RESEARCH SUMMARY

Rape: How women, the community and the health sector respond[1]

Background

This research summary is based on a desk review on women's responses to sexual violence and the appropriateness and effectiveness of sexual violence services in meeting their needs as survivors. The review examines the societal factors that influence rates of sexual violence, women's immediate and long term responses to such violence, including a range of health related harms, and the interventions and treatments developed to respond to the needs of survivors of sexual violence and reduce its prevalence.

The review draws together existing evidence and identifies gaps in the current knowledge base on this issue. It also identified the following limitations in the existing literature on sexual violence.

- Limited information on many dimensions of sexual violence, including violence prevention
- Inadequate understanding of women's responses to and recovery from sexual violence
- Lack of geographical representation and strong North American bias, with most of the research undertaken in high income countries
- Sparse evidence on the efficacy of screening interventions
- Some research on hospital and clinic based services and referral networks
- Some research on more commonly available community based services

Research findings

Societal responses

No rape free societies exist today. Sexual violence remains the least researched form of gender-based violence. For the perpetrator and the society he represents, sexual violence serves multiple functions including its use as a socially sanctioned strategy to punish women; a tactic to assert masculinity and maintain a patriarchal social order; a method to 'resolve' domestic conflicts; and a male behaviour to take sexual pleasure. Sexual violence is maintained through socio cultural beliefs about what constitutes rape and what elements reduce the likelihood of women defining forced sex as rape, rape myths that result in victim blaming and social stigmatization of victims and various cultural and religious beliefs that perpetuate rape prone societies.

Other negative social reactions include disbelief, distraction responses or simplistic advice to 'move on', as well as controlling reactions by the person to whom the victim has disclosed. Stigmatization confers a discredited identity on the victim who is disgraced, dishonoured and tainted by the sexual violence perpetrated against her and is most pronounced in male dominated societies that stress female chastity and purity and make these characteristics synonymous with a woman's worth as a human being. Societies that view rape as an affront to male/family 'honour' adopt strategies to erase the shame of this stain on honour such as coercing the victim to marry the rapist. Family and social rejection of victims is also commonplace in war and conflict situations.

The highest rates of sexual violence have been reported in relation to rape by intimate partners, including husbands. Recognition that rape can and

does occur within marriage, however, is far from universal. How rape in marriage is regarded varies, socially and legally, within and between countries. Women may feel unclear about the boundary between the uses versus abuses of their bodies in marriage and make a distinction between 'unwanted sex' and 'rape'. Many societies continue to privilege the 'rights' of husbands and instruct women that their marital obligation is to have sex whenever their partners wants it.

Lessons learned

Research indicates that hostile, victim blaming responses are common and exacerbate the harm already experienced by the victim. A cross cultural study that tested the level of acceptance of the belief that 'A healthy woman can fight off a rape' found 20% of US students endorsed this belief, compared with 45% of those surveyed in Turkey, 50% in India and 56% in Malaysia. Much lower rates of agreement were reported in Germany (7%) and the United Kingdom (8%). Similarly, 64% of US students agreed women provoked rape, 60% agreed women who go out alone place themselves at risk of rape and less than 50% of students in Barbados, Canada, Israel, Malayasia, Mexico, Turkey, Singapore, US and Zimbabwe believed male perpetrators were responsible for rape.

Another study conducted in the Dominican Republic, Peru and Venezuela found that many service providers held survivors, not perpetrators, responsible for rape. The anticipation of negative responses from support personnel in the formal service sector causes delays in the disclosure of sexual violence to medical, legal and mental health services. Community or family disapproval of victims contacting such services can further delay help seeking.

Negative responses damage the victim's positive sense of self, lead to self devaluation, higher levels of psychological symptoms and poorer self rated recovery while stigmatization predicts the severity of symptoms of Posttraumatic Stress Disorder.

Positive responses have been identified that result in better psychological and other outcomes for victims. These include living in a society that has a 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 and getting psychosocial support/counselling.

The wide variations in the prevalence of sexual violence between countries highlight the pivotal role of social, cultural and legal arrangements and beliefs in determining the extent of sexual violence reporting and the importance of targeting social attitudes in sexual violence prevention programs.

Women's responses to sexual violence

Immediate responses

In the first 2-3 hours after assault, a US study found that 96% of victims experienced physical shaking, trembling and shock. Equally high numbers of women felt scared and worried, or terrified and confused. Three common survival modes were observed in another US study of survivors receiving emergency department care namely, anxiety indicating a flight response; anger expressing a fight response and dissociation representing a frozen response. After this initial period, symptoms of depression, exhaustion and restlessness emerged that together with post traumatic stress disorder (PTSD) can be long lasting for many survivors. A French study found that 87% of victims had PTSD post assault, 70% had PTSD 3 months later and even 6 months post assault, 65% of victims still met the criteria for PTSD.

Medium to long term effects

Psychological effects in the medium to long term encompass heightened fear, anger, anxiety, guilt, self blame, loss of trust, flashbacks and PTSD, depression, dissociation, phobias, panic disorder, and obsessive compulsive disorder. When sexual violence occurs before the age of 16 years, the risk of developing negative psychological outcomes is increased 3 to 4 fold compared with that in older victims.

Physical and behavioural health consequences

Women who have experienced sexual violence compared with their non victimized counterparts have poorer self rated health and increased rates of risky health behaviours including drinking, smoking and substance misuse, as well as self harming behaviours, such as suicidal thoughts and actions. Survivors also have more medical diagnoses, higher rates of acute and chronic pain syndromes, cardiac arrhythmia, asthma, hyperventilation, nausea and choking sensations. Sexual and reproductive health problems include menstrual difficulties and sexual dysfunction, increased rates of sexually transmitted infections, unwanted pregnancy, unsafe abortion, genital fistulae and pelvic inflammatory disease. Women

raped by their husbands who have also suffered physical partner violence, exhibited higher rates of PTSD, depression, anxiety, fear and sexual dysfunction than those who experienced physical violence alone.

Mediating factors

Coping responses by individuals that reduce the risk of PTSD include positive distancing from the incident of sexual assault, having a positive self assessment, optimism, acceptance, having an explanation, actively reducing thoughts of the assault and engaging in proactive, protective behaviours, such as moving house.

Research suggests that victims' perceptions and responses are influenced by whether they name their experiences as rape/sexual assault; the extent to which victims accept/endorse victim blaming beliefs and rape myths and their understanding of legal definitions of rape. Why the same sexual acts are named as 'rape' by some but not all victims is unclear, but cultural and legal context are relevant.

Interventions

The vast majority of primary prevention programmes have been developed and implemented in the US. They have consisted primarily of education programmes, targetted at mixed sex groups of university students, and assume that positive attitude changes will result from involvement in the program and lead to sustained changes in sexual behaviour. Inconsistent results have been reported. Some positive attitude changes have been documented immediately post program but has not been sustained in the longer term. Other studies show a rebound effect and a return over time to pre intervention attitudes. Interventions have also been implemented to effect change in the level of community awareness about sexual assault and rape and promote more positive attitudes towards victims. In developing country settings, community based services offered by non government organizations can play a critical role in sexual violence service provision when government funded services are absent or inadequate.

Screening interventions targetting health professionals to routinely identify victims of violence have focused on violence by intimate partner and not other forms of sexual violence. Increases in rates of detection of violence have been reported but there is no compelling evidence to suggest that screening has a positive effect on the women who are screened. One benefit of routine screening is that it legitimizes disclosure and can reassure victims they are not being singled out. No consensus has yet been reached on appropriate outcome indicators for assessing the effectiveness of screening interventions.

Clinical interventions need to be tailored to meet the needs of, and increase feelings of, control in individual survivors. It is necessary to provide support for women from different socioeconomic and cultural backgrounds who may have different sexual violence narratives to recount. It is also necessary to offer options regarding medical, mental health, legal and social services. In low income countries such options are unlikely to be available. Integrated care or 'one stop shop' approaches have produced promising results in the period immediately after the assault occurs but their quality is dependent on adequate interagency training to ensure all professionals have appropriate knowledge, attitudes and behaviours.

Other confidential sources of support include hotlines that offer telephone counselling and referral and internet based sources of counselling and referral. Shelters and refuges are another source of support, although they usually only cater for survivors of intimate partner violence and not survivors of sexual violence alone who may have an equally high need for safe, alternative, affordable forms of shelter. Faith based groups can offer support to victims but mixed results regarding the quality of the support from members of the clergy have been reported.

Mental health interventions

Diverse therapeutic interventions have been developed in high income countries to meet the mental health needs of survivors and prevent or ameliorate symptoms of PTSD, depression and anxiety. Cognitive behavioural therapies (CBT) include Prolonged Exposure (PE) therapy, Cognitive Processing Therapy (CPT) and Stress Inoculation Training (SIT). Common elements in these therapies include the use of 'homework' between sessions, psychoeducation designed to challenge irrational cognitions and graded exposure and systematic desensitization to threatening material associated with the violence. In CPT, exposure is in the form of writing and reading about the traumatic event and this has also been shown to be effective in reducing symptoms

of PTSD and depression.

All three types of CBT approaches as well as supportive counselling reduce symptom levels of PTSD, anxiety and depression immediately after the intervention has taken place, although findings on the comparative effectiveness of these therapies are complex. Additional research has revealed beneficial effects for feminist and some other therapies. Feminist therapies seek to help the survivor to see her experience as part of a larger social problem and thus to socially reframe the causes of her sexual violence experience and reduce long term feelings of personal guilt, shame and self blame. Group therapy can be effective in reducing such feelings and group work is also a common element in feminist services. Relational therapies that integrate a survivor's social network into treatment have been reported as more effective than individual therapy in reducing depression. Traditional healing practices that address the supernatural dimension of distress have not been evaluated adequately.

Criminal justice system interventions

A tension exists between survivors' needs and the evidentiary needs of the criminal justice system. For survivors, validation and belief is central to recovery but they often face disbelief and suspicion from the criminal justice system. The current adversarial system operating in most countries causes revictimization and increases the trauma of survivors. Restorative justice approaches may more effectively meet victims' need to have the perpetrator acknowledge the crime he has committed and its impact on their lives and health.

Research recommendations

To respond better to the needs of sexual violence survivors, it is essential to conduct research from the perspective of victim/survivors as well as developing models of intervention and practice that are effective, acceptable and affordable in diverse cultural settings.

Research on survivors' perspectives
- Establish the causes of various forms of sexual violence identified by survivors, their needs as victims and their perceptions of different intervention practices
- Determine the psychological consequences of sexual violence according to the coping strategies used by victims/survivors
- Systematically document the psychological effects on victims of the responses of the criminal justice system
- Document processes of recovery/ healing, including how the disclosure process affects recovery

Intervention models and practices
- Expand research on primary prevention programs beyond university settings in high income countries to general populations in a range of settings particularly in middle- and low-income countries
- Document how traditional healing practices and faith based approaches impact on recovery
- Determine the impact of screening practices on women's emotional and physical health outcomes
- Evaluate integrated clinical care practices and different mental health therapies on the perceived well being of victims
- Review the use and relevance of PTSD diagnostic guidelines as the main method of measuring the psychological impact of sexual violence in a variety of settings particularly in middle- and low-income countries

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