Sexual Violence: Societal factors, women's responses, health consequences and interventions

The need for multilevel responses

Societal responses

- No rape free societies exist today
- But marked variations do exist in the prevalence and types of sexual violence between countries
- Sexual violence is preventable not inevitable
- Gender based violence including sexual violence serve many purposes for perpetrators/societies including:
- A socially sanctioned strategy to punish women, assert masculinity, a way to ‘resolve’ domestic conflicts and take sexual pleasure through humiliating victims

Societal influences

- Maintain the occurrence of sexual violence through:
- Social beliefs about the situational elements that constitute rape
- Rape myths that result in victim blaming
- Cultural and religious beliefs that reinforce social beliefs which underpin the perpetration of sexual violence against women

Immediate responses to SV

- In first 2-3 hours after assault (Resick, 1993)
- Physical shaking, trembling, shock, scared and worried – 96% of victims
- Terrified and confused- 92% victims
- In emergency dept- 3 survival modes commonly observed (Osterman, Barbiaz & Johnson, 2001).
- Anxiety – Flight
- Anger- Fight
- Dissociation - Freeze

The aftermath

- After this initial period, trauma symptoms including depression, exhaustion, restlessness began. Psychological effects most long lasting for many survivors (Kimerling & Calhoun, 1994)
- BUT not all survivors develop PTSD - 31% in Rape in America study ie 69% did not

Women's responses to SV

Medium to long term effects

Psychological effects include heightened fear, anger, anxiety, guilt, self blame, loss of trust, flashbacks and PTSD, depression, dissociation, phobias, panic disorder, OCD, substance use, suicidality.

When SV occurs before 16 years, the risk of negative psychological outcomes is increased 3-4 times cf risk for older victims

Physical/behavioural consequences include: Changes in sexual functioning, sleep disturbances, STIs, unwanted pregnancy, unsafe abortion, genital fistulae, PID

Social effects- social isolation, fear

Societal responses to SV

- Vary widely across cultures and change over time
- Negative reactions to victims who disclose SV include:
- Disbelief, victim blaming, stigmatization, distraction responses (ie move on) egocentric and controlling reactions by provider

Stigmatization- discredited identity

- The victim is disgraced, dishonoured and tainted by the SV
- Occurs in male dominated societies that stress female chastity and purity = women's worth
- When rape is seen as an affront to male/family 'honour', strategies to erase the shame of this stain on honour are enacted eg causing victim to marry rapist (Shalhoub-Kevorkian's study of Palestinian culture, 1999)
- Family and social rejection of girls and women raped by armed forces commonplace in war/conflict (Human Rights Watch and Amnesty) Rape in war recognised as an act of genocide eg ethnic cleansing

Victim blaming responses

- Such responses attribute the crime **against** the victim **to** the victim. Responsibility displaced from perpetrator to victim
- Did your try hard enough to stop him? Where are your injuries?
- Were you intoxicated?
- What were you wearing? You look too attractive
- What is your sexual history?
- Why were you out- at all or at the time you were raped? Cf right to freedom of movement

Some research on victim blaming

- Rape myths are widely endorsed (Ward, 1995)
- 20% of US students believed a healthy woman could fight off a rape
- 45% endorsed this belief in Turkey
- 50% in India
- 56% in Malaysia
- 7% in Germany
- 8% in the UK

More rape myths

- 64% of US students agreed women provoked rape
- 60% agreed women who go out alone place themselves at risk of rape
- Less than 50% of students in Barbados, Canada, Israel, Malayasia, Mexico, Turkey, Singapore, US and Zimbabwe believed male perpetrators are responsible for rape

Positive responses

- Cultural and legal definition of sexual coercion and assault as a crime and a rights violation
- Disclosing straight after being victimized
- Being believed
- Being understood
- Being offered empathy
- Getting psychosocial support/counselling

Positive coping responses of individuals

- These factors reduce risk of PTSD
- Positive distancing
- Positive self assessment
- Optimism
- Acceptance
- Explanation - provision of a reason
- Actively reducing thoughts of event
- Proactive, protective behaviours eg moving house

Impact of responses on victims

- Negative responses are associated with higher levels of psychological symptoms and poorer self rated recovery
- Ullman, 2000; Ullman & Filipas, 2001- Stigmatization predictive of severity of symptoms of Posttraumatic Stress Disorder
- Negative responses damage positive sense of self, lead to self devaluation
- Victims from ethnic minorities who disclose SV receive more negative responses from family, friends than white women in the US
- Positive, supportive responses lead to better psychological outcomes

Formal vs informal sources of support

- Formal support personnel may give more negative social reactions to survivors than family and friends
- In the Dominican Republic, Peru and Venezuela many service providers held survivors, not perpetrators, responsible for rape (Guedes, Bott & Cuca, 2002)
- Anticipation of negative responses by victims delays disclosure of SV to formal support services- medical, legal and mental health services. Community/family disapproval of victim contacting such services also causes delay

Victims' perceptions of sexual violence

- Large, unmet need for research on perceptions and responses of victim/survivors in many places
- Most research to date done in high income countries
- This research suggest that:
- Victims' perceptions and responses are influenced by whether they name their experiences as rape/sexual assault

Mediating factors

- Extent to which victims themselves accept/endorse victim blaming beliefs and rape myths
- Victims' understanding of legal definitions. Why are SV experiences named as 'rape' by some but not all victims?
- Only 25% of women who had been sexually assaulted considered they had been raped (Koss 1992) another 25% said it was a crime but not rape; 25% called it 'serious miscommunication' and 25% did not see it as victimization. All experiences met legal definition of rape.
- Victims' coping mechanisms
- Their willingness to disclose
- Experiences of others' reactions to them if and when they do disclose

Rape in marriage

- Variation socially and legally in how this is regarded- both within and between countries
- Uses versus abuses of women's bodies in marriage- women make distinction between 'unwanted sex' and 'rape' (Jewkes & Abrahams, 2002)
- 'Rights' of husbands- 'You as the woman will not have sex only if he does not feel like it' (Watts et al, 1998, study in Zimbabwe)
- Understanding of obligations in marriage by women

PTSD

- Of all traumatic experiences, SV is the stressor most strongly predictive of PTSD, classified as an anxiety disorder. Two symptom profiles:
- Intrusive, reexperiencing symptoms, eg flashbacks
- Numbing and avoidance symptoms. When linked to self blame leads to social withdrawal and subsequent alcohol and substance use, presciption drugs
- Also sleeping disorders- difficulty going to sleep, staying asleep, nightmares, breathing and movement disorders

Changes in PTSD over time

- Post assault – 87% victims had PTSD
- 3 months later – 70%
- 6 months post assault- 65% still met criteria for PTSD (Darves-Bornoz, France, 1997)
- ‘Post’ may be a misnomer, eg for women living in sexually violent relationships
- Complex traumatic stress a more accurate model (Herman, 1995)

Predictors of PTSD developing after sexual assault

- Common predictors of PTSD= threats to life, use of a weapon, completed rape, injury/ies, peritraumatic anxiety, panic during rape as well as social factors inc lower levels of education, high levels of self blame
- Sexual revictimization increases risk of PTSD
- Also PTSD is a risk factor for victimization-
- Dissociation, avoidance and numbing symptoms can increase survivors vulnerability to further assault and ability to judge the safety of situations
- Despite high rate of psychological disorders, less than 30% of survivors seek support from mental health professionals in a number of US studies

Physical health consequences

- Poorer self rated health/ altered health behaviours inc drinking, smoking, substance abuse- chemical dissociation. Coping strategies for symptoms of PTSD
- Altered patterns of health care
- More medical diagnoses- acute and chronic eg pain syndromes
- Cardiac arrhythmia, asthma, hyperventilation, nausea, choking sensations
- Gynecological problems, menstrual difficulties sexual dysfunction (American College of O & Gs, 1995). Retraumatization often experienced with gynecological examination- Pap screening

Effects of sexual IPV

- Some research reports relationship with perpetrator does not influence most of the documented psychological outcomes
- But, women raped by husbands who also suffered other forms of physical IPV had:
- Higher rates of PTSD, depression, anxiety, fear and sexual dysfunction (Bennice & Resnick, 2003) than women who only had physical abuse
- With Sexual IPV, the victim/survivor is exposed to violence from the perpetrator over a long duration- this may explain some of the psych effects such as learned helplessness (Nair, 1997)

Research so far: its nature, extent and limitations

- Limited research base
- Northern bias- all research literature located on primary prevention from the US
- Evidence on the efficacy of screening interventions is limited
- Some research on hospital and clinic based services and referral networks
- Some research on community based services that are more commonly available

Interventions: Primary prevention programs

- Mainly education programs targetted at mixed gender groups university students in the US. Some programs target boys/men specifically eg ‘My strength is not for hurting’ campaign
- Based on assumption that positive attitude changes will result and lead to changed behaviour
- Inconsistent results. Some positive attitude change immediately post program but not in longer term. Some studies show rebound to pre intervention attitudes
- Few studies demonstrate behaviour change

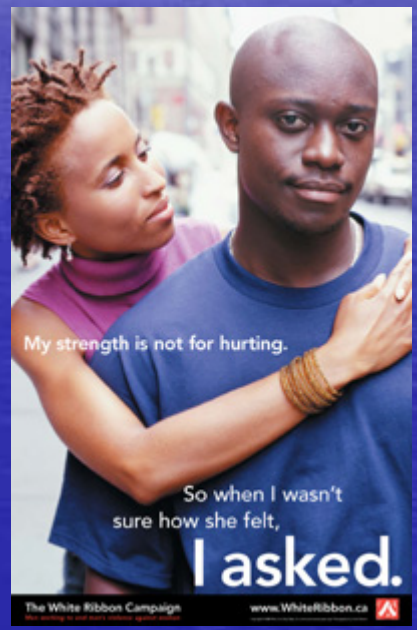
Screening interventions

- Target health professionals to routinely ask about- screen for victims of violence
- Findings show increases in rates of detection
- Evidence on beneficial effect for screened women is equivocal
- Routine screening legitimizes disclosure, reassures victims they are not being singled out
- No consensus yet on appropriate outcome indicators (Garcia Moreno, 2002)
- Ask alone and ask safely- do not risk reprisal

Social and clinical interventions

- Must be tailored to needs of each individual survivor
- Support women of different SES backgrounds and with different SV narratives to recount over the course of recovery
- Restore control- provide options re medical, mental health, legal, social services
- Integrated care/ one stop shop approaches promising immediately post assault- interagency training is essential to ensure appropriate knowledge, attitudes, behaviours of professionals
- Change in level of community awareness, attitudes and understanding to better meet survivors' needs. Community based services, NGOs important in developing country settings. Rape crisis centres counsel and advocate for survivors but often face funding probs

Social marketing to change attitudes - My strength is not for hurting postcards/posters



The White Ribbon Campaign

Men working to end men's violence against women

Other sources of support/ intervention

- Hotlines- telephone counselling and referral
- Internet based counselling and referral
- Shelters/refuges primarily IPV focussed but SV often a significant part of this
- Shelters restore safety – safe, affordable housing in short term; safety plans; provide access to other services. Rare in middle and low income countries
- Support groups and faith based support- mixed results re support from members of clergy

Therapeutic interventions

- Interventions to meet the mental health needs of survivors focus on reducing or preventing development of PTSD, depression and anxiety
- Cognitive behavioural therapies including Prolonged exposure (PE) and cognitive processing therapy (CPT) Both have homework to progressively confront fears
- Psychoeducation/ challenging cognitions/ANTs
- Systematic desensitization and prolonged exposure (PE) therapy
- Stress inoculation training (SIT)

Types of CBT

- All 3 types of CBT approaches- PE, SIT and supportive counselling can reduce symptoms levels of PTSD, anxiety & depression immediately after intervention (Foa et al, 1991)
- Elements of Prolonged exposure
- Psychoeducation (eg typical reactions to rape), breathing control, relaxation techniques and behavioural exposure to feared environmental cues
- Controlled, gradually increased imaginal exposure to trauma memory.
- SIT worked with arousal but not intrusion or avoidance symptoms but worked better than supportive counselling over the longer term ie at 3 month follow up. PE worked best with general anxiety

Cognitive Processing Therapy

- Exposure in CPT is in the form of writing and reading about the traumatic event- also effective in reducing symptoms of PTSD and depression (Resick et al, 2002)
- CPT more effective than PE in remediating guilt cognitions in areas of hindsight bias but not in decreasing global guilt

Feminist and other therapies

- Help survivor see her experience as part of a larger social problem
- Use this social reframing of the causes of her SV to reduce long term feelings of guilt, shame and self blame
- Group therapy also effective in reducing such feelings (Campbell, 2001) and group work common in feminist services
- Relational therapies integrate survivors social network into treatment- more effective than individual therapy in reducing depression
- Traditional healing address supernatural dimension of distress- not adequately evaluated

Criminal justice system interventions

- Validation and belief of survivors central to recovery BUT victims often face disbelief and suspicion from criminal justice system.
- Positive experiences can contribute to psychological health and recovery
- Victims often believe their SV experience is a low priority in the system
- Tension between needs of victim and goals of police re evidence for trial

Need for change

- Reform of the criminal justice system is required in many places
- The current adversarial system which operates in most countries is responsible for revictimizing survivors and increasing their trauma
- Restorative justice approaches may more effectively meet victims needs to have the crime committed against them acknowledged by the perpetrator as well as its impact on their lives and health

Research on therapeutic interventions

- Interventions to improve psychological recovery include:
- Cognitive behavioural therapies including cognitive processing therapy
- Feminist therapies
- Group therapy
- Relational therapy
- Traditional healing practices

Future research: Victims perceptions

1. Establish the causes of various forms of SV identified by survivors, their needs as victims and their perceptions of different intervention practices
2. Determine the psychological consequences of SV according to coping strategies used by victim/survivors
3. Review use of PTSD diagnostic guidelines for measuring psych impact of SV in a variety of settings
4. Systematically document the psychological effects on victims of the responses of the criminal justice system
5. Document processes of recovery/ healing including how disclosure process affects recovery

Future research: Intervention models and practices

- Expand research on primary prevention beyond university settings in high income countries to general populations in range of settings
- Document impact on recovery of traditional healing practices and faith based approaches
- Determine impact of screening practices on women's emotional and physical health outcomes
- Evaluate integrated clinical care practices and different mental health therapies on the well being of victims