

Services for victim/ survivors of sexual assault Identifying needs, interventions and provision of services in Australia

JILL ASTBURY

Little research has been done on the services that currently exist for victim/survivors of sexual assault. Yet high quality services can minimise the harm experienced by the victim/survivor. This paper summarises the international and national literature that exists on sexual assault services. It focuses on the needs of victim/survivors, on existing interventions, and data on the services that currently provide these interventions.

Services for victim/survivors of sexual assault form an essential component of the effort to provide an adequate response to sexual violence in Australia. High quality sexual assault services can minimise all forms of harm experienced by the victim/survivor, including long-term physical and psychological harm, many of which are likely to compound in the absence of an appropriate and timely response. Furthermore, it is being increasingly recognised that there is a need to strengthen the quality of existing services that support and provide care to women and girls who have experienced sexual violence (World Health Organization [WHO], 2004).

However, there has been little research on the services that currently exist for victim/survivors of sexual assault. Both in Australia and internationally, very little research has been carried out to assess either the effectiveness of specialist sexual assault services, or the ability of generalist health services in meeting the perceived needs of victim/survivors. Indeed, the Australian Bureau of Statistics ([ABS], 2004) identified the evaluation of programs that seek to respond to sexual assault as one of the three highest priority areas for new research and data collection in the field.

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This paper begins to address this gap by providing a summary of the international and national literature that exists on sexual assault services. The paper focuses



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on three key areas. Firstly, the perceived needs of victim/survivors are identified. Secondly, literature on the existing interventions that are perceived to address these needs, and data on their effectiveness are reviewed. Currently, most of these interventions are therapeutic or counselling interventions. Finally, data on the services that currently provide these interventions, with patterns of service usage, barriers to using these services, and the characteristics of these services that victim/survivors find particularly valuable are identified. The paper will end by making some recommendations for primary health care providers working with victim/survivors of sexual assault.

The paper employs a gendered, health and human rights perspective and an 'ecological framework' to inform the overall aim of investigating current intervention programs for victim/survivors of sexual assault. A multilevel ecological perspective informed by a gender and human rights perspective is considered the most appropriate model for understanding interpersonal violence including sexual violence (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). The ecological framework recognises the multifaceted nature of sexual violence and encourages exploration of the relationship between individual and contextual factors. Sexual violence is seen as the product of multiple levels of influence on behaviour from the level of the individual, to relationships, community and society.

The general term 'sexual violence' will be used interchangeably with the specific terms used in the various research papers and reports cited throughout the paper. 'Survivors' will include both adult survivors of childhood sexual assault (infancy to 17 years of age), who are frequent users of counselling services in Centres Against Sexual Assault and their equivalents, as well as survivors of adult sexual assault. The most common reason survivors contact CASAs is to access counselling services (National Association of Services Against Sexual Assault [NASASV], 2000)

Sexual violence is a human rights issue. Sexual violence violates the notion that victims are full human beings 'born free and equal in dignity and rights'. Among other rights violations, sexual violence transgresses the right of victim/survivors to enjoy the highest attainable standard of physical and mental health (Astbury, 2005). Health service providers therefore have a particular responsibility to identify, understand and ameliorate the harmful health effects of sexual violence.

Background to service provision: The prevalence of sexual violence, and barriers to reporting and disclosure

Before discussing the adverse outcomes of sexual assault, the prevalence of sexual assault, and barriers to reporting and disclosure victim/survivors face are discussed. This is in order to provide background conveying the scope of the issues needing to be addressed by services providers.

The prevalence of sexual violence

The true prevalence of the many forms of sexual violence against girls and women is not known. Available data are drawn from different populations using a variety of measures of sexual violence and data accuracy is affected by non reporting (Lievore, 2003). A full discussion of underreporting and non disclosure can be found in the ACSSA Briefing Paper by Neame and Heenan (2003).

Prevalence rates differ for women and men. In Australia, it is thought that more than one in three women, compared with one in six men reported having unwanted sexual experiences in childhood (Najman, Dunne, Purdie, Boyle, & Coxeter, 2005) and just over 21% of adult women, compared with less than 5% of men experience sexual coercion (de Visser, Smith, Rissel, Richters, & Grulich, 2003). Similar gender disparities in rates of sexual violence are found in recorded crime statistics where more than 80% of all sexual assault victims are female (ABS, 2003) and service use data, where 85% of services are provided to girls and women (NASASV, 2000). Young girls are most vulnerable. Recorded crime statistics reveal that girls between 10 and 14 years of age experience the highest rate of sexual assault (462 per 100,000) (ABS, 2003).

Findings from the International Violence Against Women Survey (IVAWS) indicate that sexual violence is three times more common among Indigenous women than other Australian women. Women from non-English speaking backgrounds in this study reported similar rates to those in the general population. Estimates of lifetime prevalence of sexual violence in national, community based surveys range from 16% in the Women's Safety Survey to 34% in the IVAWS (Mouzos & Makkai, 2004).

Barriers to the reporting and disclosure of sexual violence, and implications for service use

Reporting and disclosure of sexual violence represents an important opportunity for victim/survivors to receive assistance from service providers and begin the process of recovery. However, numerous barriers to reporting and disclosure operate at both the personal level and at the level of the criminal justice system. Furthermore, victims who have been sexually assaulted by someone they know well, particularly an intimate partner, may not even name what has happened to them as a crime and are far less likely to report than victims who have been sexually assaulted by a stranger. Barriers to reporting and disclosure thus may also be barriers to victim/survivors accessing the specialist services they might require.

Lievore (2005) argued that the process of silencing women about sexual violence occurs from the macro level of social discourses and representations, including discourses around women's lack of entitlement to sexual autonomy or stereotypical media representations of 'real rape', through to the micro level of interpersonal interactions. Her study of women's help-seeking decisions and service responses to sexual assault found that a quarter of the women interviewed either did not

or could not name what they had experienced as sexual assault. Yet, even if an experience is unnamed it can still exert a profound impact. All these women experienced psychological and physical consequences, ranging from depression and suicide attempts to poor health and eating disorders. At the same time, when an experience of sexual violence remains unnamed, delays in accessing services may occur and victim/survivors may not link negative personal, health and social outcomes that appear over time with past violence.

Lievore (2003) cited a number of personal barriers to disclosure including:

- shame, embarrassment;
- regarding it as a private matter;
- not thinking what has happened is a crime or not thinking it is serious enough to report to police;
- not wanting anyone else to know;
- self blame or fearing blame by others for the attack;
- dealing with it themselves; and
- wanting to protect the perpetrator, the relationship or children.

Barriers at the level of the justice system include:

- believing that the police would not or could not do anything or would not think it was serious enough;
- fear of not being believed or being treated with hostility;
- fear of the police and/or the legal process;
- lack of proof that the incident occurred;
- not knowing how to report; and
- doubt that the justice system will provide redress.

... the process of silencing women about sexual violence occurs from the macro level of social discourses and representations ...

The barriers identified by Lievore (2005) have a personal and social dimension and provide a map of the psychological terrain likely to be inhabited by many survivors. All are capable of engendering emotional distress in addition to that generated by the sexual assault. In this way, these barriers may complicate and compound the psychosocial burden already carried by survivors. This burden is the one with which service providers must grapple when they work with victim/survivors and develop interventions to meet their needs.

In addition to these matters, sexual violence is associated with both immediate and long-term effects. Service providers must be able to identify and respond appropriately to these effects if victim/survivors are to receive meaningful assistance. Most research on these effects has been conducted in the US: a brief review follows.

Adverse outcomes of sexual assault experienced by victim/survivors

Immediate effects of sexual violence for the victim/survivor

Immediate effects include shock, fear and feelings of helplessness. Illusions regarding personal safety and being invulnerable in the world are shattered, and levels of psychological distress are very high in the first few weeks after the sexual assault but abate over the longer term (Koss et al., 1994). Victims can experience a range of physical injuries and damage to the urethra, vagina and anus and are at increased risk of contracting sexually transmissible infections including HIV/AIDS. Fears of contracting HIV and/or becoming pregnant as a result of sexual assault are pervasive (Holmes, Resnick, Kilpatrick, & Best, 1996; Resnick, Acierno, & Kilpatrick, 1997).

Long-term effects of sexual violence on the victim/survivor

Sexual violence, whether this occurs in childhood or adult life, is associated with a plethora of poor, long-term, physical health outcomes. These physical health problems include sexual and reproductive health problems, pain syndromes, eating disorders (especially bulimia nervosa), and gastro intestinal problems (Krakow et al., 2002; Leserman, Li, Drossman, & Hu, 1998).

Mental health problems such as major depression, generalised anxiety, panic, phobias, symptoms of traumatic stress and suicidal thoughts and actions are common. These can co-occur with reduced self-esteem and a damaged sense of gender identity.

Relationships can also suffer depending on how well or badly those closest to the victim such as a partner, family or friends are able to understand the impact of the sexual assault and how they respond to its disclosure (Coker et al., 2002; Fleming, Mullen, Sibthorpe, & Bammer, 1999; Koss, 1993; McMahon, Goodwin, & Stringer, 2000; Resnick et al., 1997). Being better informed about the psychological effects of sexual violence would greatly assist family and friends of survivors to feel more confident in providing support and understanding.

Women who have been sexually victimised as children face increased risks of subsequent rape and domestic violence in adult life and experience even higher rates of adverse health outcomes (Fleming et al., 1999).

'Post-traumatic stress disorder'

Of all the traumatic stressors researched so far including natural disasters such as earthquakes, hurricanes and tsunamis, it is the 'man made' trauma of sexual violence that most strongly predicts the subsequent development of post-traumatic stress disorder (PTSD) (Bruce et al., 2001; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Women who have experienced sexual violence constitute the single largest group of people suffering from PTSD (Calhoun & Resnick, 1993). Rape victims are six times more likely to develop PTSD at some point in their lives than non victimised women (Kessler et al., 1995; Kilpatrick, Edmunds, & Seymour, 1992). Women's risk of developing PTSD following exposure to trauma has been found to be approximately two-fold higher than men's. Women's PTSD also tends to last longer. This parallels the gender difference found for depression, with which PTSD frequently co-occurs (Breslau et al. 1998).

Feminist researchers have criticised the use of the psychiatric diagnosis of PTSD as the main way of understanding and responding to the psychological distress and the meaning of sexual violence for women. Both Edna Foa and her colleagues (Foa, Cashman, Jaycox, & Perry, 1997) and Judith Herman (1992) have argued that the assumptions and the symptoms that define the diagnosis of PTSD do not accurately reflect the range of traumatic experiences and traumatic effects experienced by survivors of sexual violence and whose PTSD is of a more complex type than that experienced by survivors of discrete traumatic events.

Like all psychiatric diagnoses, PTSD relies on the individualising and pathologising language of 'psychiatric symptoms' and represents the victim of sexual violence as the bearer of a psychiatric disorder. By focusing on the victim/survivors as a person with a mental illness needing treatment, attention is deflected from the social causation of rape and the generalised oppression of women. Moreover, the concentration on a set of decontextualised and medicalised set of problematic

symptoms inherent in the diagnosis of PTSD also shifts attention from survivors' psychological concerns including the impact of sexual violence on their sense of themselves, their lives, their relationships, their sense of safety in the world and their overall health and wellbeing.

Sexually victimised women who develop PTSD are significantly more likely than those who do not, to have to contend with a number of other co-occurring or co-morbid psychological difficulties that may persist for many years (Kessler et al., 1995). Survivors who develop PTSD can be impacted by this both during the day when they experience intrusive thoughts and distressing recollections of the violence, and at night when nightmares and other sleep disturbances may be the norm rather than the exception (Choquet, Darves-Bornoz, Ledoux, Manfredi, & Hassler, 1997; Krakow et al., 2000; Krakow et al., 2002; Roberts, 1996). A number of the women interviewed in Lievore's (2005) study commented on being unable to sleep, not sleeping properly and having nightmares.

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Nightmares are listed within the symptom cluster describing 're-experiencing symptoms' and difficulty getting to sleep and staying asleep are listed within the symptom cluster describing 'arousal symptoms'. One US study found that survivors with PTSD recalled having more than five nightmares per week on average (Krakow et al., 2002). Sleep problems affect the daytime functioning of those who experience them and impair functioning at work, diminish quality of life and are associated with a higher risk of accidents and increased health care costs (Roth, 2005). Prescribed medications for sleep problems include anxiolytics and hypnotics but over-the-counter medications, alcohol or other drugs are often used to self-treat (Roth, 2005).

Health providers have a unique opportunity to identify a history of sexual violence, diagnose psychological disorders and provide accurate and meaningful responses to survivors' sleep and other violence related health problems. Research to date suggests that few take this opportunity. A study of more than 3000 women attending general practitioners in Victoria found that only 9% of women who had experienced sexual abuse had ever disclosed this to their general practitioner, primarily because the practitioner had never asked about a history of victimisation (Mazza, Dennerstein, & Ryan, 1996). Yet recent Australian research (Vos et al., 2006) demonstrates that intimate partner violence including sexual violence is the single largest risk factor for ill health (primarily poor mental health) for Victorian women aged between 15 and 45 years.

'Secondary victimisation'

A victim/survivor's negative experiences regarding the assault with those closest to them (family members, friends), and with the criminal justice system and health service providers (including counsellors) can contribute to what has been termed 'secondary victimisation'. Such victimisation is likely to exacerbate existing psychological distress (as outlined above) and delay recovery from the initial trauma (Campbell & Raja, 1999).

Secondary victimisation by service providers is a major preventable form of harm to the survivor and its elimination should be a priority for all professionals working with victim/survivors of sexual violence. Both the initial sexual assault and secondary traumatisation can initiate or reinforce harmful health behaviours including smoking, heavy alcohol and illicit drug use and reliance on prescribed

and non prescribed medication. These behaviours are independently associated with poor mental and physical health (Resnick et al., 1997).

Patterns of utilisation of different forms of health care reveal some interesting variations. Overall, sexually victimised women have increased rates of utilisation of medical services compared with non-victimised women. However, they have lower rates of using mental health, services for victims and preventive health care (Jewkes, Sen, & Garcia-Moreno, 2002; Koss, Koss, & Woodruff, 1991; Springs & Friedrich, 1992).

Interventions to reduce psychological distress and their effectiveness

To be meaningful, contemporary sexual assault interventions must respond to survivors' needs and concerns. At the present time, the evidence base on this and other aspects of sexual violence is incomplete. Currently available interventions may not be the most appropriate ones to respond to survivors' needs.

In Australia, the pressing need to deliver services has understandably taken priority over evaluation of those services. As already mentioned, research on existing interventions and different approaches to working with survivors is lacking. Some sexual assault service workers may also have philosophical reservations about psychological research if this is perceived to 'label' and psychopathologise victim/survivors. A small amount of research exists on service users and their perceptions of sexual assault services. This will be discussed below, but first the largely US research on mental health interventions for survivors will be reported.

Mental health interventions

The main focus of mental health interventions for victim/survivors has been on the treatment of the mental health consequences of sexual violence including guilt, shame, anxiety, depression, hypervigilance, anger, mood swings and social discomfort (Campbell, 2001; Foa, Rothbaum, Riggs, & Murdock, 1991; Trowell et al., 2002; Vaa, Egna, & Sexton, 2002). Some of these consequences equate with symptoms of PTSD (Foa et al., 1991; Lubin, Loris, Burt, & Johnson, 1998). However, as mentioned previously, victims of sexual assault may experience forms of psychological distress that do not meet criteria for the diagnosis of psychological disorders such as intense feelings of shame, existential insecurity and self blame. Alternatively, they may present with symptoms that do meet criteria for disorders such as depression, anxiety and dissociative disorders. These conditions may also co-exist with symptoms of PTSD (Lubin et al., 1998; Nishith, Nixon, & Resick, 2005; Vaa et al., 2002). The literature identifies two main psychotherapeutic approaches in relation to the treatment of victims of sexual assault: cognitive behavioural therapy and feminist (or group) therapy.

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Cognitive therapy

Cognitive therapies include cognitive behaviour therapy, rational emotive therapy and cognitive processing therapy. All share the assumption that psychological distress and behavioural dysfunction can be produced by inaccurate and dysfunctional thinking. The goal of therapy therefore, is to change psychological distress by challenging and changing the distorted cognitions which give rise to it.

Clients are taught, in a variety of ways to “recognize, observe, and monitor their own thoughts and assumptions, especially their negative automatic thoughts” (Corey, 2005, p. 285).

Cognitive behavioural therapy (CBT). CBT involves a number of different techniques, such as exposure to traumatic memories, cognitive restructuring and eye movement desensitisation and reprocessing (Bradley, Greene, Russ, Duttra, & Westen, 2005).

Prolonged exposure therapy. Under the cognitive behavioural framework, Foa and Rauch (2004) evaluated the outcomes of prolonged exposure therapy on its own as well as the combination of prolonged exposure and cognitive restructuring therapies. Prolonged exposure requires the client to confront traumatic memories repeatedly (through imaginal exposure) as well as confronting trauma related situations which are usually avoided (in vivo exposure) (Foa & Rauch, 2004). The goal of this type of therapy is to present the client with information that invalidates PTSD-related cognitions.

Cognitive restructuring therapy. Cognitive-restructuring targets the negative cognitions associated with a traumatic event. The aim of this therapy is to actively engage the client in challenging negative automatic thoughts in order to alter PTSD related cognitions. Foa and Rauch (2004) found that prolonged exposure therapy was effective in reducing PTSD related symptoms in victims of sexual assault; however the addition of cognitive restructuring did not enhance the outcome of therapy.

Women who received the [cognitive processing therapy] program ... showed significant improvement on measures of PTSD and depression and this improvement was maintained for six months.

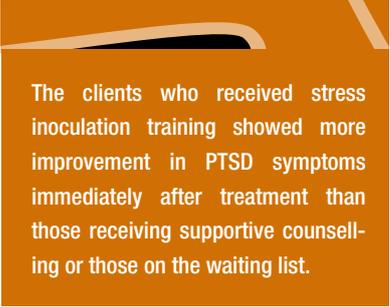
Other therapeutic services that address PTSD. Therapeutic services to prevent sexual assault victims from experiencing chronic symptoms of PTSD and depression have also been explored. Resick and Schnicke (1992) used cognitive processing therapy involving education, exposure and cognitive components in a 12-week program using a pre-test post-test design. Women who received the program compared with a wait list (control) group showed significant improvement on measures of PTSD and depression and this improvement was maintained for six months. Foa, Hearst-Ikeda, and Perry (1995) developed a brief cognitive behavioural program for recent victims

of sexual assault. The program involved education about common reactions to sexual assault, breathing and relaxation training, prolonged exposure therapy and cognitive restructuring therapy. Immediately following the program, women who received the brief therapy were less likely to meet the criteria for PTSD than those who did not receive the therapy. Five and a half months after the end of treatment, women who had experienced the therapy maintained low levels of PTSD symptomatology and were also significantly less depressed than those who had not.

The efficacy of cognitive-behavioural techniques in comparison to solution-focused counselling was investigated by Foa et al. (1991) for the treatment of PTSD in victims of rape. Participants were assigned to either stress inoculation training, prolonged exposure therapy, supportive counselling or a waiting list group (control group). Stress inoculation training involved education about coping strategies, breathing and relaxation exercises, cognitive restructuring and role playing to prescribe new models of behaviour. Prolonged exposure involved asking the client to imagine the rape event repeatedly within the session, and outside the session to expose herself to feared or avoided situations that were judged by both the client and the therapist to be safe. Supportive counselling was governed by a solution-

focused framework in which the client was asked to report and generate strategies to deal with problems in a highly supportive environment.

Each of the therapeutic procedures was effective in reducing PTSD symptoms, immediately after the treatment and at follow up. However, the timing of the effect differed between the two therapeutic approaches. The clients who received stress inoculation training showed more improvement in PTSD symptoms immediately after treatment than those receiving supportive counselling or those on the waiting list. By contrast the clients who received prolonged exposure therapy showed the lowest levels of PTSD symptoms at follow up more than three months later.



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Interventions that address victim blaming and feelings of guilt. Victim blaming and feelings of guilt are commonly reported by sexual assault survivors and have become a focus of psychotherapeutic intervention in their own right (Campbell et al., 1999). Trauma-related guilt has been associated with the etiology of depression in victims of sexual assault (Andrews, 1995; Gladstone et al., 2004). Nishith et al. (2005) compared the effectiveness of cognitive processing therapy and prolonged exposure on female rape victims. Cognitive processing therapy was equally effective in treating women with 'pure' PTSD or PTSD together with major depressive disorder and significantly more effective than prolonged exposure in reducing guilt cognitions related to the trauma.

Interventions that address sleep difficulties. As noted earlier, chronic nightmares and other sleep difficulties occur frequently in clients with PTSD but have not been a major focus of treatment to date. Krakow et al. (2001) treated chronic nightmares in female sexual assault victims using imagery rehearsal therapy and cognitive restructuring. This treatment decreased chronic nightmares, improved sleep quality and decreased PTSD symptom severity. Another positive outcome was that the clients' experiences in therapy were generalised to and helpful with other areas of maladaptive functioning such as negative and obsessive thinking.

Eye movement desensitisation and reprocessing therapy. Eye Movement Desensitisation and Reprocessing (EMDR) is another component of cognitive behavioural therapy that has been used quite extensively in traumatised populations (Shapiro, 1989). During EMDR the client is asked to move their eyes rapidly from side to side while imagining an aspect of their trauma experience; such as a visual image, negative cognition, negative emotion or physical sensation (Wilson, Becker, & Tinker, 1995). This process is repeated until the client has altered self-cognitions in a positive manner and has become desensitised to disturbing aspects of their trauma experience. Wilson et al. (1995) found that psychologically traumatised individuals, including sexual assault victims, showed reductions in their trauma related issues and anxiety and increases in positive self-cognitions. These results were maintained at three-month follow-up and EMDR was shown to be effective regardless of type of trauma experienced by the client.

Feminist therapy

Feminist therapy stresses the importance of considering the social and cultural context, including gender-based oppression, in understanding the causes and nature of women's psychological difficulties. In this way, feminist therapy contrasts with traditional psychotherapies that attribute problematic behaviours

and emotions to intrapsychic causes, have a tendency to blame the sufferer for her own distress and ignore the role of sociocultural factors and how women are treated in society in gendering psychological disorder (Astbury, 1996).

There is ample empirical evidence linking material disadvantage, the inferior sociopolitical position of women, the rights violations and exposure to sexual and other forms of gender-based violence women experience to their higher rates of certain psychological disorders including PTSD, depression and eating disorders (for review see Astbury & Cabral, 2000).

Feminist therapies ... focus on survivors' difficulties with guilt and self blame in the long term, not merely the alleviation of psychological symptoms in the short term.

The goal of feminist therapy with a victim of sexual violence is to help her understand that such violence is a societal problem not just an individual problem and that sexual violence is reinforced by gender-based differences in privilege and power that play out within interpersonal relationships. Feminist therapies also focus on survivors' difficulties with guilt and self-blame in the long term, not merely the alleviation of psychological symptoms in the short term (Campbell, 2001).

The findings of an early study (Hutchinson & McDaniel, 1986) suggested feminist therapy was, indeed, more successful in reducing survivors' levels of guilt and self blame than traditional counselling. A more recent study (Morgan, 2000) with survivors of childhood sexual abuse also demonstrated that survivors who participated in feminist therapy had greater improvements in depression, social adjustment, self-blame and post traumatic stress than their counterparts in the control group. Most therapeutic services in the United States use a combination of CBT and feminist therapy according to Campbell (2001).

Vaa et al. (2002) used a multimodal group therapy treatment approach with adult survivors of child sexual abuse and recent adult victims of sexual assault. The therapy ran in five phases each with its own specified goal including developing a sense of group identity and social support, re-experiencing and working through trauma, learning assertiveness, experiencing oneself as a victim and regaining control over one's life, evaluating present circumstances and developing future goals. Of the 50 women who participated in the program, 38 were involved in long-term follow-up some four-and-a-half years later. Those who improved immediately after the treatment were likely to retain this improvement at follow up. Women who were older at the time of treatment and initially showed improvement in psychological symptoms were most likely to lose these gains by the time of follow up. Better post-treatment outcome was found in younger women, who had fewer presenting symptoms at the start of the therapeutic program and had received no previous treatment.

Another group model using a feminist approach was evaluated by Lubin et al. (1998) with a female sample of multiply traumatised women. The therapy was psychoeducationally based and was conducted in three phases. The therapy:

- explored the effects of trauma on the sense of self with particular emphasis on feelings of shame, guilt and issues related to feminine identity;
- examined the impact of trauma on interpersonal relationships; and
- focused on existential approaches of generating meaning in one's life despite trauma.

Results indicated that this form of therapy was consistently effective in reducing PTSD symptoms and other forms of psychiatric distress, regardless of the type of trauma experienced. Moreover, these improvements were maintained at six-

month follow-up. The researchers suggest that group therapy does not need to be limited by focusing strictly on individualised emotional and interpersonal issues as a more structured, psychoeducational format may contribute to more success in symptom reduction and overall outcome.

Very little literature exists on therapeutic frameworks beyond the cognitive behavioural and feminist approaches. Bowling and Weiland (2002) recently conducted a study utilising a family systems framework in order to test its efficacy in treating victims of sexual assault when compared to traditional individual therapy. The clients receiving family systems therapy showed greater improvement in depressive symptoms than individual therapy clients, however reductions in PTSD symptoms were at the same level for both types of treatment. Family functioning was not affected by either type of therapy.

Specialist sexual assault services in Australia: The existing research

Little research has been conducted into therapeutic approaches or interventions with survivors in Australia and what there is tends to be descriptive in nature. No studies could be identified in the Australian literature that focused on the reduction of symptoms linked to specific psychological disorders using experimental or quasi-experimental designs. Some of the research that has been conducted does identify what survivors perceive to be emotionally helpful versus unhelpful about the services they have accessed. Before discussing this, a background to the sexual assault services sector in Australia is provided.

Historical background to Australian services

Efforts to draw public attention to the importance of violence in the lives and health of Australian women were critically connected to second wave feminism (Weeks, 1994). Violence against women was made a priority area for focus at the first Women's Liberation Conference held in Melbourne in 1970. The first Rape Crisis Centres were established in Sydney and Melbourne in 1974. The Melbourne Rape Crisis Centre was run by Women Against Rape at the Women's Liberation Centre in Melbourne with medical services provided by the Melbourne Women's Health Collective in Collingwood. The Queen Victoria Hospital started providing gynecological check-ups and counselling to recent victims of sexual assault in 1977 and the Geelong Rape Crisis Centre was started in 1978. These early services came into being as a direct result of activism by grassroots women's health groups who shared a passionate interest in what was then called 'women's liberation'.

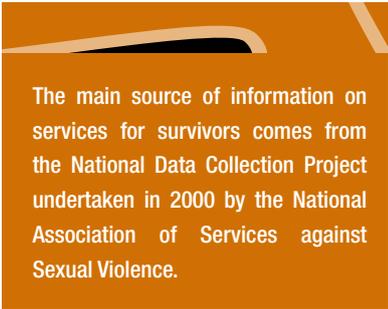
The first services were run as collectives and relied on the work of highly committed volunteers. They were informed philosophically by feminist analyses of society that attributed sexual violence to a patriarchal social order. Women who gave their time to run the early services were initially loath to consider government funding because of the belief that such funding would have unpalatable strings attached, encourage cooption, weaken women's control over services and dilute their agenda of radical social change and emphasis on the prevention of sexual violence (Broom, 1991; Hewitt & Worth, n.d.; Weeks, 1994). Male control of social institutions such as the criminal justice system and the low rate of conviction of men for crimes of sexual violence were seen to illustrate the way in which patriarchy served the interests of men while denying legitimacy to the interests and concerns of women and blocking women's access to justice, power and resources.

The number of funded services increased after the Whitlam Government came to power in 1972. Its platform of social change was more compatible with the philosophical views espoused by the feminists who had set up the first women's health and sexual violence services. A seminal publication that further galvanised women's activism around rape was *Against our will: Men, women and rape* by Susan Brownmiller published in 1975. The first funded Sexual Assault Centre, at Melbourne's Queen Victoria Medical Centre, began in 1979. It was not until the late 1980s that a significant number of government-funded Centres Against Sexual Assault (CASAs) and other Centres that shared the same philosophy of service provision (but have somewhat different names) began to be set up throughout Australia.

Some 118 sexual violence services were identified as potential participants by the National Association of Services against Sexual Violence (NASASV) by the time the National Data Collection Project on these services and their clients was undertaken by NASASV in 2000. These services continue to be informed by feminist notions of practice and situate the crime of sexual violence as an abuse of rights, particularly the rights of women and children (NASASV, 2000).

Research on Australian sexual assault services and on 'mainstream' health services that see the vast majority of sexually victimised women is extremely limited, and presented here below.

Data on services



The main source of information on services for survivors comes from the National Data Collection Project undertaken in 2000 by the National Association of Services against Sexual Violence.

The main source of information on services for survivors comes from the National Data Collection Project undertaken in 2000 by the National Association of Services against Sexual Violence. These services, in keeping with their feminist principles and rights based perspective, prioritise service users' rights to informed consent, information, confidentiality and respectful responses. Many place a priority on violence prevention programs and campaigns and aim to "enhance community understanding of sexual violence against women and children by countering myths with current and comprehensive data" (NASASV, 2000, p. 1).

The objective of the Project was to gain information from all 118 services identified as eligible to participate but unfortunately only 37 services nationwide returned complete evaluation data. This resulted in a participation rate of just over 31%. Nevertheless during the three-week period of data collection in April–May 2000, more than 4,000 contacts with services were recorded and provide a valuable snapshot of services against sexual violence. Most service users (85%) were female and the largest single group (62%) were victim/survivors of sexual assault, followed by professionals (17%). More than half of the contacts were made in person (2,039) followed by phone contacts (1,760) while a small number of people (49) contacted services through writing. Counselling was the most commonly requested service (1,918) followed by information (1,451) and crisis support (639). No information was collected on the length of time service users spent in counselling.

Characteristics of service users

More than 27% of those who contacted sexual assault services were in the age group, 20–29 years, and they comprised the largest group of survivors to contact

the services followed by those in the 30–39 age group (22%). The study does not provide data on whether all those who contacted services received the type of service they were seeking.

Indigenous service users

Around 3.5% of service users identified as Indigenous while in the Australian population overall, Indigenous Australians make up only 2%. It would be a mistake, however, to conclude that Indigenous people are high users of sexual violence services. Indigenous Australians as a group are significantly younger than other Australians and younger age is a risk factor for sexual assault. For example, in 2001, the proportion of Indigenous people under 15 years of age was 39% compared with 20% of non-Indigenous persons and the median age of Australia's Indigenous population was 20 years, some 16 years younger than the median age for the non-Indigenous population (36 years) (ABS, 2005).

Service users with a disability

Around 20% of service users indicated that they had a disability of some sort. The largest group ($n = 350$) however did not specify the nature of their disability. Of those who did specify, a mental health disability was the most common ($n = 270$).

Characteristics of the sexual assaults experienced by service users

Child sexual assault was the most common form of sexual assault for which services, presumably counselling, was requested. More than 1,100 victim/survivors had sought services for this form of assault during the study. This was followed by rape, for which services were sought by slightly less than 600 victim/survivors.

Sexual assaults mainly occurred in the victim's home (46%) with a further 18% occurring in the perpetrator's home. Twelve per cent of assaults were perpetrated by multiple offenders and most offenders (10%) were known to the victim, with the majority being male (79%).

Relationship of services users to the perpetrator

In line with previous research, the vast majority of victim/survivors knew the person who assaulted them. Given the large number of service users seeking assistance with issues related to child sexual assault, it is not surprising that the largest group of perpetrators identified were parents. They were followed by friends and acquaintances, other family members, trusted adults and step-parents. Ninety six per cent of single perpetrator assaults were reported as male. The majority of offenders were aged between 16 and 49 years.

'No longer silent'

The main source of evidence on service users decision making around help seeking and survivors perceptions, views, and experiences of sexual assault services, is Denise Lievore's (2005) study *No longer silent: A study of women's help seeking decisions and service responses to sexual assault*.

This qualitative study focused on service users who had experienced adult sexual assault and consisted of two components. The first examined social and personal factors that influenced victim/survivors' decisions to seek help from a variety of

sources including sexual assault services. It involved semi-structured interviews with 36 female survivors recruited through sexual assault services across Australia. Service users' views were complemented by 65 sexual assault counsellors representing 23 services. The second component involved consulting with 55 sexual assault workers regarding their perceptions of the efficacy of coordinated service provision, their experiences of collaborating with criminal justice and forensic medical personnel and their recommendations for improving service delivery. We discuss the findings of this study here, including the context of other research on service provision from overseas.

Disclosure, decision-making and social support

The study revealed how sexual assault had affected and disrupted every dimension of survivors' lives. Victim/survivors faced making decisions about a range of important life issues, not just the decision about whether to report sexual assault. Help-seeking decisions involved multiple decision points and were affected by survivors' relationships with people from different social contexts and their reactions to disclosures about sexual assault.

The quality of support survivors received was variable within both formal and informal sources of assistance. Of the formal helping agencies, sexual assault counsellors were the most highly valued. Medical, mental health services and services provided by other organisations were judged as less empathetic and less helpful. Among informal support networks, survivors were more likely to disclose to friends and to find them more helpful than family members. Even when friends or family members wanted to be helpful and supportive, they were often unsure about how to provide this or what to say. Women who lacked informal sources of support and had poor mental or physical health were particularly vulnerable to violence and its effects.

Overseas studies have also found that social support is a critical mediator of mental health outcomes. In a study of more than 300 survivors Ullman and Filipas (2001) found that women with lower education, whose assaults were characterised by greater threat to life and who received more negative social reactions on disclosing adult sexual assault, had more severe symptoms of PTSD. Conversely, survivors who had someone believe their account of what happened or were allowed to talk about the assault *and* considered these reactions to be healing had fewer physical and emotional health problems (Campbell, Ahrens, Sefl, Wasco, & Barnes, 2001). Social support also moderates long-term mental health outcomes (Murthi & Espelage, 2005).

Service users' perspectives on disclosure

Of the 36 service users interviewed in Lievore's study, slightly more than three quarters knew their perpetrator and slightly fewer than half of the women first disclosed the sexual assault to a friend. Of the remainder, five had disclosed to strangers including neighbours or passers-by. Disclosure to police or a doctor was less common than disclosure to family members, a counsellor or a psychologist. Three patterns of disclosure were identified. These were: unsolicited disclosures ($n = 25$); solicited disclosures ($n = 7$); and disclosure in the context of being rescued ($n = 4$).

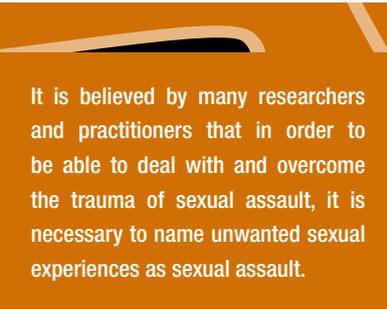
The first disclosure of sexual violence was not always a planned action or a conscious decision with a clear objective in mind. Time to disclosure ranged from

immediately after the sexual assault to decades after its occurrence. Disclosure and help-seeking were largely determined by the context of the sexual assault and/or the social context that made disclosure possible. Other people's confirmation that a serious crime had occurred coupled with an offer of support was instrumental in persuading many survivors to report to police. Unlike the majority of survivors, most of the participants in Lievore's study reported the offence to police. Only six of the 36 women did not report to police. Of the women who did report, 17 reported on their own behalf and 13 had reports made for them by other people. Despite the high percentage of women who reported to police, most reported concerns or negative perceptions about becoming involved in the criminal justice process.

Common threads in the narratives of the participants around their needs at the time of disclosure included the need for safety and protection, emotional or medical help in crisis whether this was months or years after the assault, emotional support and being believed by someone who was sympathetic, not being blamed, making sense of what had happened and having their experiences validated. Needs specifically related to the time when the sexual assault occurred included medical help and practical help such as getting to the police or accessing advice on available options.

It is believed by many researchers and practitioners that in order to be able to deal with and overcome the trauma of sexual assault, it is necessary to name unwanted sexual experiences as sexual assault. A quarter of the women interviewed did not or could not do so even though all of these women had experienced serious psychological and physical consequences, ranging from depression and suicide attempts to poor health and eating disorders.

Lievore (2005) commented that this finding is consistent with previous research about the naming of sexual assault. For example, one early study (Koss & Gidycz, 1985) found that 43% of women who said 'yes' to questions about sexual assaults that met the legal definition of rape, answered 'no' to the question, 'Have you ever been raped?' Part of the difficulty in naming sexual assault may derive from the fact that the efforts, cognitive and emotional, that women make to cope with and contain the distress associated with sexual violence, may also minimise perceptions of its severity. Kelly's (1998) argument cited by Lievore is somewhat different although not necessarily incompatible with this and centres on the silencing of women by dominant male discourses that limit what "is deemed unacceptable (sexual behaviour) to the most extreme, gross and public forms" (Kelly, 1988). Lievore (2005) contended that "this process of silencing occurs from the macro level of social discourses and representations, including discourses around women's lack of entitlement to sexual autonomy or stereotypical media representations of 'real rape' through to the micro level of interpersonal interactions" (p. 32).



It is believed by many researchers and practitioners that in order to be able to deal with and overcome the trauma of sexual assault, it is necessary to name unwanted sexual experiences as sexual assault.

As noted earlier, participants rated sexual assault counsellors as their most valued source of support but at the same time all participants were recruited through sexual assault services suggesting the possibility of selection bias. A few women in Lievore's study did express dissatisfaction with these services but most made highly favourable comments about their counsellor/advocates including "fundamental to my recovery", "my lifeline", "amazing" and "my lifesaver".

Sexual assault services provide a context that functions as an antidote to the culture of censorship and silence that victims can experience in the wider society. Participants' comments underline how psychologically powerful it was to be able to talk and freely express their emotions about what had happened to them and to be believed.

The following comments were from participants in Lievore's (2005) study:

I needed to talk to just get stuff off my chest, I needed to cry, because I held it in, even with my best friend. (Annabelle, p. 67)

I let everything out and that helped put things in perspective. (Alison, p. 67)

It was helpful to talk about anything and everything to the counsellors. (Michelle, p. 67)

This benefit also characterised group work, where the ability to talk with other women was combined with having a sense of belonging at a time when most women's capacity to trust had been violated and they felt profoundly isolated.

I enjoyed group therapy, it was really good meeting women in the same situation. They were as close as I had to friends. I didn't want friends because I didn't trust people. (Kate, p. 68)

Besides group therapy, women valued many other types of activities that occurred in groups such as art therapy and yoga as well as being given brochures on relaxation, tips on how to sleep, information on self-defence and anger management, being able to borrow books on relevant subjects such as relationships and abuse and receiving practical assistance such as help with letters about compensation. These and other activities 'value-add' to standard therapeutic approaches. Moreover, techniques for stress management, weight control, smoking cessation and increasing physical exercise have proven benefits to mood, depression and anxiety levels (Resnick et al., 1997). Sharing information on these techniques with victim/survivors can contribute to the overall goal of healing, namely, by helping to restore power and control to the victimised woman over her life and health.

This approach accords with Herman's (1992) view that violent victimisation is damaging psychologically primarily because it robs the victim of a sense of power and control and is congruent with the feminist, rights-based philosophy of sexual assault services.

Besides group therapy, women valued many other types of activities that occurred in groups such as art therapy and yoga...

Lievore's (2005) study revealed that many of the elements perceived by participants to contribute to the "helpfulness" of services, satisfied survivors' needs for psychological safety. Being able to speak freely to counsellors who understood the effects of sexual violence, were understanding, compassionate and non judgemental, provided emotional support, information, a sense of belonging and ran a service that was accessible at all times, were all thought to be important in "putting things in perspective" and "getting through the process" (p. 67).

Amanda, another participant from Lievore's (2005) study, said:

It's helpful being able to pour your heart out in confidential surroundings, where you're safe and it's okay to ask about your fears. (p. 67)

The establishment of safety represents the first stage in the healing process when feelings of being unsafe extend to the external environment, the perpetrator and

women's sense of being unsafe in their own bodies (Herman, 1992). Stage two involves remembrance and mourning and the third stage relates to reconnection with ordinary life. Herman (1992) cautions that stages "are an attempt to impose simplicity and order upon a process that is inherently turbulent and complex" (p. 155). Nevertheless, the idea of stages has utility for sexual assault workers and other health professionals in suggesting the likely preoccupations and needs of victim/survivors at different points in the healing process. Unfortunately, it is not possible to examine the responses of the participants in Lievore's (2005) study regarding what they found helpful in service provision according to Herman's model of stages, due to insufficient data.

Research on the help-seeking patterns of adult survivors of child sexual abuse and their perceptions of what has been helpful versus unhelpful in their attempts to seek meaningful assistance is needed to complement the research undertaken by Lievore with survivors of adult sexual assault. For example, while the research with survivors of adult sexual assault indicated that most women believed that their needs on initial disclosure had been met, it is not known whether the same would be true for survivors of child sexual assault. The greater vulnerability of children, their higher likelihood of experiencing protracted periods of abuse at the hands of adults in positions of trust and their difficulty in accessing services, all suggest that their experiences of disclosure might be more problematic than is the case with adult survivors.

Sexual assault workers' views on models of service provision

The sexual assault workers consulted in Lievore's study endorsed a model of service provision that incorporated a coordinated response to sexual assault involving interagency collaboration between all agencies with whom victims of sexual assault might have contact including criminal justice agencies, forensic services, health and sexual assault services. For a detailed overview of health sector and interagency protocols, see the detailed overview by Olle (2005) in a previous ACSSA Issues paper.

The ideal of full interagency collaboration has not yet been achieved. Of the 14 sexual assault centres consulted in Lievore's (2005) study, only nine were covered by interagency protocols. Workers in the centres were generally optimistic that progress was being made but a number commented on the sources of tension that can arise between personnel working in different agencies and carrying out different and sometimes contradictory roles. Further research is needed to explore how the existing barriers to the full implementation of integrated service models can best be dismantled.

As one worker in Lievore's (2005) study put it:

The process often works well and when it does it's great, but there are glitches, which are mainly to do with different roles and attitudes. We provide support, advocate for the victim/survivor, have an attitude of belief and are focused on client wellbeing. We define a recent sexual assault as occurring within the last two weeks. We go through the survivor's options face to face: we explain about reporting; that she can contact police if she wants to, or just meet with them; we'll go with her to the crisis care unit. This can conflict with the role of other services. The police are focused on investigating the crime and collecting evidence. They talk about the 'alleged' offender and define a recent sexual assault as up to 72 hours.

They might not attend the crisis care unit. The police look at it from the view of court processes and the paper work involved. So there's a different language, a different belief system (p. 137).

Workers made several recommendations for promoting organisational change and improving social responses to sexual assault. They recommended dismantling barriers to accessing sexual assault services, increasing support for sexual assault centres and specialised service providers, providing specialised training for all systems dealing with marginalised groups and collecting reliable statistical data on sexual assault among women with disabilities and from Indigenous and non-English speaking backgrounds. For a full discussion of sexual assault workers' views on service provision, see Chapter 14 of Lievore's (2005) report.

Most participants in Lievore's study held sexual assault services in high regard. Further research is needed to identify the precise mental health outcomes associated with the feminist, rights based approach to counselling used by these services.

Innovations in service provision in Australia

Shared counselling

The only attempt to describe a therapeutic approach used within a sexual assault service that could be located was a small pilot study on Shared Counselling undertaken in 2005 by CASA House in Melbourne. Shared counselling provides an alternative to one-to-one counselling, decentres the therapist and uses outsider witnesses who engage each other in conversations about what is heard in counselling. By using a narrative, feminist perspective, the shared counselling approach reflected a commitment to "validate women's voices and their stories in the face of inequality" (White, 1995).

Three women, all of whom were survivors of child sexual assault, participated in the program and were interviewed pre-counselling, at six weeks and after completion of the program. At the final evaluation, two women gave shared counselling the maximum rating of five and the third gave it a rating of four. The experience of not being alone, hearing the stories of others and seeing how these resonated in their own lives were all highly valued.

Shared counselling provides an alternative to one-to-one counselling, decentres the therapist and uses outsider witnesses who engage each other in conversations about what is heard in counselling.

One participant described how shared counselling made her "feel special and strong enough to be at ease" (White, 1995, p. 6). For another, identifying the grief she felt helped her to understand "where" she was in herself. Another came to the new belief that there was, after all, a place in the world for her. The women changed how they felt about themselves. Day to day life became less of a struggle. Moments of strength and clarity occurred, relationships and sleep improved and there was "less noise and confusion in my head" and less anger. Sexual assault was no longer seen as being their fault.

The shared counselling approach appears to support existential changes that empowered the women to feel on more solid ground within themselves and as such differs quite markedly from the symptom reduction approach that characterise most of the interventions described earlier. A much larger study of the impact of shared counselling is needed.

Rape Crisis Online

The NSW Rape Crisis Centre established a new service, Rape Crisis Online, in December 2005. The service provides a person-to-person, on-line, real-time information and support service for anyone who has been sexually assaulted and is the first of its kind. Targeted at young people, the service responds to the finding that many survivors of sexual assault report that the most difficult thing after the assault, is telling what has happened for the first time. Advantages of this approach as a first contact with services include survivors being able to access help from a quiet, private location, being able to type words rather than say them and being able to access instant support and information backed up by a website (NSW Rape Crisis Centre, 2005).

Information on the first seven months of operation provided by Jacqueline Burke, Counselling Coordinator at the NSW Rape Crisis Centre, indicates that a total of 149 online contacts were made by 93 individual people to Rape Crisis Online up to July 31, 2006. Around a third had never spoken to anyone before about the violence. The majority (64%) were aged between 16 and 34 years, with approximately 30% from rural NSW. Callers were encouraged to make contact with the NSW Rape Crisis Centre and over a third made subsequent telephone contact. For those who did not want to make contact, counsellors suggested other options.

In line with Lievore's (2005) finding, 30% of callers did not talk directly about being assaulted but asked questions such as "if someone did ... to me, is that sexual assault?". The language and content of most of these calls indicated that the authors were young and wanting help but were unsure of the outcome of 'telling'. Of the callers who spoke directly of sexual violence, 30% had been assaulted in the past seven days and 50% had been assaulted six months or more ago. Overall, 40% had been sexually assaulted as adults, 30% had been assaulted when they were children and a few had been gang raped. On line contacts followed the same pattern as telephone contacts with 68% of calls being received between 3 pm and 11 pm.

General health service providers working with victim/survivors of sexual assault: Some recommendations

The vast majority of women who experience violence including sexual violence do not access formal support agencies such as sexual assault centres. In the most recent analysis of a large scale Australian study of violence against women, Mouzos and Makkai (2004) found only 16% of women who experienced intimate partner violence and only 9% of those who experienced non-partner violence subsequently contacted an agency. Furthermore, while the limited evidence on formal sexual assault services indicates that users regard them highly, no research has yet been conducted in Australia to determine how survivors of sexual violence regard the quality of care and support they receive from primary health care providers.

Given that the majority of survivors access primary health care services rather than specialist sexual assault services, it is imperative that primary health care providers are equipped to enquire about and respond appropriately to disclosures of sexual violence, to detect negative health outcomes including adverse psychological outcomes and to conduct consultations and examinations so as to minimise secondary trauma.

All health care professionals who see female clients need to keep in mind that up to a third of them are likely to have experienced some form of sexual violence over their lifetime.

The need to work differently

Primary health care providers have been trained to develop expertise in the diagnosis and treatment of ill health and to act as authority figures in relation to their clients. As such, they become accustomed to devising treatment plans, giving advice and expecting clients to adhere to those plans and advice.

Increasing patient compliance may be desirable in other spheres of health care but it should not be a goal when working with victimised girls or women. Indeed it is likely to be highly counterproductive because it mimics the controlling behaviour of the perpetrator and reinforces the woman's sense of powerlessness and lack of agency. Health care workers must strive to be as unlike the perpetrator as possible in all their interactions with victimised women. A non-directive, woman-centred therapeutic approach is indicated.

Unlike sexual assault counselling and advocacy services where no physical examinations are carried out, primary care providers routinely engage in a range of physical examinations that have the potential to cause secondary traumatisation.

Intimate or intrusive physical examinations

Secondary traumatisation is most likely to occur in situations that share some or many of the same features as previous episodes of violence. Intimate gynecological examinations are a case in point.

Any clinical examination or procedure that places women in a helpless, powerless or humiliating position where it is impossible for them to exercise control or express preferences or participate in decisions which impact on their emotional wellbeing and/or physical integrity and dignity, will serve as strong reminders of the violence endured outside the consulting room.

A history of trauma and violent victimisation can transform what health care providers might consider 'ordinary' or 'everyday' procedures into formidable challenges to victimised women's abilities to cope physically and psychologically.

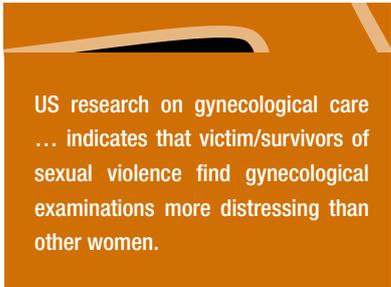
Primary health care providers need to reconsider the traumatic potential of a range of procedures from a client centred perspective and ask the following questions:

- Is there any way this procedure or the manner in which I am carrying it out might be humiliating or traumatic to victims of sexual violence?
- How can I engage women in shared decision making around this kind of clinical care to maximise them feeling safe, informed and in control of what happens?

Some procedures such as Pap testing and other intimate gynecological examinations that occur routinely in pregnancy and labour or in testing for sexually transmitted infections are likely to trigger reminders of past violence and to provoke the same physical and psychological responses as the original violence. Apart from a small pilot study on the Pap testing experiences of survivors carried out at CASA House

(Carlson, 2002), no Australian research to date has been funded to investigate this critical aspect of service provision for victim/survivors.

US research on gynecological care, however, indicates that victim/survivors of sexual violence find gynecological examinations more distressing than other women. Survivors are more likely than non-abused controls to rate their gynecological care experiences negatively and during a gynecological examination report more trauma like responses including overwhelming emotions, intrusive or unwanted thoughts, memories, body memories and feelings of detachment from their bodies as well as more shame, fear and anxiety than other women. Most women (82%) had *never* been asked about a history of sexual violence by a gynecological care provider (Robohm & Bутtenheim, 1996). Similarly, Smith and Smith (1999) reported that survivors of childhood sexual abuse reported higher levels of anxiety during a gynecological examination than non-abused women. The traumatic stress following sexual violence is thus evidenced in the trauma like responses of victimised women to gynecological examinations and may explain why some find Pap tests unbearable (Farley, Golding, & Minkoff, 2002). A traumatic experience of the Pap smear procedure could significantly delay the length of time to subsequent screening or prevent it from occurring altogether. This needs to be investigated further.



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Primary health care that is responsive to the needs of survivors

Primary health care that is responsive to the needs of survivors has an important role in supporting the empowerment of survivors as opposed to reinforcing their disempowerment. It is only in the presence of a trustworthy ally that a survivor is likely to feel comfortable in telling her story or as Herman (1992) puts it, being able to “speak of the unspeakable”.

The establishment of trust is therefore critical. A strategy to achieve this includes ensuring that all discussions about sexual violence occur in a safe and private place. A number of WHO documents on violence against women stress the importance of prioritising women’s safety in any encounter they might have with researchers or clinicians (WHO, 1999; WHO, 2004). This might be summarised as: “Ask alone and ask safely”.

If there is any likelihood of interruption during the discussion that could violate confidentiality, warn of this possibility in advance and agree on a change in the topic of conversation (WHO, 1999).

To provide psychological support, both the words and actions of the health care provider must demonstrate to the victimised girl or woman (who has taken the risk of trusting that provider with her disclosure of violence) that the provider:

- believes what she says about her experience of violence;
- acknowledges her feelings and validates that her emotional reactions to the sexual assault/abuse are normal;
- will work with her and support her to make her own decisions on what is best for her;
- will provide her with information and contacts to other services that could help her;
- says that ‘no one deserves violence’ and no one can deal with the trauma it causes alone;

- informs her that sexual assault is a crime and a violation of her human rights;
- takes a careful history of sexual victimisation including the type or types of violence experienced, when the violence started and how long it continued and an assessment of its severity;
- undertakes an evaluation of each woman's current psychological needs, symptoms and concerns and whether and in what way these have changed over time (signs of depression, anxiety and traumatic stress including sleeping difficulties are particularly important indicators of gender based violence); and
- keeps up-to-date information in a convenient form to provide survivors information and referral to sexual assault, legal and other human services within the community.

The notion of stages in healing from sexual violence may be 'a convenient fiction' (Herman, 1992) but it is this convenience that most recommends it. When listening to women talk about their concerns and preoccupations about sexual violence and its effects, primary health care workers are likely to be able to respond more meaningfully if they understand the different stages and their associated concerns and psychological tasks.

Conclusion

Sexual violence is a multidimensional problem. In attempting to work sensitively and effectively with survivors in a way that contributes to them regaining control over their lives following the devastation of sexual assault, it is salutary to keep in mind that no single factor explains such violence and equally, no single person can overcome it. Just as sexual violence results from the complex interplay of individual, relationship, social and cultural and environmental factors, so, too, its solution must also involve all those who have the opportunity to reduce such violence and eliminate its preventable harms by working together, where possible, to build synergistic relationships.

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