staff. Similar centers have been established in Israel: at Bnai Zion Medical Center in Haifa in 2002, the Bat Ami Center at Hadassah Medical Center (Ein Kerem Campus) in Jerusalem in 2009, and at the Soroka Medical Center in Beer Sheva in 2012.

The multidisciplinary treatment of acutely sexually assaulted patients is becoming a profession. There are very few reports in the literature describing the activity and the effectiveness of therapeutic modalities. In their retrospective analysis of all sexual assault victims treated at the Regional Israeli Center for Care of Sexual Assault Victims over 10 years, Golan et al. [1] describe the extent and complexity of treating such patients in the most vulnerable moments of their lives. The authors also indicate some risk factors for predicting the outcome of the assault, as derived from their data which can be utilized for future preventive programs.

Mankuta and collaborators [2] report their unique experience of a local short-term intervention involving a small and low cost medico-psychological team in a war zone. This activity integrated the identification of sexually assaulted patients with post-traumatic stress disorder by means of validated questionnaires. Pelvic inflammatory disease and other sexually transmitted diseases were treated by the interventional team at the site. The authors evacuated patients who suffered from mutilated genitals to a central hospital. They also offered an EMDR (eye movement desensitization and reprocessing) intervention for patients with severe PTSD. The activity of the Mankuta team was performed alongside the fighting in a war zone in the Democratic Republic of Congo, proving that such a crucial type of medical support could and should be carried out even under such complicated conditions.

Both of these studies, in the present issue of *IMAJ* [1,2], are important for informing us – in a snapshot – of the

PTSD = post-traumatic stress disorder

characteristics of rape in two very different social environments. Additional prospective investigations are needed to determine the preferred management in immediate and long-term medical care centers.

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