International Society
for Traumatic Stress Studies

Written Statement from the

International Society for Traumatic Stress Studies

for the

House Foreign Affairs Committee

On

Peace Corps at 50

May 11, 2011

On behalf of more than 2000 members of the International Society for Traumatic Stress Studies (ISTSS), we thank you for holding this important hearing to discuss the critical issues of safety and security of U.S. Peace Corps volunteers. ISTSS is the premier society of professionals dedicated to the discovery and dissemination of knowledge about traumatic stressors and their immediate and long-term consequences. Our membership includes psychiatrists, psychologists, social workers, nurses, counselors, researchers, administrators, advocates, journalists, clergy, and others with an interest in the study and treatment of traumatic stress. ISTSS members are among the world's leading experts on various forms of trauma, including sexual assault. As such we appreciate the opportunity to share our thoughts regarding this important public health problem with members of this Committee.

Sexual Assault in the Peace Corps and the General U.S. Population

There are several key points that Congress should consider as it determines how to address the problem of sexual assault among Peace Corps volunteers. First, sexual assault is a prevalent problem among U.S. women in the general population as well as among U.S. female higher education students. A recent research project funded by the National Institute of Justice found that 18.0% of a national household probability sample of U.S. women age 18 and older had been raped during their lifetime and that 11.5% of U.S. female higher education students had been raped (Kilpatrick, Ruggiero, Conoscenti, & McCauley, 2007). When these sample estimates were generalized to the populations of U.S. adult women and female higher education students, the authors of this study estimated that over 20 million out of 112 million adult women in the U.S. and 673,000 out of nearly 6 million female higher education students in the U.S. had been raped. It was also estimated that over one million adult women in the U.S. and 300,000 female higher education students in the U.S. were raped during the past year. These estimates do not include attempted rapes or other forms of sexual assault, so the number of women experiencing any type of sexual assault would have been far higher than the estimates for rape alone. Therefore, it is clear that sexual assault is a prevalent problem for women in America.

Next, there is reason to believe that Peace Corps statistics on rape and other types of sexual assault substantially underestimate the extent of the problem. The primary source for information about rape and other types of sexual assault among Peace Corps volunteers is provided in the Peace Corps Annual Report on Volunteer Safety, which provides statistics on cases of these crimes that were officially reported to the agency. The latest report, *Safety of the Volunteer 2009*, indicated that 15 rapes/attempted rapes, 20 major sexual assaults, and 76 other sexual assaults were reported to the agency during 2009 (Peace Corps, 2010a). The total number of all sexual assaults reported to the Peace Corps in 2009 was 111. These statistics on reported cases do not include rape and other sexual assault cases that Peace Corps volunteers did not report to authorities.

The Peace Corps collects additional information about rape and other types of sexual assault experiences of volunteers from its Annual Volunteer Survey that includes questions about personal safety (Peace Corps, 2010b). The 2010 survey is not clear on whether the reference period for personal attacks is the year 2010, the past year, or ever. It also fails to provide a breakout for rapes and other sexual assaults against female versus male volunteers. Volunteers disclosed having experienced 17 rapes, 28 attempted rapes, and 213 other types of sexual assaults. Without more information about the time period covered by the survey and a

breakdown of cases among female versus male volunteers, it is impossible to determine how many of these cases occurred among female versus male volunteers or how this survey estimate of cases compares with the cases officially reported by women to the Peace Corps. Moreover, a comparison of the survey questions used to measure rape and other types of sexual assault with those demonstrated to be "state-of-the-science" (Fisher, 2009; Kilpatrick, 2004) suggests that the Volunteer Survey likely did not capture many rape and sexual assault cases. Even without better data, it is evident that the incidence of rape and other types of sexual assault in the Peace Corps is unacceptably high.

Finally, a considerable amount is known about why women are reluctant to report rapes to authorities, including rape-related concerns that are likely to deter their willingness to report (Fisher, Daigle, Cullen, & Turner, 2003; Wolitzky-Taylor, et al., 2010). Primary concerns include not being believed and being blamed. Given these concerns, it is reasonable to assume that a victim's expectations about how she would be treated if she were to report the crime or what types of services she would receive would impact her willingness to report. Clearly, creating an organizational environment in which victims are believed, supported, and offered services should improve women's willingness to report. If properly implemented, the Peace Corps' newly stated policy outlined in its Commitment to Sexual Assault Victims (2011) would mark an important step toward establishing such a supportive organizational environment.

Consequences of Sexual Assault

The physical, psychological, and social consequences of sexual trauma are potentially vast and long-lasting. Physical consequences of sexual assault include: chronic pain, gastrointestinal disorders, gynecological complications, migraines/headaches, and disability that prevents work (Jewkes, Sen, & Garcia-Moreno, 2002). More than 32,000 pregnancies result from rape every year (Holmes et al., 1996). There are also increased rates of death following sexual violence that may be a result of suicide, HIV infection, or homicide (Jewkes, Sen, & Garcia-Moreno, 2002).

Psychological effects of sexual violence include posttraumatic stress disorder (PTSD) and other anxiety symptoms (Martin, Macy, & Young, 2011; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993), depression (Kilpatrick, et al., 2003), suicide attempts (Ullman, 2004; Waldrop et al., 2007) and drug/substance use (Hedtke et al., 2008). In fact, according to the 2002 World Health Organization's *World report on violence and health*, victims of sexual assault are three times more likely to suffer from depression, six times more likely to suffer from PTSD, thirteen times more likely to abuse alcohol, twenty-six times more likely to abuse drugs, and four times more likely to contemplate suicide.

Rape is among the most virulent and powerful types of experiences known to result in PTSD. Surveys indicate that 25% of women who have experienced sexual assault have PTSD at the time of interview. Moreover, symptoms of PTSD can wax and wane over the years. Indeed, PTSD can develop years after an event so that, from a lifetime perspective, 63% of women who have experienced a sexual assault will develop PTSD at some point in their lives (Resnick et al., 1993).

Victims report negative reactions and perceptions among friends, families and professionals expected to help them, which can lead to feelings of shame as well as disengagement in family,

social and professional relationships (Filipas & Ullman, 2001; Wilson, Drozdek, & Turkovic, 2006). Sexual violence affects the survivors' social functioning, leading to strained relationships with family, friends, and intimate partners. Sexual assault is associated with reduced contact with friends and relatives and with lower likelihood of marriage (Golding, Wilsnack, & Cooper, 2002; Sarkar & Sarkar, 2005). Further, the economic impact of sexual assault, excluding child sexual abuse, is estimated at $127 billion a year to the U.S. population (Miller, Cohen, & Wersema, 1996). It is estimated that each rape costs approximately $151,423 due to medical and mental health services and lost productivity (DeLisi, 2010).

Treatment for Sexual Assault

Still, despite the horrors of sexual assault, there are several things that can be done to protect against or to reduce its often long-term effects. Social support provided by friends, partners, families and communities, and other trauma survivors in the aftermath of a sexual assault, as in other types of traumatic event, can make a critical difference in promoting recovery (Charuvastra & Cloitre, 2008). In addition, there are several mental health interventions that are highly effective in reducing or resolving PTSD and other problems such as anxiety and depression. The large majority of these are cognitive behavioral therapies that focus on reviewing and revising negative beliefs about oneself and others (e.g., safety, shame and guilt) that have developed as a result of the sexual assault. They include therapies such as Prolonged Exposure, Cognitive Processing Therapy, Eye Movement Desensitization and Reprocessing, and Stress Inoculation Training (see ISTSS Treatment Guidelines, Foa et al., 2009). In addition, there are therapies that help women regain or develop even stronger skills in managing stress and facing life challenges such as Stress Inoculation Therapy (see ISTSS Treatment Guidelines). Lastly, it is not unusual for women to develop significant problems other than PTSD as a result of rape such as Major Depression, eating disorders and other anxiety disorders. Effective treatments focusing specifically on these problems are also available.

Even though there are many effective treatments available for PTSD and other mental health problems associated with sexual assault, the key to getting good treatment is having appropriate screening and referral to effective treatment when needed. Unfortunately, screening and referral is often unavailable to survivors. It is critical that prompt screening and treatment be available to survivors of sexual assault, both in the Peace Corps and the general population, to ensure opportunities for timely recovery.

In summary, ISTSS would like to offer five specific recommendations for the Committee's consideration.

Recommendation 1: Better data are clearly needed to establish the magnitude, nature and impact of rape and other types of sexual assault among Peace Corps volunteers. Therefore, we recommend that the Peace Corps commission an independent survey of past and present volunteers using state-of-the-art screening questions, gathering information on formal reporting and reasons for non-reporting, measuring the potential mental health impact of sexual assault, and collecting data about the use of and potential barriers to the utilization of victim assistance and mental health services.

Recommendation 2: The Peace Corps should develop and disseminate evidence-based educational information about sexual assault and its consequences for volunteers, victims, victim assistance professionals, administrators and staff, and mental health professionals. Tendencies to blame the victim rather than the perpetrator of the crime must be corrected. Education concerning the adverse effects of "victim blaming" attitudes and behaviors on the recovery of the victim should be emphasized. Such information will help these groups understand the crime, its consequences for victims, the assistance victims need, and where the assistance can be obtained.

Recommendation 3: In order to increase the Peace Corps volunteers' access to and utilization of effective services, the Peace Corps should consider developing methods to deliver information and services to victims of rape and other types of sexual assault via the web and/or evidence-based mental health assessment or counseling services via tele-mental health methods.

Recommendation 4: The Peace Corps should incorporate regular monitoring of perceived safety and potential incidences of sexual assault or violence among its volunteers during their period of service. This may allow the Peace Corps to implement targeted preventive measures as appropriate, as well as to provide more timely administration of victim assistance and mental health services as indicated (O'Neill & Kramer, 2001).

Recommendation 5: The Peace Corps and other appropriate related authorities should ensure that the perpetrators of rape and sexual assault are brought to justice, and that the justice processes be reparative to the victims (Danieli, 2009).

In closing, the International Society for Traumatic Stress Studies would like to thank you for the opportunity to share our comments as you consider issues of safety and security in the Peace Corps. We appreciate the Committee's ongoing commitment to ensuring the safety and well-being of Peace Corps volunteers. Our organization stands ready to assist the Peace Corps, its volunteers, and the Committee on this critical issue.

References

Charuvastra, A., & Cloitre, M. (2008). Social bonds and posttraumatic stress disorder. *Annual Review of Psychology, 59*, 301-328.

Danieli, Y. (2009). Massive trauma and the healing role of reparative justice. *Journal of Traumatic Stress, 22*, 351-357.

Delisi, M. (2010). Murder by numbers: Monetary costs imposed by a sample of homicide offenders. *The Journal of Forensic Psychiatry & Psychology, 21*, 501-513.

Filipas, H., & Ullman, S. (2001). Social reaction to sexual assault victims from various support sources. *Violence and Victims, 16*, 673-692.

Fisher, B.S. (2009). The effects of survey question wording on rape estimates: Evidence from a quasi-experimental design. *Violence against Women, 15*, 133-147.

Fisher, B.S., Daigle, L.E., Cullen, F.T., & Turner, M.E. (2003). Reporting sexual victimization to the police and others: Results from a national-level study of college women. *Criminal Justice and Behavior, 30,* 6-38.

Golding, J.M., Wilsnack, S.C., & Cooper, M.L. (2002). Sexual assault history and social support: six general population studies. *Journal of Traumatic Stress, 15*(3), 187-197.

Hedtke, K., Ruggiero, K., Fitzgerald, M., Zinzow, H., Saunders, B., Resnick, H., & Kilpatrick, D. (2008). A longitudinal investigation of interpersonal violence in relation to mental health and substance use. *Journal of Consulting and Clinical Psychology, 76*, 633-647.

Holmes, M.M., Resnick, H.S., Kilpatrick, D.G., & Best, C.L. (1996). Rape-related pregnancy: Estimates and descriptive characteristics from a national sample of women. *American Journal of Obstetrics and Gynecology, 175*, 320-324.

Foa, E.B., Keane, T.M., Friedman, M.J., & Cohen, J.A. (2009). Effective Treatments for PTSD: Practice Guidelines from the International Society of Traumatic Stress Studies. New York: Guilford Press.

Jewkes, R., Sen, P., Garcia-Moreno, C. (2002). Sexual violence. In: E. Krug, L. Dahlberg, J. Mercy et al., (Eds.), *World Report on Violence and Health* (pp. 213–239). Geneva: World Health Organization.

Kilpatrick, D., Ruggiero, K., Acierno, R., Saunders, B., Resnick, H., & Best, C. (2003). Violence and risk of PTSD, major depression, substance abuse/dependence, and comorbidity: Results from the National Survey of Adolescents. *Journal of Consulting and Clinical Psychology, 71*, 692-700.

Kilpatrick, D.G. (2004). What is violence against women? Defining and measuring the problem. *Journal of Interpersonal Violence, 19,* 1209-1234.

Kilpatrick, D.G., Resnick, H.S., Ruggiero, K.J., Conoscenti, L.M., & McCauley, J. (2007). Drug-facilitated, Incapacitated, and Forcible Rape: A National Study. Final report submitted to the National Institute of Justice, May 2007, NCJ 219181.

Martin, S., Macy, R., & Young, S. (2011). Health and economic consequences of sexual violence. In J. White, M. Koss & A. Kazdin (Eds.), *Violence against women and children, Vol 1: Mapping the terrain* (pp.173-195). Washington, DC: American Psychological Association.

Miller, T., Cohen, M., & Wiersema, B. (1996). Victim costs and consequences: A new look. Washington, DC: National Institute of Justices, U.S. Department of Justice.

O'Neill, M.O., & Kramer, E. (2002). The Peace Corps Volunteer Safety Support System. In Y. Danieli (Ed.), *Sharing the front line and the back hills: International protectors and provides, peacekeepers, humanitarian aid workers and the media in the midst of crisis* (pp.157-160). Published for and on behalf of the United Nations. Amityville, New York: Baywood Publishing Company Inc.

Peace Corps. (2010a). *Safety of the Volunteer 2009.* Washington, DC: Author.

Peace Corps. (2010b). *Peace Corps Volunteer 2009 Annual Volunteer Survey: Global Report*. Washington, DC: Author.

Peace Corps. (2011). Commitment to Sexual Assault Victims. Retrieved from http://multimedia.peacecorps.gov/multimedia/pdf/documents/Commitment%20to%20Sexual%20Assault%20Victims.pdf

Resnick, H.S., Kilpatrick, D.G., Dansky, B.S., Sanders, B.E., & Best, C.L. 1993. Prevalence of civilian trauma and post-traumatic stress disorder in a representative national sample of women. *Journal of Consulting and Clinical Psychology, 61*, 984–91.

Sarkar, N., & Sarkar, R. (2005). Sexual assault on woman: Its impact on her life and living in society. *Sexual and Relationship Therapy, 20*, 407-419.

Ullman, S.E. (2004). Sexual assault victimization and suicidal behavior in women: A review of the literature. *Aggression and Violent Behavior, 9*, 331–351.

Waldrop, A.E., Hanson, R.F., Resnick, H.S., Kilpatrick, D.G., Naugle, A.E., & Saunders, B.E. (2007). Risk factors for suicidal behaviors among a national sample of adolescents: Implications for prevention. *Journal of Traumatic Stress, 20*, 869−879.

Wilson, J.P., Drozdek, B., & Turkovic, S. (2006). Posttraumatic shame and guilt. *Trauma, Violence, and Abuse, 7*(2), 122-141.

Wolitzky-Taylor, K.B., Resnick, H.S., McCauley, J.L., Amstadter, A.B., Kilpatrick, D.G., & Ruggiero, K.J. (2011). Is reporting of rape on the rise? A comparison of women with reported versus unreported rape experiences in the National Women's Study-Replication. *Journal of Interpersonal Violence, 26*, 807-832.