SEXUAL VIOLENCE RESEARCH INITIATIVE

Rape: How women, the community and the health sector respond

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World Health Organization

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The Sexual Violence Research Initiative (SVRI) is an international initiative of the Global Forum for Health Research. The SVRI Secretariat was first hosted by the World Health Organization Department of Gender, Women and Health, and since January 2006 has been hosted by the Medical Research Council of South Africa. The SVRI promotes and disseminates action-oriented research to reduce and respond to sexual violence through: identifying gaps, building capacity, supporting research, raising awareness and building partnerships. The SVRI aims to build an experienced and committed network of researchers, policy-makers, service-providers, activists and donors to ensure that the many aspects of sexual violence are addressed.

The SVRI is guided by a Coordinating Group of experts on research on sexual violence. The members of the SVRI Coordinating Group are: Jill Astbury, Mary Anne Burke, Nata Duvvury, Mary Ellsberg, Claudia Garcia-Moreno, Alessandra Guedes, M. E. Khan, Nduku Kilonzo, Mary Koss, Tandiar Samir Mossaad and Latamze Verulashili. The SVRI secretariat manages the day to day activities. Members of the SVRI Secretariat are: Rachel Jewkes, SVRI secretary and Liz Dartnall, SVRI Programme Officer.

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Executive summary

This review (hereafter, the Review) documents currently available research findings on the perceptions of adult women victims of sexual violence, their responses to incidents of sexual violence, and the types of interventions available to address issues of sexual violence, and to meet various needs of victims in the aftermath of assault. The Review covers the following overarching topics:

- societal perceptions of and responses to sexual violence and its victims;
- perceptions and responses of women victims to sexual violence; and
- intervention models and practices.

Within each section, the Review highlights the quantitative and qualitative research that has been undertaken internationally, in both academic and service-delivery fields. Although the Review is intended to summarize and synthesize current understanding about women's experiences of rape, it also aims to provide policy-makers, service-delivery professionals and researchers with a clear picture of the gaps in current knowledge within the spectrum of related issues. The Review offers concrete recommendations for addressing these gaps, and is intended to inform decisions about future research in this area.

Terminology

Sexual violence and rape

The Review adopts the definition of sexual violence accepted by the World Health Organization in the World Report on Violence and Health as,

> "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work."

Although sexual violence manifests itself in many forms, such as sexual harassment, sexual abuse, forced marriage, forced abortion, forced prostitution and trafficking of people for the purpose of sexual exploitation, the primary focus of the Review is on rape. Rape is defined as "physically forced or otherwise coerced penetration – even if slight – of the vulva or anus, using a penis, other body parts or an object."

The forms of rape addressed in the Review include rape within marriages or dating relationships and rape by strangers, with a focus on the latter.

Survivor(s) and victim(s)

Some individuals who have been sexually assaulted prefer to refer to themselves as survivors, whereas others feel that avoidance of the word victim denies the damage that has been done to them. The Review adopts both terms, survivor(s) and victim(s), interchangeably throughout the text to refer to individuals who have experienced sexual violence.

Female(s) and woman/women

Although the term female(s) is often used with a biological reference to the sex of individuals, and the terms woman or women are used to indicate the sociocultural construction of gender, the Review adopts both terms, woman/women and female(s), with no distinction, to refer to individuals who were identified as woman/women or female(s) in the research studies included in the Review.

Methodology

The findings of previously conducted research presented in the Review were identified and compiled through a variety of resources. These include the following:

- published literature;
- direct communication with experts, including academic researchers, and service-delivery programme professionals;
- grey literature obtained through the World Wide Web.

Summaries of areas of focus

Societal perceptions of sexual violence

Taken from Sanday's (1981) classification of societies with regards to rape prevalence, the review of the existing literature reveals the predominance of rape-prone societies, and the absence of rape-free societies today. The Review highlights a number of conceptual frameworks through which societies understand the dynamics of sexual violence.

Violence, including physical and sexual, as a socially-sanctioned means of punishment, for resolving domestic conflicts, asserting manhood, asserting control, attaining pleasure, and as an acceptable everyday event in many areas of the world has been documented. In places where rape is now widely recognized as a crime against the victim and/or the state, societal beliefs about the situational elements that constitute rape still vary. In many cultures, perceptions at the societal level, such as rape myths and patriarchal ideologies surrounding sexual violence that have transcended time, have led to victim-blaming and social stigmatization of survivors. Additionally, the literature indicates that segments of populations within a society may also vary in their adherence to rape myths and their perceptions of rape. Indications of the powerful and long-lasting effects of cultural and religious beliefs on societal perceptions are also documented.

Societal responses to sexual violence

The literature reviewed, uniformly indicates that societal perceptions of rape have significant impacts on the responses that rape survivors receive from others upon disclosure of their assault(s). Thus, a large portion of the literature on societal responses to rape used the rape perception framework as a medium to explore the various factors contributing to such responses.

Several studies found negative social reactions in general to be related to more psychological symptoms and poorer self-rated recovery. More specifically, it is documented that negative responses received from informal and formal support sources may act together to discourage disclosure and treatment-seeking behaviours. Nevertheless, research has consistently documented stigmatization and blame of rape victims to be widespread in many cultures, affecting the recovery of both the mental and physical health of victims.

Women victims' perceptions of sexual violence

The literature reviewed documented that views of sexual violence at the societal level can have strong influences on how rape survivors perceive their victimization experiences. It has been found that although the circumstances under which survivors are raped may be very similar, their experi-

ences will differ according to their individualized perceptions of sexual violence in general and their specific situations. As victims' perceptions of rape significantly influence their subsequent experiences and behaviours as survivors, a large body of literature has been devoted to the investigation of the factors contributing to whether or not the victim perceives the sexual assault as having been rape. The research identified victims' endorsement of rape myths and victim blaming beliefs, their understanding of legal definitions, and the coping mechanisms adopted, as significant factors in determining how survivors perceive and label their victimization experiences.

Women victims' responses to sexual violence

Although rape survivors adopt varying coping strategies throughout their recovery processes, Burt and Estep (1981) cautioned that victims' rights to "claim assistance, sympathy, temporary relief from other role responsibilities, legal recourse, and other similar advantages" cannot be exercised if survivors do not identify their experiences as rape. Therefore, rape victims' perceptions of sexual violence have significant implications for their subsequent responses to victimization experiences.

With the identification of various frameworks for examining response patterns, this section covers women victims' psychological, physical and behavioural responses to incidents of sexual violence. Aspects of psychological and behavioural response investigated include individual factors influencing responses, characteristics of the assault, and cross-cultural comparisons among ethnic groups within the same country. Specific coping strategies employed and support-seeking behaviour exhibited by victims are also discussed in this Review.

The literature often described avoidance, explanation, and substance use and abuse as common methods used in the process of recovery. Rape survivors may cope by organizing their lives around and avoiding cues including people, activities or memories that they have found to be distress-provoking. Explanation, a survivors' identification of a reason for the occurrence of the assault, is the coping mechanism that has been most studied in the psychological research literature. In addition, the relationship between being a victim of sexual violence and subsequent alcohol and substance abuse has been well established.

Although only a small percentage of survivors of sexual violence disclose their experiences immediately following the assault, most articulate their victimization experiences to others at some point. While the decision to disclose experiences to formal or informal support networks allows victims to obtain the assistance necessary for recovery, upon disclosure to support sources, survivors can face varying reactions, which may in turn affect their processes of recovery.

It has been found that despite well-documented mental health sequelae of sexual violence, the women most in need of mental health care rarely seek support from mental health professionals. The Review illuminates factors contributing to the behaviour of victims seeking mental health services following rape. Similarly, studies have found exposure to trauma and its psychological consequences to be substantial contributors to physical health outcomes. However, despite demonstrated physical health sequelae, few rape victims seek medical services, especially immediately following the assault.

Although much of the scientific literature on psychological responses to sexual violence comes from industrialized countries, cross-cultural studies of these issues have also been undertaken, and the results point to similar conclusions.

Intervention models and practices

Screening interventions

In both industrialized and developing countries, great emphasis has been placed on the training of health care workers to improve screening for sexual violence as an intervention strategy within hospitals and clinics. The body of literature on these screening efforts has focused primarily on the impact of screening on the identification of victims of violence against women in general, its impact on women victims, and also the effectiveness of training efforts. Researchers have also articulated

their concerns about the potential harmful effects routine screening for violence against women may have on women victims. However, evaluation studies of screening programmes and training efforts have been scarce and inadequate in determining the effectiveness of current practices.

Acute, short- and long-term interventions

The existing literature illuminated intervention efforts implemented by hospital- and clinic-based services as well as community-based services. The body of research provided descriptions of intervention programmes, and also described the challenges faced by these models and practices.[1]

Community-based services

The research has found that in many settings, especially in developing countries, the health care system lacks sufficient resources to provide hospital- or clinic-based services to rape survivors, leaving victims to the care of community-based services. As perhaps the most commonly established institution to help rape victims, the services provided by rape crisis centres or programmes in many settings have been described in detail. Although the evaluations of rape crisis centres or programmes have not been systematic or sustained, the available studies have found these centres and programmes to be effective in assisting rape survivors in their recoveries. In addition, shelters have also been documented as a community-based service often used by rape victims. However, as shelters are typically designed to address the needs for protection of individuals experiencing physical abuse alone or in combination with sexual abuse by intimate partners, their services are usually not oriented towards meeting the specific needs of sexual violence survivors. So far, there has been no adequate systematic evaluation of shelters. Furthermore, support groups have been set up internationally by many organizations to offer peer support to victims of sexual violence. Similarly, faith -based support has also played a part in providing community-based services to rape victims. However, the body of literature has focused mainly on Western institutions with Protestant Christianity backgrounds, and has included no efforts at systematic evaluation.

Therapeutic approaches

The research literature describes, evaluates and compares various therapeutic approaches in treating victims of sexual violence, including cognitive behavioural therapies, cognitive processing therapy, therapy for the prevention of post-traumatic stress syndrome (PTSD), feminist therapies, group therapy, relational therapy, and traditional healing practices. Although the measurement standards used varied, all therapy approaches were found to be helpful to the psychological recovery of women rape victims. However, findings on the comparative superiority of approaches were inconsistent.

Criminal justice system interventions

The body of literature reviewed consistently revealed that while the criminal justice system can provide important services for victims of sexual violence, they often face disbelief or other negative responses from system personnel during their dealings with the system, resulting in revictimization and other damaging psychological consequences. Research has highlighted the differences between the focuses and goals of the police and those of the victims as factors contributing to the responses exhibited by criminal justice system personnel. The literature further explored the impact of legal interventions on the subsequent mental health of victims, as well as the psychological benefits victims derive from participation in legal processes.[2]

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[1] For more information on clinic and hospital based models of care for sexual assault refer to Kelly L. *A review of health service models for provision of care to victim/survivors*. Geneva: World Health Organization, 2004.

[2] The following review provides a global overview of the uses and impacts of medico-legal evidence in cases of sexual assault: Du Mont, J. & White, D. *The uses and impacts of medico-legal evidence in sexual assault cases: a global review*. Sexual Violence Research Initiative, World Health Organisation, 2007. It is available online at: http://www.svri.org/en/medico.pdf

Recommendations for future research

The Review identifies a need for additional research in all regions of the world, particularly in middle- and low-income countries, to examine the perceptions of and responses of women victims to sexual violence. The majority of the existing research was conducted in high-income countries, revealing a significant need for more research in middle- and low-income countries. In addition, findings from high-income countries need to be assessed before applying them to middle- and low-income countries. The gaps in the current literature listed below serve as recommendations for future research initiatives.

Women victims' perceptions of sexual violence

Future research on women victims' perceptions of sexual violence should include systematic documentation and analysis of the following:

- the definitions of sexual violence adopted by women victims from various demographic backgrounds;
- women victims' perceptions of the causes of various forms of sexual violence;
- women victims' perceptions of their needs as victims of sexual violence;
- women victims' perceptions of various intervention practices.

Women's responses to sexual violence

Future research on women's responses to sexual violence should include:

- examination of the psychological consequences of sexual violence for women victims using standardized measurements;
- analysis of the mental health outcomes of women victims according to the coping strategies employed, and mental health state prior to the incident of sexual violence;
- review of the use of PTSD diagnostic guidelines as a framework for measuring the psychological impact of sexual violence on women victims;
- systematic documentation of the psychological effects of the responses of the criminal justice system on women victims;
- documentation of the processes of recovery experienced by women victims;
- examination of the disclosure process as it affects the recovery processes of women victims.

Intervention models and practices

Suggested areas of research on intervention models and practices are as follows:

- systematic documentation of primary prevention practices in general population settings;
- systematic evaluation of primary prevention programmes;
- systematic documentation of existing screening practices in various settings;
- evaluation of current screening intervention practices, and documentation of their impacts on women victims of rape;
- evaluation of training programmes for health care providers in treating women victims;
- examination of the effects of receiving treatment (including medical, mental health and legal services) on recovery;
- systematic documentation of traditional healing practices in treating women victims;
- examination of the impact of traditional healing practices on the recovery processes of women victims;
- systematic documentation of services provided to women victims by religious institutions;
- examination of the impact of interventions provided by religious institutions on the recovery processes of women victims;

- evaluation of integrated clinical care practices in treating women victims;
- documentation and comparison analysis of the mental health outcomes resulting from the different types of therapeutic approaches used to treat women victims;
- systematic documentation and comparison analysis of criminal justice interventions and their impact on the recovery of women victims.

Introduction

Sexual violence is a major global health concern. It has profound negative effects on its victims and on societies at large. Although there has been increasing recognition of this widespread phenomenon, as reflected in research and intervention initiatives, minimal attention has been paid to understanding the psychological and psychosocial needs of women victims after experiencing sexually violent episodes. Similarly, examinations of effective approaches to address the needs of survivors of sexual violence in varying cultural contexts have not been comprehensive.

This review (hereafter, the Review) focuses on the existing research literature addressing women's perceptions of and responses to sexual violence, and more specifically, rape. The Review also documents the intervention methods available to address the issues of sexual violence, and to meet the needs of rape victims in the aftermath of assault. The Review does not address the issues relating to sexual violence in conflict settings, nor does it cover victims who are children, adolescents and/or male.

Review objectives

The Review addresses the following questions:

- How do adult women victims perceive and react to sexual violence before, during, and after victimization experience(s)?
- What is the impact of the circumstances related to sexual violence (e.g. profiles of perpetrators and victims, physical injuries sustained by victims, multiple versus single events) on the responses of the women victims?
- What are the psychological and psychosocial needs of women victims in the immediate, intermediate and long-term aftermath of the assault(s)?
- What models of practices are used in high- and low-income settings to provide necessary services to women victims of sexual violence?
- What are the strengths and weaknesses of current models of practices in providing services to women who are victims of sexual violence?

In summarizing current understanding of these issues, the Review aims to identify gaps in the current evidence base as well as differences between research findings. Furthermore, based on the findings of research to date, the Review offers concrete recommendations for future research.

Terminology

Sexual violence and rape

The Review adopts the definition of sexual violence accepted by the World Health Organization's World Report on Violence and Health (2002) as,

> "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work."

Although sexual violence manifests itself in many forms, such as sexual harassment, sexual abuse, forced marriage, forced abortion, forced prostitution and trafficking of people for the purpose of sexual exploitation, the primary focus of this review is on rape. Rape is defined as physically forced or otherwise-coerced penetration – even if slight – of the vulva or anus, using a penis, other body parts or an object. The forms of rape addressed in the Review include rape within marriages or dating relationships and rape by strangers.

Survivor(s) and victim(s)

Some individuals who have been assaulted sexually prefer to refer to themselves as survivors; others feel that avoidance of the word victim denies the damage that has been done to them. The Review adopts both terms, survivor(s) and victim(s), interchangeably throughout the text to refer to individuals who have experienced sexual violence.

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While the term female(s) is often used with a biological reference to the sex of individuals, and the terms woman or women are used to indicate the sociocultural construction of gender, the Review adopts both terms, woman/women and female(s), with no distinction, to refer to individuals who were identified as woman/women or female(s) in the research studies included.

Methodology

The main sources consulted for the Review include the following:

- published literature from medical, psychological, and sociological texts and journals;
- telephone and e-mail communication with identified experts within the field of sexual violence (see annex 1);
- Internet-based information from local and international organizations supporting and/or implementing initiatives addressing issues of sexual violence (see annex 2).

While the majority of resources collected on high-income countries are from peer-reviewed journals and organizational publications, the primary sources of information on middle- and low-income countries are gathered through direct e-mail correspondences with individuals representing local organizations.

Details on the search terms used, as well as the experts and Internet resources consulted are provided in annexes 1, 2 and 3 of the Review, respectively. The search was limited specifically to references related to sexual violence, rather than more general terms such as gender-based violence, violence against women, intimate-partner violence or domestic violence. However, articles and other resources that dealt more broadly with these topics were consulted where experiences of sexual violence were explicitly identified.

Note that the majority of the literature reviewed describes studies based in the United States. Throughout the Review, unless the country of study is specified, it was conducted in the United States. See annex 4 for details of all empirical studies reviewed.

Societal perceptions of sexual violence and its victims

There is significantly more research literature on perceptions of sexual violence on the societal level than from the standpoint of women victims. A review of the literature revealed differences in societal perceptions across both time and cultures. While the primary focus of the Review rests on the perceptions and responses of women victims, this section briefly examines this evolution and illuminates current perceptions.

Although written over 20 years ago, the work of Sanday (1981) continues to influence the literature on societal perceptions of and attitudes towards rape. Sanday classified cultures into two categories: rape-free and rape-prone. Rape-free societies are those in which rape is either non-existent or infrequent; rape-prone societies are those in which the incidence of rape is high, rape is used as a ceremonial act, and/or rape is used by men as a means to punish or dominate women. Sanday found significant correlations between rape-prone societies and the lack of female authority, lack of female participation in decision-making processes, male contempt for female decision-makers, and greater gender-based social segregation. A review of the literature reflected the widespread existence of rape-prone societies, and the absence of rape-free societies today.

Violence, including physical and sexual, as a socially-sanctioned means of punishment, for resolving domestic conflicts, asserting manhood, attaining pleasure, and as an acceptable everyday event has been documented. In Gender Violence in Africa, Green (1999) recounted the mass rape at a secondary school in Kenya in 1991 and highlighted the infamous quotation of the school's vice-principal, "the boys never meant any harm against the girls. They just wanted to rape". In a survey of women and girls in Tajikistan, less than half (44%) perceived sexual violence as a common form of violence (World Health Organization, 2000). Sexual violence was also the least commonly recognized form of violence against women, although among females aged 15 years and over, 47% reported personal experiences of sexual violence within marriages, and 24% reported attempted or completed rape by a non-family member. In 2003, Human Rights Watch noted that in Sierra Leone, sexual violence within marriage was not a violation of the law, and only the rape of a virgin was considered a serious crime. Watts and colleagues (1998) reported that in Zimbabwe where violence is used by men within families to deal with disputes and retain familial control, and where rape within marital contexts is not legally defined as a crime, women perceive violence as a normal part of marital relationships. Similarly, in an epidemiological study of rape in South Africa, Jewkes & Abrahams (2002) depicted rape as "a manifestation of male dominance over women and an assertion of that position". The study also described sexual entitlement as an inevitable part of the construction of masculinity. Nair (1997) attributed sexual violence within marriages in South Africa to women's lack of rights to make decisions on many aspects of their lives, including sexuality. In these contexts, women often submit to sexual violence through fears of other physical violence, abandonment, and sexual engagement of their husbands with other women. In addition, sexual violence is used by men as a means of punishment in many cultures. In the United States, Russell & Bolen (2000), reported that some people describe sexual violence perptrated by a husband on his wife as simply exercising his rights to punish 'his property' for lack of obedience and servitude. Likewise, Green (1999) noted that in Zambia beating a woman for refusing sexual relations is a crime only outside of the context of marriage.

In places where rape is now widely recognized as a crime against the victim, societal beliefs about the situational elements that constitute rape still vary. Analogous to other cultural beliefs, societies construct a set of beliefs about sexual violence that are founded on multiple assumptions of circumstances under which rape occurs. These assumptions make up what are called "rape myths" (Burt, 1998) and "practical ideologies" (Lea & Auburn, 2001), and can include particular settings, behaviours and self-presentation as precursors to rape (Bachar & Koss, 2001; Doherty & Anderson, 1998; Koss, 1992, 1998). In the Western world, cultural beliefs often depict rape as a sexually violent act performed by a stranger or a group of strangers, which often occurs in the dark at a secluded location. Whereas this may hold true in some instances, it does not accurately reflect the reality of most rapes.

Consistent with the adoption of these culturally constructed rape myths and practical ideologies, it was not until the 1970s that the concepts and terminologies of marital rape, acquaintance rape, and courtship or dating violence came into existence in the United States (Muelenhard & Kimes, 1999). Before the 1970s, sexual violence was not thought of as problematic when it occurred between intimate partners, but rather, a concept exclusively designated to sexually violent behaviours taking place between strangers. Legal definitions of rape at the time, which included a marital exemption clause, reflected this ideology. It was not until 1992 that the Law Lords in England overturned the 250 year old notion that there could be no such thing as rape in marriage and described this idea as 'anachronistic and offensive' and a common law 'fiction'.

This cultural ideology is not unique: the rape myths and practical ideologies have transcended time, and still hold true in many societies and cultures. Segments of populations within a society may also vary in their adherence to rape myths and their perceptions of rape. Furthermore, constructed cultural beliefs were found to have permeating effects on personal perceptions and behaviours. In particular, greater endorsement of rape myths has been noted among older women than younger women (Kalra et al., 1998). Burt (1998) found that the acceptance of interpersonal violence is correlated with acceptance of culturally ingrained myths about them. Lea & Auburn (2001) stated that, as "rape is constructed through discourse, women and men become positioned in relation to practical ideologies" (p. 13). It is these myths and practical ideologies that have provided endorsement for rape in many cultures. Studying the impact of rape myths on men, Garcia (1998) found men tended to interpret mild refusal to sexual relations as "token resistance,"[1] rather than non-consent, and may proceed to engage in sexual activities with women, and therefore, to perpetrate sexual violence. The common perception that "good girls" can never consent to sexual relations before marriage perpetuates men's interpretation of refusal by women as "token resistance."

A study of Chinese, Japanese, Korean and south-east Asian immigrants in the United States reported that only a small minority (3.5%) believed that sexual violence against women was often perpetrated by family members (Yee Lee & Law, 2002). The authors noted that although it is possible that sexual violence against women within families was not common in this population, the perception may represent a "communal blind spot" in denying that such issues exist. Respondents who had lived in the United States for over 20 years, however, reported a more common perception that rape often occurs between acquaintances, and less between strangers, which may be a result of more frequent exposure to educational intervention efforts to reduce sexual violence in the United States. The study also found significant variation in perceptions between the four groups surveyed. Whereas the majority of the Chinese respondents did not identify sexual violence against women as a problem, more than 40% of Japanese and south-east Asian respondents perceived it to be a severe problem. Despite the later influence of United States culture on ethnic minority immigrants, the differences in perception found in Yee Lee and Law's study may serve as an indication of the powerful and long-lasting effects of cultural beliefs on perceptions held by segments of populations.

[1] "Token resistance" has been defined as "a woman's indicating that she did not want to have sex even though she had every intention to and was willing to engage in sexual intercourse" (Muehlenhard & Hollabaugh, 1988).

As part of cultural beliefs constructed by societies, faith may exert a significant influence on perceptions of sexual violence as well. Faiths that emphasize a wife's obligations to fulfil sexual duties and obedience to husbands as integral parts of a marriage may not recognize sexual violence within marriage as an issue, and thus, may also discourage women victims from seeking help (Kennedy Bergen, 1999). Examining the connection between societal beliefs and faith, Fortune (2004) asserted that a theological norm underlies a dominant Western cultural belief that violence against women is a normal part of life. Focusing on the influence of Protestant Christianity, Fortune stated, "Theologically, our understanding of violence against women reflects our understanding of God and of the nature of people. If the world as we know it is created order intended by God, then one might conclude that God created two categories of people, victims and victimizers, and these categories are generally gender-specific."

Societal responses to sexual violence and its victims

As societies derive their perceptions of rape from beliefs that vary across cultures and may evolve over time, responses to rape victims reflect these differences and changes (Lamb, 1999). Negative societal reactions to rape victims upon disclosure of their experiences are manifestations of and contribute to cultural attitudes such as beliefs in rape myths. Negative reactions may include responses such as disbelief, victim-blame, stigmatization, distraction responses,[1] egocentric reactions[2] and controlling responses. Conversely, positive societal reactions stem from cultural definitions of rape as a violent crime. Positive reactions may include belief, understanding, empathy and support.

The rape perception framework,[3] which examines factors that contribute to societal responses and impact the assignment of responsibilities, indicated that victim-focused factors such as the degree of resistance exhibited during assault, level of intoxication, choice of attire, prior sexual history and physical attractiveness are all factors that can influence societal perceptions of sexual violence against women (Anderson & Swainson, 2001; Cann, Calhoun & Selby, 1979; Deitz, Littman & Bentley, 1984; Edmonds & Cahoon, 1986; Kanekar & Kolsawalla, 1980; L'Armand & Pepitone, 1982; Mason, Riger & Foley, 2004; Richardson & Campbell, 1982; Stormo & Lang, 1997; Tieger, 1981; Van Wie & Gross, 1995; Workman & Freeburg, 1999; Wyer, Bodenhausen & Gorman, 1985; Yescavage, 1999). Moreover, research studies of adult sexual assault have shown that these factors coupled with prevalent societal adoptions of rape myths resulted in responses of victim-blaming, disbelief, and stigmatization of women survivors of rape (Arata, 1999a,b; Filipas & Ullman, 2001; Filipas & Ullman, 2006; Frese, Moya & Megias, 2004; Symonds, 1980).

Victim-blaming

The results of a study by Ward (1995) indicated that, among the study population, 20% of students in the United States believed that a healthy woman could fight off a rape; higher percentages held this belief in Turkey (45%), India (50%) and Malaysia (56%); lower proportions of students were found to hold this belief in Germany (7%) and the United Kingdom (8%). A subsequent study found that among students at a university in the United States, only 36% of respondents disagreed that women's appearances provoke rape, and 60% agreed that women who go out alone are placing themselves at risk of rape. As a consequence of these attitudes, the belief that women rape survivors are responsible for being raped is generated and held. Overall, research has found victim-blaming attitude to be widespread in many countries. Ward (1995) found that in Barbados, Canada, Israel, Malaysia, Mexico, Turkey, Singapore, the United States and Zimbabwe, less than 50% of students believed that men perpetrators are responsible for occurrences of rape. Kopper (1996) showed that women who fought back early on in an assault were significantly less likely to be blamed for the rape incidences, and are more likely to be believed that the assault could not have been avoided.

[1] Distraction responses are those that are aimed at re-focusing victims' attention on matters other than their victimization incidents or their consequences ("e.g., telling the victim to move on with her life") (Ullman & Filipas, 2001b).

[2] Egocentric responses are responses "where the support provider focuse[s] on his or her own needs instead of the victim's" (Ullman & Filipas, 2001b).

[3] The rape perception framework is a term often used in social psychology to refer to a study approach that "examines the effect of victim, perpetrator and situation characteristics on negative attributions in rape" (Anderson, 2004).

Stigmatization

A response often experienced by rape victims is stigmatization. The basic notion underlying stigma is that the affected person is disgraced, dishonoured or otherwise tainted by the event. Stigma has been well documented in the literature, mainly in the forms of narratives and general descriptions of societal responses to survivors of both stranger rapes and acquaintance rapes. Highlighted in studies from different cultural contexts was that the emphasis on patriarchy in many societies perpetuated the shame and stigma attached to women rape victims. Mollica & Son (1989) described the social, political and cultural traditions of male-dominant societies that often embrace ideas of female chastity and purity as measures of women's goodness and worth. Once the valued purity of women has been violated through rape incidents, survivors are stigmatized. Shalhoub-Kevorkian (1999) demonstrated the prevalence of similar perceptions in Palestinian culture. In the predominant Palestinian culture, rape of female virgins is considered an extremely serious affront to family honour, and a threat to male power and control. The need for men to ensure that their power and status are maintained may translate into acts such as forcing women rape survivors to marry their rapists or killing the survivors as a means of erasing social shame and stigma that sexual victimization brings to survivors' families.

The research literature has documented the devastating consequences of stigmatization for survivors of sexual violence. Human Rights Watch and Amnesty International have both issued reports on sexual violence within the contexts of internal conflicts in the Democratic Republic of Congo, and observed that societal rejection of women and girls sexually victimized by members of armed forces is commonplace. Human Rights Watch noted that although some husbands of rape survivors support their wives, many survivors are thrown out of their households without any financial support. Likewise, Amnesty International described the widespread discrimination faced by rape survivors at the community level in addition to isolation and rejection by their families. However, reports have also indicated signs of solidarity among survivors, and described their speaking out against the violence they have endured and the injustice of the stigma they subsequently faced (Amnesty International, 2004a,b; Csete & Kippenberg, 2002).

Several studies have found negative social reactions to be related to more psychological symptoms and poorer self-rated recovery (Campbell R et al., 1999; Davis, Brickman & Baker, 1991; McAuslan & Abbey, 1998; Ullman, 1996a; Ullman, 2000). Using the Social Reactions Questionnaire, studies have found that a range of negative social reactions, specifically, stigmatizing and distraction response, are strongly related to greater severity of symptoms of PTSD (Ullman, 2000; Ullman & Filipas, 2001b). Treating victims differently by responses, such as stigmatization, was most predictive of severity of symptoms of PTSD in the study by Ullman & Filipas (2001b). Examining the mechanisms for this association, Janoff-Bulman (1992) asserted that while traumatic events disrupt positive assumptions of the self, stigmatizing responses contribute further to this disruption, victims of rape faced with stigmatization may feel permanently transformed and devalued by the assault, and may predict the severity of Post Traumatic Stress Disorder.

Responses from informal sources of support

A study in the United States found that the greater extent of disclosure, disclosure to more persons, and less severe sexual victimization were related to receiving more positive social reactions (Ullman & Filipas, 2001b). However, research has also shown that more severe sexual victimization is correlated with more negative social reactions (Ullman, 1996b). Moreover, it has been documented that victims from ethnic minorities receive more negative responses from informal support sources, such as family and friends, upon disclosure than white women in the United States (Ullman & Filipas, 2001a, b; Pollard, 1992; Williams & Holmes, 1981). Specifically, Wyatt (1992) found that African American survivors of rape were not taken as seriously, and received less emotional support, especially from other African Americans. Situational factors found to be correlated with heightened risk

of receiving negative reactions are victims' use of alcohol at the time of assault and victimization by acquaintances (Campbell, 1998; Campbell R et al., 1999). Additionally, survivors of marital rape were less likely to receive supportive responses from family and friends; more support from friends and family was offered to survivors of stranger assault (Golding, Wilsnack & Cooper, 2002).

Responses of formal sources of support

In addition to the negative social reactions exhibited by informal sources of support, rape survivors are also at risk of receiving negative responses from formal sources of support, even when tangible assistance is offered (Ullman & Filipas, 2001a). In fact, research has documented that victims report more negative social reactions from formal support personnel than from informal sources (Golding et al., 1989; Ullman, 1996b), especially from service providers such as the police and physicians (Ullman, 1996b; Ullman, 1999; Ullman & Filipas, 2001b). Guedes, Bott & Cuca (2002) reported that in the Dominican Republic, Peru and Venezuela, many service providers held women rape survivors, rather than the perpetrators, responsible for rape incidents. The study documented that 53% of respondents believed that some women victims provoke their husbands' violence through inappropriate behaviour, and 41% of respondents indicated that adolescents encourage sexual abuse through their own inappropriate sexual behaviour.

Research has clearly shown that negative reactions exhibited by formal support providers can result in poorer psychological and physical well-being for rape victims than for victims who do not receive negative responses (Ullman & Filipas, 2001b). For example, a study found that victims who sought formal support and received victim-blaming responses from support personnel had more symptoms of post-traumatic stress (Campbell R et al., 1999). Due to the possible negative responses from formal support sources, rape victims are likely to delay their disclosure and thus, delay receiving necessary support services (Kilpatrick, Edmunds & Seymour, 1992; Sudderth, 1998; Ullman & Filipas, 2001b). Therefore, negative responses, especially from formal support providers, are significant barriers to rape victims seeking support from medical and mental health services as well as legal services.

Negative responses from informal and formal sources of support may act together to discourage disclosure. For example, limited success has been noted in a gender-based violence treatment intervention programme in Eritrea (von Kerenshazy, et al., 2002). Despite the programme's effort to minimize potential stigmatization by integrating the intervention services into the broader health care system, many women were still reluctant to disclose their victimization experiences. The study found that community members, particularly middle-aged men, disapproved of the intervention programme and opposed the idea that women might disclose their experiences to non-family members. Consequently, women survivors were faced with the choice between seeking support services to address physical and mental health sequelae of sexual victimization and ignoring the ramifications of victimization in order to keep their positions within their families and avoid social stigma and rejection. In a study of the responses of adolescents to sexual violence in developing countries, such as Kenya, Nigeria, Colombia and Peru, Jejeebhoy & Bott (2003) identified the fear of negative responses from informal and formal sources as barriers to young people seeking support after being raped.

Shalhoub-Kevorkian, in her study of the victim-blaming phenomenon within the context of Palestinian culture (1999) found that women's physical and mental health needs are often subsumed by societal perceptions and responses. She stated, "owing to her sociocultural background, the Palestinian victim is virtually always held responsible for her victimization," and "the crime of rape is experienced as more of a personal, female problem than a sociocultural or political one requiring formal social intervention." Evidently, social attitudes that blame and stigmatize survivors of sexual violence are common in many cultures, and can impinge on the recovery of the psychological and physical health of victims.

Women victims' perceptions of sexual violence

Views of sexual violence at the societal level can exert strong influences on how rape survivors perceive their victimization experiences. Although rape survivors adopt varying coping strategies throughout their recovery processes, Burt & Estep (1981) cautioned that the rights of victims to "claim assistance, sympathy, temporary relief from other role responsibilities, legal recourse, and other similar advantages" cannot be exercised if survivors do not identify their experiences as rape. Therefore, rape victims' perceptions of sexual violence have implications for their subsequent responses to victimization experiences. This section of the Review explores the individual perceptions victims hold of their own victimization episodes.

Conceptualization of rape experiences

It has been noted that although the circumstances under which survivors are raped may be very similar, their experiences will differ according to their individual perceptions of sexual violence in general and their specific situations (Smith & Kelly, 2001). The following are all factors that may influence the experiences of the victims and their perceptions of their own victimization.

- *pre-existing conditions* including prior life stress; economic stress; prior chronic problems, such as alcoholism, drug use or low self-esteem; relationship of victim and offender; and prior history of victimization (Burgess & Holmstrom, 1979a, b,c; Cohen & Roth, 1987; Regehr, Cadell & Jansen, 1999).
- *characteristics of the assault* such as style of attack, number of assailants, language used by the assailant, the amount of violence or the sexual acts demanded (Burgess & Holmstrom, 1979a);
- *post-assault encounters and characteristics* such as social responses to victims post-rape, concentration on why the rape occurred, self-blame, and subsequent victimization (Burgess & Holmstrom, 1979a,b,c; Frazier & Schauben, 1994).

Numerous studies have found that many of the women who have experienced unwanted vaginal, oral or anal intercourse do not acknowledge or label their experiences as rape (Bondurant, 2001; Kahn et al., 2003; Kahn & Mathie, 2000; Kahn, Mathie & Torgler, 1994; Koss, 1985; Pitts & Schwartz, 1993; Schwartz & Leggett, 1999). Studies have also investigated factors contributing to victims' acknowledgment of their experiences as rape. Botta & Pingree (1997) suggested that rape survivors may be uncertain of the definition of rape and, thus, may not acknowledge their experiences as such. In fact, Koss (1992) found that women are often unfamiliar with the legal definitions of rape. In her examination of epidemiological surveys of the prevalence of rape, she found that one quarter of survivors of sexual assault (by legal definitions) considered their experience as one of rape; one quarter considered it a crime, but did not label it as rape; one quarter considered it "serious miscommunication"; and one quarter did not consider it as a victimization experience. A similar study documented that women who were forced to have sexual intercourse with acquaintances were less likely to label their experiences as rape than women assaulted by strangers (Koss et al., 1988). These findings led Koss (1992) to conclude that "the great majority of rape victims conceptualized their experience in

highly negative terms and felt victimized whether or not they realized that legal standards for rape had been met."

As a result of the variability in pre-existing conditions and assault characteristics, studies from the United States have indicated that there is ambiguity in women's perceptions of sexual violence. Assault characteristics such as the force used by the assailant, resistance exhibited by survivors and the level of intoxication of victims have also been found to be important factors contributing to the perception of victims. Muelenhard & Kimes (1999) suggested that cultural adherence to rape myths and the focus on stranger assaults in the United States can lead survivors who have experienced other forms of sexual violence not to recognize and/or label these experiences as sexual violence or rape. Women more often use the label rape to describe a forceful, traumatic assault by a non-intimate partner, accompanied by the perceived lack of control to prevent the attack. Many research studies have concluded that women who acknowledged their experiences as rape reported more violent assaults (Bondurant, 2001; Emmers-Sommer & Allen, 1999; Kahn, Mathie & Torgler, 1994; Layman, Gidycz & Lynn, 1996; Schwartz & Leggett, 1999). Studies have often found that women who consider a typical rape to involve a sexually violent encounter with a stranger rather than a less violent sexual assault by an acquaintance are less likely to label their sexual victimization experiences as rape (Bondurant, 2001; Kahn, Mathie & Torgler, 1994). However, Koss (1985) and Levine-MacCombie & Koss (1986) found no relationship between force used by the assailant and how women labelled their experiences. Prior consensual sexual relations and feelings of love toward the assailant are also factors found to be related to women not labelling their victimization as rape (Kahn et al., 2003; Koss, 1985). Bennice & Resick (2003) affirmed this finding, stating, "numerous studies have substantiated the pattern that as the victim-offender relationship becomes more intimate, the likelihood that the incident is defined as rape decreases." Bondurant (2001) found the perceived violence of a rape (indicated by physical harm experiences, and verbal and physical resistance) to be the best predictor of acknowledgement of the victimization incidents as rape. Likewise, Layman, Gidycz & Lynn (1996) found that in comparison to unacknowledged victims, acknowledged victims reported more forceful assaults and indicated more resistance and clearer refusal.

With regard to alcohol use, although no direct correlation has been found between intoxication and the labelling of victimization experiences, research has found higher levels of intoxication to be related to greater self-blame (Abbey et al., 1996; Kahn et al., 2003). Self-blame among victims may contribute to their not labelling their experiences as rape, and may also lead to delayed disclosure. Research findings on self-blame and labelling sexual victimization experiences have been inconsistent, however. Whereas Frazier & Seales (1997) and Pitts & Schwartz (1993) found greater self-blame among victims who do not acknowledge their experience as having been rape, Bondurant (2001) found the opposite, and Kahn & Mathie (2000) and Layman, Gidycz & Lynn (1996) found no correlation between the two.

Muelenhard & Kimes (1999) hypothesized that women may be reluctant to label their experiences as rape due to their fear of losing a sense of control; thus, they may choose to interpret their experiences differently as a coping mechanism. Similarly, Phillips (2000) suggested that women who deny their victimization may do so to preserve the positive assumption of self as mature adults, and to allow them to believe that they are able to change their behaviour in the future to prevent subsequent assaults.

In examining the cultural aspects of violence against women in Asia, Finney (2002) noted that although 37% of women respondents reported having experienced sexual abuse, social norms dominated to the extent that married women did not consider marital rape to be a form of abuse. Research from Africa pointed to similar perceptions among women. In a study of educated Ghanaian women's perceptions of sexual violence, Amoakohene (2004) observed, "the issue of sexual violence provoked rather hostile reactions from respondents." Although the majority of respondents reported experiences of domestic abuse, they did not consider sexual relations with their husbands

to be an appropriate topic of discussion outside of their families. The study found that cultural norms do not recognize marital rape as a concept or a problem. A respondent in Accra explained, "A woman cannot refuse her husband sex. It would be taboo. After all, he married you and you agreed to live with him knowing very well that he is not your family member. In fact, your family should not hear that you have denied your husband sex. Denying him sex could be grounds for divorce."

Research has documented similar views being held by women in Zimbabwe (Watts et al., 1998) where violence was perceived by women as an inevitable part of relationships. As one woman asserted, "you as the wife will not have sex only if he does not feel like it." Additionally, the study indicated that the perceptions of both men and women about the acceptability of forced sex within marriage depend on the circumstances under which it occurs (e.g. pregnancy, intoxication) and the extent of the violence used.

A study in Nicaragua found that the use of physical violence against women by their husbands as punishment is acceptable, and perceived as an expected part of life (Ellsberg et al., 1999). Research has also documented, however, that marital rape within the same cultural context is acknowledged as an extremely serious form of violence (Ellsberg, Lijestrand & Winkvist, 1994).

Coker & Richter (1998) examined the perceptions of Sierra Leonean women who had experienced sexual violence within intimate partnerships and found that, despite their histories of sexual victimization, many of the women interviewed did not hold a negative view of sexual relations as a result. They were also more likely than women who had not experienced sexual violence within intimate partnerships to believe that the purpose of sexual relations is procreation and that it is the man's responsibility to discuss safe sex.

In their work on South African adolescents, Jewkes & Abrahams (2002) highlighted the variations in interpretations of sexual coercion. They referred to a case-control study of teenage pregnancy in which both cases and controls reported lower percentages of "rape," and very high levels of "unwanted sex". They noted that although differences exist between the use of force and other forms of non-violent coercion, they can still result in unwanted sex.

In an investigation in the United States of possible differences of perception among a population according to ethnicity, Chasteen (2001) found several differences between the responses of Caucasian women and those of African American women in labelling the same scenario of sexual violence. The study suggested that African American women were more likely to identify the scenario as a case of rape, and that Caucasian women more often responded "do not know". In addition, women who themselves had experienced rape were less likely to give a definitive label of rape to the scenario.

The responses of women victims to sexual violence

This section covers the psychological, physical, and behavioural responses of women victims to incidents of sexual violence. Although the existing literature shows women's responses to be related in part to their own perceptions of sexual violence, the issue of psychological response certainly encompasses more than the connection between perceptions and response. In an effort to improve the understanding of the responses of rape survivors to victimization experiences, different researchers have used various frameworks for studying response patterns. One prominent approach is to study responses according to the period of time since the attack (i.e, immediate and long-term responses). Studies that have categorized responses according to PTSD diagnostic criteria also feature often in the literature. Additional aspects of psychological and behavioural responses that have been investigated include individual factors influencing response, characteristics of the assault; and cross-cultural considerations. Specific coping strategies employed by victims and the support seeking behaviours adopted are also discussed in this section.

Although the long-term mental health consequences of sexual violence in childhood and the increased risk of sexual violence continuing into adulthood cannot be disregarded, the literature covering these issues is extensive and is beyond the scope of this Review.

Studies of the psychological responses of survivors to sexually violent events began with the documentation of the immediate psychosocial impacts of rape trauma and the subsequent formulation of the Rape Trauma Syndrome by Burgess & Holmstrom (1974). Rape Trauma Syndrome, as constructed by Burgess and Holmstrom, consists of two main response stages – the immediate or acute phase, and the longer-term or reorganization phase. Since then, numerous studies have described the immediate and long-term somatic, emotional and behavioural reactions to experiences of sexual victimization. In addition to mental health consequences of rape experiences, research has also documented the negative physical health sequelae resulting from sexual trauma (Burgess & Holmstrom, 1973, 1979b; Burt & Katz, 1988; Cohen & Roth, 1987; Ellis, Atkeson & Calhoun, 1981; Frazier & Schauben, 1994; Koss & Kilpatrick, 2001; Roth, Wayland & Woolsey, 1990).

A wide range of negative psychological and physical consequences of rape trauma has been documented. Rape survivors commonly experience psychological difficulties such as heightened fear, anger, anxiety, depression, guilt, self-blame, loss of trust, flashbacks, withdrawal and PTSD (Jewkes, Sen & Garcia-Moreno, 2002; Resick, 1993; Burt & Katz, 1988; Cohen & Roth, 1987; Frazier & Burnett, 1994; Lovell, 1988; Meyer & Taylor, 1986; Smith & Kelly, 2001). In addition to the documented psychological responses, victims may experience negative physical consequences of sexual victimization including change in sexual functioning, sleep disturbances, sexually transmitted infections, unsafe abortion, genital fistulae, pelvic inflammatory disease and unwanted pregnancy (Jewkes, Sen & Garcia-Moreno, 2002). Resick (1993) found that immediately after victimization episodes, the majority (96%) of victims described themselves as scared and worried, and exhibited physical shaking and trembling; 92% of respondents described themselves as terrified and confused. The researchers also found that these negative reactions lessened only slightly in severity two to three hours after the assault, when trauma symptoms of depression, exhaustion and restlessness began. The duration and severity of these somatic and psychological symptoms vary among survivors, and

some consequences are more lasting than others. Resick (1993) claimed sexual dysfunctions as the most lasting consequences of sexual victimization.

It is generally agreed among researchers that individuals process traumatic events differently from ordinary events (Brewin, Dalgleish & Joseph, 1996; Epstein, 1994). Research has clearly delineated the tremendous variability in the responses of rape survivors to their experiences. It is important to note that although sexual violence can have serious negative consequences, the extent and ways in which women victims are affected vary. Gavey (1999) suggested that victimization experiences may differ vastly from victim to victim and that, "not all women are traumatized by rape".

Studies have been conducted to investigate the factors that may influence victims' experiences of sexually violent events (Koss, Heise & Russo, 1994). Walker & Katon (1996) suggested that the circumstances of sexual assault may be important in understanding post-assault responses. Frazier (2000) found that survivors with a history of psychological problems and prior victimizations, and victims of more violent assaults experienced more distressing psychological effects post-rape. Researchers have also observed degrees of perceived danger and sustained physical injuries to be related to the severity of post-rape sequelae (Kilpatrick et al., 1989; Resnick et al., 1993). Furthermore, a woman's age at the time of the sexual assault may play a role in survivors' responses and subsequent adjustment. For instance, older women have been found to have more difficulty in adjusting to victimization events psychologically (Ruch & Chandler, 1983; Sales, Baum & Shore, 1984). Foley & Davies (1983) attributed this finding to older women's reservations regarding disclosure owing to their fear of negative reactions from support sources. Poverty, discrimination and oppression have also been investigated as factors contributing to women's abilities to cope with traumatic stressors (Wolfe & Kimmerling, 1997). Forbes & Adams-Curtis (2001) found little evidence that factors such as attitude measures, childhood variables, self-esteem, and the Big-Five Personality[1] factors are related to the responses of survivors to their victimization experiences.

Mental health sequelae

Experiences of sexually violent events can be devastating. Burgess & Holmstrom (1974) found that in the acute phase, immediately following experiences of victimization, victims may express emotions such as fear, anger and anxiety, or may repress and control these feelings, exhibiting a calm and subdued exterior. A qualitative study in Mexico documented dissociative behaviours, vulnerability, terror, sadness and rage as post-rape responses of survivors (Saltijeral, Ramos & Caballero, 1998). Mulugeta, Kassaye & Berhane (1998) studied the prevalence and mental health effects of sexual violence among female secondary school students in Ethiopia and found that among students who reported completed rapes, 33% experienced feelings of social isolation, 19% experienced fear and phobia, 22% reported hopelessness and 6% reported attempted suicide. Campbell (2001) found that psychological distress tended to be very distinctive in the first week after the assault, peaking at about three weeks following the assault, being sustained at high levels for one to two months, and typically beginning to decline at two to three months after the incident of assault.

Beyond the immediate negative psychological effects of sexual victimization, studies have consistently documented the association between a history of sexual assault and long-term mental health problems such as sustained anxiety, phobia, depression, substance abuse disorders, panic disorder, obsessive–compulsive disorder and PTSD (Bifulco, Fown & Adler, 1991; Burnam et al., 1988; Foa & Riggs, 1993; Resick, 1993; Resnick et al., 1993; Ullman & Filipas, 2001a). Investigating the long-term responses of women survivors to sexually violent events, Kimerling & Calhoun (1994) studied the experiences of victims one year after an assault, and found that survivors of sexual violence had significantly higher levels of psychological distress than non-victims. In a study in the United States, researchers found that rates of psychological distress (depression, phobia, panic disorder and

[1] See Lippa (1991).

obsessive–compulsive disorder) and alcohol and substance abuse were higher among survivors of sexual violence than among non-victims (Burnam et al., 1988). Their study also found that among victims who developed psychological disorders, the time that elapsed between experiences of victimization and the onset of disorders was shorter for victims for certain disorders. For example, among those who developed major depression post-assault, 22% experienced this depression within the first year, and 40% within four years following assaults, compared to 8% and 21%, respectively, of non-victims. In a study in Pakistan using the Aga Khan University depression scale, Finney (2002), found higher mean measures of depression in women survivors of various forms of sexual, physical and psychological abuse than in non-victims.

Although suicide as a response to sexual victimization is less common than other negative psychological consequences, the association between victimization and suicide rates has been documented in many geographical areas including, Papua New Guinea, Scandinavia and the United States (Campbell, 2002). In a study based in the United States, researchers found a significantly higher rate of lifetime suicide attempts among individuals with a history of sexual victimization than in other population groups (Davidson et al., 1996). The study also indicated that among women, those who had experienced sexual assault before the age of 16 years were three to four times more likely to attempt suicide than women who had been sexually assaulted at or after the age of 16 years.

Studies have attempted to identify the factors contributing to differences in the responses of victims following rape. Less has been written about the psychological reactions of women who experience sexual violence perpetrated by an intimate partner than those who experience sexual violence perpetrated by a stranger. Some studies have found that sexual violence perpetrated by known assailants and strangers causes similar levels of psychological distress (Koss et al., 1988; Ullman & Siegel, 1993). Similarly, Beckerman (2002) found that psychological trauma and subsequent development of psychopathology is similar for all victims regardless of the relationship between the victim and the offender. Moreover, Bennice & Resnick (2003) noted that women survivors of marital rape showed similar levels and types of psychological distress to those exhibited by survivors of rape by a non-marital acquaintance or a stranger. Within marital relationships, however, they noted that there is evidence to indicate that women raped by their husbands who also suffered other forms of physical abuse had higher incidences of PTSD, depression, anxiety, fear and sexual dysfunction than women who experienced physical abuse without rape. They also found that even after controlling for severity of physical abuse, marital rape is associated with higher rates of PTSD symptoms. It was concluded that sexual violence combined with other forms of physical violence may result in greater psychological harm than physical violence unaccompanied by sexual violence.

Conversely , research in South Africa has suggested that because survivors of marital rape must live with their rapists, they may suffer more severe psychological trauma of a longer duration (Nair, 1997). Nair also noted that victims of repeated marital rape may suffer from learned helplessness as a consequence. It has also been noted that victims of acquaintance rape who received negative reactions from informal and formal sources of support had more symptoms of post-traumatic stress (Campbell et al., 1999). As a result of societal attitudes towards rape and the prevailing myths about sexual violence in the United States, researchers have found that victims of acquaintance rape are at a particular risk of secondary victimization, which is subsequently related to increased psychological distress and delayed recovery (Campbell et al., 2001).

Post-traumatic stess disorder

The use of the PTSD framework to describe symptoms of rape survivors is common among researchers. Studies undertaken in industrialized countries have found that many rape survivors experience symptoms such as nightmares, numbing and increased arousal that are similar to the diagnostic criteria for PTSD, and thus, have suggested the usefulness of the framework in the diagnosis and treatment of rape victims (Foa, Riggs & Gershuny, 1995; Neville & Heppner, 1999; Rothbaum et al., 1992).

While PTSD is associated with many different types of traumatic events, research has consistently shown that sexual violence is one of the traumatic events most likely to lead to the diagnosis of PTSD among survivors (Baker et al., 2005; Breslau et al., 1991; Norris, 1992; Ullman & Siegel, 1994). Rates of life-time prevalence of PTSD after sexual assault have been found to range from from 30 to 94%, and current PTSD from 12 to 16% (Baker et al., 2005; Kilpatrick, Edmunds & Seymour, 1992; Kilpatrick et al., 1987; Resnick et al., 1993; Rothbaum et al., 1992). A longitudinal study of rape victims found that PTSD characterized 94% of victims within 2 weeks post-assault, and 47% of victims within 3 months post-assault (Rothbaum et al., 1992). Similarly, an analysis of the 1996 Detroit Area Survey of Trauma found that although a small percentage (5.4%) of the sample population had experienced rape, the risk of suffering from PTSD as a result was higher than that following other types of sexual assault, 49% and 23.7% for rape survivors and survivors of other types of sexual assault respectively (Breslau et al., 1999). A study by Faravelli and colleagues (2004) in Italy reported similar results. They found that rates of PTSD among rape survivors were significantly higher than among survivors of other life-threatening trauma, 95% and 47% respectively. Darves-Bornoz (1997) studied a population of survivors of sexual abuse in France and also found similar results. The study documented that at 1 month post-assault, 87% of victims were diagnosed with PTSD, 70% met the PTSD diagnostic criteria at 3 months post-assault, and 65% still met the diagnostic criteria at 6 months post-assault. The consistency of the results underscores the intense psychological impact of sexual violence on women who survive such attacks.

Researchers have investigated various factors that may be associated with the heightened risk for survivors of sexual violence of developing PTSD following the assault. Specific assault characteristics including perceived threat to life during the assault, peri-traumatic anxiety, completed rape, and injury due to the assault have been found to be associated with increased risk of PTSD among survivors (Bownes, O'Gorman & Sayers, 1991a,b; Frazier & Borgida, 1997; Kilpatrick et al., 1989; Kilpatrick & Acierno, 2003; Ullman & Siegel, 1994). In addition, lower levels of education, and greater self-blame post-assault among victims have also been found to be associated with heightened severity of PTSD symptoms (Frazier & Borgida, 1997). A study in Northern Ireland found a statistically significant difference in physical injuries between survivors with PTSD diagnoses and those without (Bownes, O'Gorman & Sayers, 1991a). Specifically, among those diagnosed with PTSD, 72% had suffered severe physical injuries from the assault, while among survivors without PTSD, 40% had sustained severe injuries from the attack. Resnick et al. (1994) found that retrospective reports of panic symptoms during rape were associated with both PTSD and panic symptoms at 3 months post-assault. Furthermore, Girelli et al. (1986) indicated that reports by rape survivors of their levels of psychological distress during the attack significantly predicted increased levels of fear and anxiety at 3–12 months post-rape. Studies have also found the perpetrators' use of a weapon during assault to be predictive of greater severity and frequency of PTSD symptoms for survivors after the assault (Dutton, 2003a,b; Dutton et al., 2006; Hattendorf, Ottens & Lomax, 1999). Similarly, Cascardi et al., (1996) documented that women raped in locations rated as safe and women raped by dangerous assailants developed more PTSD symptoms. Conversely, Ullman & Filipas (2001b) did not find physical injury sustained or the relationship between the victim and offender to be predictive of the severity of PTSD symptoms post-assault.

A body of literature addresses sexual revictimization and its subsequent effects. Sexual revictimization has consistently been found to be related to increased distress and greater severity and frequency of PTSD symptoms among survivors (Arata, 1999a,b, c, 2000; Banyard, Williams & Siegel, 2001; Cohen & Roth, 1987; Ellis, Atkeson & Calhoun, 1982; Filipas & Ullman, 2006; Follette et al., 1996; Gibson & Leitenberg, 2001; Gold et al., 1994; Maker, Kemmelmeier & Peterson, 2001; McCauly et al., 1997; Murphy et al., 1988; Roth, Wayland & Woolsey, 1990; Ruch et al., 1991; Santiago et al., 1985). In contrast, some studies have found no differences between levels of distress experienced by victims of multiple and single assaults (Marhoefer-Dvorak et al., 1988; Sorenson et al., 1991).

Classen, Palesh & Aggarwal (2005) suggested that the lack of consensus in the findings regarding the relationship between revictimization and psychological distress may be an indication of other factors that may affect this relationship.

Although studies strongly suggest a causal and temporal relationship between sexual violence and subsequent development of PTSD, it is important to recognize, however, that the link may not be as direct as a uni-directional causal relationship. Choquet et al. (1997) cautioned that, depending on the research design employed, it can be difficult to attribute the development of PTSD to survivors' rape experiences alone. Acierno et al. (1999) identified younger age and active episodes of PTSD as risk factors for sexual victimization and revictimization. In addition, prior victimization during adulthood may also increase the likelihood of revictimization due to direct effects of self-dysfunction (Messman-Moore, Brown & Koelsch, 2005). Messman-Moore, Brown & Koelsch (2005) found that post-traumatic stress alone did not appear to increase survivors' risk of being revictimized, but in conjunction with self-dysfunction, post-traumatic stress did serve as a risk factor for further victimization. Messman-Moore & Long (2003) suggested that the psychological distress responses such as post-traumatic stress, dissociation and interpersonal dysfunction that developed following previous experiences of victimization increases survivors' vulnerability to subsequent victimization. Likewise, Sanberg, Matorin & Lynn (1999) proposed that the dissociation and numbing symptoms of post-traumatic stress may reduce survivors' ability to notice and process danger cues, and they therefore contribute to the risk of revictimization. Furthermore, re-experiencing symptoms may interfere with survivors' ability to judge the safety of a situation or their capability to protect themselves, and may thus also contribute to revictimization. Taken together, these findings support the notion that the relationship between revictimization and development of PTSD is not clear-cut and is influenced by many factors.

Although much of the scientific literature on psychological responses to sexual violence comes from industrialized countries, some cross-cultural studies of these issues have also been undertaken, and the results point to similar conclusions. In a study of Indochinese refugees in the United States, Mollica & Son (1989) stated, "the experience of sexual trauma on a personal level appears to be similar among women across cultures; that is, sexual trauma is characterized by the ultimate violation of woman's privacy and personal identity." Researchers have also found post-traumatic stress to be a relevant and measurable construct for survivor responses to rape in Mexico (Norris et al., 2001; Norris, Perilla & Murphy, 2001). However, some researchers have noted the limited applicability of the PTSD framework to certain situations of sexual violence. Herman (1995) found evidence to support a broader definition of PTSD to accommodate symptoms ranging from relatively simple reactions resulting from single incidents, to a complex stress disorder that accompanies long-term exposure to repeated trauma.

Physical health sequelae

In addition to mental health sequelae, exposure to trauma may result in a wide range of physical health sequelae. Many researchers have documented increased health complaints, more objective indicators of poorer health, more medical diagnoses and increased use of medical services among victims of trauma than among non-victims (Davidson et al., 1991; Dutton et al., 2006; Friedman & Schnurr, 1995; Golding et al., 1988; Kimerling & Calhoun, 1994; Koss, Woodruff & Koss, 1990; Ullman & Brecklin, 2003). As a form of trauma exposure, sexual victimization also negatively affects physical health and often leads to increased health problems for victims in the acute, short- and long-term stages post-assault. Golding (1994) found that victims of sexual violence experienced more acute and chronic medical problems than non-victims. Immediately following an assault, Tjaden & Thoennes (2000a,b) found that 31.5% of women rape victims had sustained rape-related physical injuries.

Infection with sexually transmitted infections (STIs) and human immunodeficiency virus (HIV), and genital and other bodily trauma resulting from sexual victimization are among the pressing

physical concerns survivors may face. In addition, sexual violence survivors may experiences other somatic symptoms including headaches, stomach aches, cardiac arrhythmia, insomnia, fatigue, asthma, nausea, rashes, choking sensations, hyperventilation, gastrointestinal symptoms, menstrual symptoms, sexual dysfunction, and chest, back, and pelvic pain (American College of Obstetricians and Gynecologists, 1995; Amnesty International, 2004b; Becker et al., 1986; Becker et al., 1982; Dutton et al., 2006; Dutton, Haywood & El-Bayoumi, 1997; Kimerling & Calhoun, 1994; Letourneau et al., 1996; United Nations Population Fund, 1999). Moreover, researchers have also found trauma exposure to be associated with more severe symptoms, greater functional impairment and a poorer prognosis of disease outcomes among survivors with specific medical conditions (Green & Kimlerling, 2004; Leserman et al., 1996).

In addition to the physical health sequelae that are directly related to experiences of sexual victimization, histories of sexual assault among women are associated with perceptions of poor health, increased rates of chronic diseases and greater medical-care seeking (Arnow et al., 1999; Campbell & Soeken, 1999; Golding, 1994, 1999; Golding, Cooper & George, 1997; Golding et al., 1988; Koss, Koss & Woodruff, 1991; Green et al., 2001; Laws, 1993; Lown & Vega, 2001; Resnick, Acierno & Kilpatrick, 1997; Ullman & Brecklin, 2003). More specifically, sexual victimization is linked to increased gynaecological symptoms as well as pelvic, abdominal and stomach pain symptoms (Campbell & Soeken, 1999; Green CR, et al., 2001; Lown & Vega, 2001). In addition, survivors of sexual violence may also be more likely to engage in health-damaging behaviours such as smoking and alcohol use, and may suffer from eating disorders, which further compromise their physical health (Crome & McCabe, 1995; Dickinson et al., 1999; Faravelli et al., 2004; Koss, Heise & Russo, 1994; Lobmann et al., 2003; Resnick et al., 2000).

Although research evidence has consistently documented a relationship between a history of sexual victimization and poorer health status, the mechanism for this relationship has not been clearly elucidated (Golding, 1999; Golding, Wilsnack & Cooper, 2002). Studies have investigated and found a relationship between mental health and physical health sequelae among rape victims (Dutton et al., 2006; Friedman & Schnurr, 1995; Green & Kimerling, 2004). Psychological distress and mental health sequelae were identified by a few studies as being influential factors in increased rates of physical health problems and medical service usage among survivors of sexual violence. A study by Arnow and colleagues (1999), found that individuals with histories of sexual abuse had higher rates of utilization of medical facilitites only if they reported experiences of psychological distress. Similarly, another study of women with histories of sexual abuse suggested that depression may be the moderator between childhood sexual abuse and adult medical problems (Newman et al., 2000).

Researchers have found greater severity of PSTD to be related to poorer physical health (Beckham et al., 1997; Davidson et al., 1991; Litz et al., 1992; Wolfe et al., 1994). Furthermore, after controlling for history of previous assault, severity of assault and physical reactions during assault, Clum, Calhoun & Kimerling (2000) found symptoms of PTSD and depression to be associated with overall health perceptions and severity of self-reported physical health symptoms. Thus, PTSD may be an important factor in the development of physical health symptoms. Ullman & Filipas (2001) found the severity of PTSD to be a stronger predictor of self-reported physical symptoms than general life stressors and depression. They also found the severity of re-experiencing symptoms to be predictive of self-reported physical symptoms. Specifically, severe re-experiencing symptoms such as flashbacks, nightmares and physiological reactivity on exposure to internal and external cues were often accompanied by physiological symptoms such as rapid heart rate, shaking, trembling and sweating. Golding (1999) asserted that although depression does not fully account for the relationship between experiences of sexual victimization and later physical health problems, it may partially mediate the association.

Despite these findings, researchers have recognized that in some populations, it is difficult to

examine the relationship between sexual violence and health outcomes in isolation because women often experience physical violence together with sexual violence (Coker et al., 2000). However, the combined effects of physical and sexual violence have been found to be more detrimental to women victims than physical violence alone (Dutton et al., 2006).

Coping strategies

When faced with sexual violence, victims activate various coping responses to deal with the traumatic situation and its aftermath. Draucker & Stern (2000) reviewed the literature on coping, which they noted was considerably sparser than the research on the prevalence and negative impacts of sexual violence. During an assault, the activation of the sympathetic nervous system may serve to assist victims in escaping or fighting off assailants. Immediately following an assault, numbing and stress-induced analgesia may serve to prevent responses to the pain of physical wounds (Feuer, Nishith & Resick, 2005). From a clinical perspective, Osterman, Barbiaz & Johnson (2001) observed that survivors of sexual violence usually arrive at emergency services (e.g., hospital emergency departments) in a psychologically overwhelmed state, which can be manifested in one of three survival-mode functions – anxiety (flight), anger (fight) or dissociation (freeze). Many survivors experience extreme confusion about what has happened to them. Crome & McCabe (1995) stated, "most survivors of rape suffer from many uncomfortable sensations and perceptions which are in effect in their interpretation of what happened during the rape. There are elements of confusion and bewilderment which may cause the survivor to experience a state of numbness or shock. These emotional reactions may be so overwhelming that many survivors deny the rape and its effect."

Valentiner et al. (1996) documented that at 2 weeks post-assault, rape survivors who relied more on wishful thinking as a coping strategy were experiencing more severe symptoms of PTSD than survivors who employed other coping strategies. Filipas & Ullman (2006) recorded revictimization rates for survivors who engaged in maladaptive coping responses as being twice as high as those for survivors who did not adopt these coping responses. In contrast, coping responses such as positive distancing, optimism, and acceptance have been found to reduce the severity of PTSD symptoms (Ullman & Filipas, 2001b). A longitudinal study by Burgess & Holmstrom (1979a) found that those who recovered most quickly used adaptive strategies (e.g., positive self-assessment), defensive mechanisms (e.g., provision of a reason behind the rape), minimization (e.g., actively reducing thoughts of the event), conscious suppression, dramatization and proactive behaviour (e.g., changing residence). Coping mechanisms associated with a poor psychological outcome included negative self-assessment, inaction, substance abuse and attempted suicide. The study highlights that the use of adaptive coping strategies is an aid to the successful recovery of survivors and minimize risks of further victimization.

The body of literature on coping strategies employed by women rape survivors often described explanation, avoidance and substance use and abuse as common methods used in the aftermath of rape and throughout the processes of recovery. The following sections provide an overview of the relevant literature.

Explanation

Meyer & Taylor (1986) stated that explanation is the coping mechanism that has been most studied in the psychological research literature. This coping strategy was first described by Burgess & Holmstrom (1979a) and focused on survivors' identification of a reason for the occurrence of the assault. Although attempts by survivors of sexual violence to make sense of their experience have been identified as an important component of recovery and an adaptive coping strategy, Lobmann et al. (2003) pointed out that self-blame as part of the explanation is not helpful to the recovery process. They asserted that self-blame can allow the survivor to understand the event in such a way that they are able to regain feelings of control, however, research has consistently shown self-blame to be a hindrance to long-term recovery.

A significant portion of research literature has focused on self-blame as a coping mechanism. Janoff-Bulman (1979) distinguished between two different types of self-blame commonly exhibited by rape survivors – characterological and behavioural. Whereas characterological self-blame focuses on the inherent aspects of rape survivors as they perceive themselves, behavioural self-blame focuses on assigning blame for actions that survivors can change. Filipas & Ullman (2006) suggested that it may be necessary for some survivors to engage in self-blame to give themselves a sense of control, supporting the suggestion by Janoff-Bulman (1979) that some individuals may engage in behavioural self-blame to allow them to be comforted by the belief that through personal behavioural changes future assaults can be avoided. It has been suggested that survivors who engage in behavioural self-blame experience more effective adjustment to trauma than those who engage in characterological self-blame (Meyer & Taylor, 1986). However, research has also shown that behavioural self-blame as a coping strategy is not effective for rape survivors, and that there is no correlation between behavioural self-blame and belief in future control over the occurrence of rape (Frazier, 2003). Furthermore, other studies have observed that both types of self-blame are associated with more distress (Arata, 1999a; Arata & Burkhart, 1996; Frazier, Mortensen & Steward, 2005; Hill & Zautra, 1989; Meyer & Taylor, 1986). Koss, Figueredo & Prince (2002) found self-blame to be predictive of difficulty adjusting to interpersonal situations, the severity of symptoms of PTSD and greater physical health consequences. On the other hand, Regehr, Regehr & Bradford (1998) found behavioural self-blame to be unrelated to PTSD symptom levels, and Arata & Burkhart (1998) found behavioural self-blame to be only marginally related to the severity of symptoms of PTSD symptom levels.

Avoidance

Research has suggested that some coping responses by rape survivors such as organising their lives around and avoiding cues including people, activities or memories that they have found to be distress-provoking may reduce the risk of PTSD (Foa, Zinbarg & Rothbaum, 1992). However, Roth & Cohen (1986) suggested that there is little evidence that avoidant coping strategies such as avoidance of problems and social withdrawal are adaptive in the immediate aftermath of sexual violence. In fact, research has found that those survivors who relied more on avoidance as a means of coping also reported higher levels of distress. Frazier, Mortesen & Steward (2005) explained, "part of the reason why behavioural self-blame was associated with more distress is that it was related to greater use of social withdrawal as a coping strategy. Conversely, part of the reason why perceived control over the recovery process was associated with less distress is because it was associated with less use of social withdrawal as a coping strategy." Other studies have also documented that the use of avoidance coping that results in failure to seek help may manifest in negative psychological and behavioural sequelae such as low self-esteem, depression, unsatisfying sexual relationships, abuse of drugs or alcohol, and possible further victimization (Cohen & Roth, 1987; Frazier, Klein & Seales, 1995; Santello & Leitenberg, 1993). Conversely, it has also been found that effortful avoidance and numbing responses served to decrease distress caused by PTSD (Foa, Riggs & Gershuny, 1995; Litz et al., 1997; Taylor et al., 1998).

Substance use and abuse

Research has consistently found associations between experiences of rape and negative psychological and behavioural consequences. In particular, the relationship between being a victim of sexual violence and subsequent alcohol and substance abuse has been well established and documented (Atkeson et al., 1982; Kilpatrick et al., 1997; Kilpatrick, Veronen & Best, 1985; Resick, 1993; Steketee & Foa, 1987). An analysis of the National Women's Study in the United States found that rape may lead to alcohol and drug abuse in women who previously did not use them (Kilpatrick et al., 1998). Burnam and colleagues (1988) found that after a traumatic event, 16% of subjects started to abuse

alcohol and 19% developed drug abuse behaviours, compared to 8% and 2% of matched controls. Studies have observed that rape survivors engage in alcohol and substance use when faced with anxiety-provoking situations post-assault, and thus, suggested that survivors of sexual violence may engage in the use and abuse of substances as a coping response (Bremner et al., 1996; Sharkansky et al., 1999; Stewart, 1977; Stewart et al., 2000).

Stewart (1996) studied the relationship between specific PTSD symptom clusters and certain types of drug use, and found several correlations. Specifically, numbing symptoms were correlated with dependence on anxiolytics and analgesics; intrusion was correlated with dependence on prescription drugs; hyperarousal symptoms were correlated with excessive drinking and dependence on prescription drugs. Acierno and colleagues (2003) suggested that the utilization of substances may be an attempt to resolve symptoms that are causing impairment of the daily functioning of survivors. Survivors may engage in the use of prescription drugs and other modes of self-medication to aid sleep, reduce irritability, reduce difficulties with concentration, reduce hypervigilance or to control excessive startle responses. Research has also identified other factors such as accessibility to alcohol and drugs, dosage, influence of peers, sensation seeking, alcoholic predisposition and risk, adherence to specific beliefs and expectations, and general arousal following consumption to contribute to the development of substance use and abuse after being raped (Peyser, 1999).

Support seeking

Even though survivors of sexual violence seldom disclose their experiences immediately following the assault, most survivors communicate their victimization experiences to others at some point (Golding et al., 1989; Koss et al., 1988). When disclosing their rape experiences, survivors often seek support from informal sources such as family members, friends and church members, and a smaller portion of survivors seek formal support from medical, mental health, legal and social services (Golding et al., 1989).

As detailed earlier, research has consistently demonstrated a host of serious psychiatric and physical health problems to be associated with sexual victimization (Golding, 1994, 1999; Kilpatrick et al., 1998; McMahon, Goodwin & Stringer, 2000; Plichta & Falik, 2001). Yet the rate of utilization of medical and mental health services by rape survivors is low (George, Winfield & Blazer, 1992; Kilpatrick, Edmunds & Seymour, 1992; Mahoney, 1999; Resnick et al., 2000; Resnick, Acierno & Kilpatrick, 1997). Campbell and co-workers (2001) reported that 39% of rape survivors sought mental health services, 21% utilized rape crisis centres and 18% sought support from religious services following their victimization.

Studies in the United States have found that African American women, in particular, prefer support from informal social networks to formal assistance (Wyatt, 1992; Wyatt, Notgrass & Newcomb, 1990). In Ghana, Prah (1999) reported that disclosure of sexual violence by both older and younger survivors was primarily within the family, the extended family and friends. Few survivors made a formal disclosure to the health system, police or department of welfare, and even fewer to the available traditional systems, such as chiefs or elders. Ullman & Filipas (2001a) found that whereas white women received more emotional support from informal networks, women from ethnic minorities reported receiving more emotional support from mental health and medical professionals.

Utilization of medical services

In terms of service-seeking behaviour, Koss, Koss & Woodruff (1991) observed that rape victims made greater usage of medical services up to two years post-assault than non-victims, and also found sexual victimization to be a more powerful predictor of visits to physicians and medical costs of outpatient treatment than other health-related factors such as alcohol use, smoking and age. However, despite demonstrated physical health sequelae of rape and the demonstrated increase in use of medical services by survivors, there are still few rape victims who seek medical services, especially

immediately following victimization. In the United States, women who are seen for medical care immediately after being assaulted were likely to have reported the rape to police or other authorities (Resnick et al., 2000). Survivors seeking medical services shortly after episodes of victimization are also more likely to have been raped by unknown assailants, report more physical injuries, perceive serious threat to their lives and been concerned about sexually transmitted infections. In addition, the study showed that survivors from certain ethnic groups (e.g., African American, Latin American and Native American) were more likely to receive medical care than victims of other ethnicities. Survivors who did not consume alcohol or drugs at the time of assault were also more likely to receive medical care after the assault.

Stewart et al. (1987) found that victims of acquaintance rape were less likely to seek help than to those who had been raped by a stranger, as they may not perceive the sexually violent incident as rape, may be reluctant to seek care for fear of stigmatization or victim-blaming responses, or may not be aware of the services available to victims of sexual violence. Furthermore, Mahoney (1999) found that victims of marital rape were less likely to seek formal support services than those who had been raped by an acquaintance or a stranger.

Utilization of mental health services

In general, studies indicated that women in difficult circumstances view mental health services as important element in their recovery. A study in Canada observed that almost half of respondents identified counselling and emotional support as the most important types of assistance they had received in response to seeking help with their victimization situations (Grasely et al., 1999). However, some studies, have also found that trauma survivors, including rape survivors, were more likely to seek care from health care professionals when they were faced with mental health problems such as anxiety, depression and substance use (Collins et al., 1999; Golding et al., 1988; Koss, Koss & Woodruff, 1991). Similarly, despite the well-documented mental health sequelae of sexual violence, the women most in need of mental health care rarely seek support from mental health professionals (Ullman & Filipas, 2001a). Research has shown that less than 30% of victims seek mental health services for psychopathology related to sexual assault (George, Winfield & Blazer, 1992; Golding et al., 1989). Frazier, Rosenberger & Moore (2000) found that only 9% of assault victims admitted to a hospital emergency department returned for follow-up counselling, and distressed women from ethic minority groups were even less likely to attend follow-up counselling sessions.

Examinations of factors contributing to mental health services-seeking behaviour found life-time victimization history, demographic factors, psychosocial factors and medical insurance to be predictive of help-seeking behaviours among rape survivors. Specifically, in the United States, individuals who reported sexual victimization both in childhood and as adults, survivors of multiple episodes of victimization, survivors of European American ethnicities, and more highly educated women were most likely to seek mental health services (Ullman & Brecklin, 2002). In studies of possible barriers to seeking support, it has been found that women from minority groups received more negative responses from formal support personnel (Ullman & Filipas, 2001a). Women survivors currently attending school as well as victims who were physically injured and reported a perceived threat to life also received more negative reactions and blame when seeking formal support.

Effects of disclosure on recovery

The importance of reaching out to others for assistance after being raped has been documented by researchers. Draucker & Stern (2000) found that among women who experienced sexual violence perpetrated by male intimate partners, telling others about their victimization was important in their recovery. Routbort (1998) reported that fewer trauma-related symptoms were noted in women who were able to talk more freely about their assault experience.

Koss (1985) suggested that there may be numerous reasons underlying survivors' decisions not

to disclose their experiences in order to seek support from either informal or formal sources. These include concerns about confidentiality, interviewers' sensitivity, and the context of questioning about the assault. Research has also pointed to societal responses towards survivors such as victim-blaming and stigma as contributory factors to non-disclosure.

While the decision to disclose experiences to formal or informal support networks allows victims to obtain the assistance necessary for recovery, upon disclosure to support sources, survivors can face varying reactions, which may in turn affect their processes of recovery. A history of sexual assault is found to be associated with low levels of social support. Compared with non-victims, people with histories of sexual victimization were less likely to be married, were more likely to be divorced, reported less frequent contacts with friends and relatives and reported receiving less emotional support from friends, relatives and spouses (Bifulco, Brown & Adler, 1991; Finkelhor et al., 1989; Golding, Wilsnack & Cooper, 2002; Moeller, Backmann & Moeller, 1993; Radomsky, 1992).

Several studies document that supportive reactions to disclosure of victimization experiences are related to lower distress levels and better physical health (Burgess & Holmstrom, 1978; Cohen, 1988; House, 1981; Kimerling & Calhoun, 1994; Testa et al., 1992; Turner, 1983; Ullman & Siegel, 1995). On the other hand, survivors may experience negative reactions such as victim-blame, controlling reactions and stigmatization that hinder the recovery process. Based on these findings, Testa et al. (1992) suggested that social support may have a moderating effect on the relationship between sexual violence and the physical and mental health of survivors after an assault. Davis, Brickman & Baker (1991) examined the relationship through their study of the experiences of rape survivors, and found that negative reactions such as victim-blame and emotional withdrawal exhibited by survivors' partners were associated with more pronounced psychological symptoms in survivors eight weeks post-assault. In a study of Palestinian culture, Shalhoub-Kevorkian (1999) noted, "the loss of social support and assistance made victims further blame and hate themselves, feeling totally alone, without understanding or sympathy from those closest to them. These feelings of neglect, fear, and loneliness increased victims' vulnerability and sense of helplessness, leading them to develop severe anxiety and depression symptoms, even pushing some to attempt suicide."

Screening interventions

In both industrialized and developing countries, great emphasis has been placed on training of health workers to improve screening for sexual violence as an intervention strategy in hospitals and clinics. This section explores the body of literature on these screening intervention efforts. The studies described focus primarily on the impact of screening in identifying victims of intimate-partner violence in general (including, but not limited to, sexual violence), its impact on women victims and the effectiveness of screening training efforts.

Although the application of various screening tools can increase rates of detection, at least in the short-term, the evidence on the impact of screening on women's well-being is inconclusive (Morrison, Ellsberg & Bott, 2004). Wathen & MacMillan (2003) reviewed the research literature focusing on interventions to prevent the abuse and re-abuse of women, and found that several different screening tools could be used effectively in the identification of women experiencing various forms of violence. Looking at the the quality of screening tools to detect psychological distress in particular, Darves-Bornoz and colleagues (1998) examined the usefulness of the General Health Questionnaire (GHQ-28), as applied to a French population of rape survivors at a university hospital, and found this instrument to have good overall reliability.

Although most screening instruments are developed to detect specific conditions, within a specific setting, they can be adapted to meet the needs of other environments. Guedes, Bott & Cuca (2002) described the development of a screening tool to detect violence against women, including sexual violence, adapted from an instrument developed in the United States. Application of the tool in a clinic increased average detection rates from 7% to 30%. From the perspective of the health care providers, the advantages of introducing a screening tool with written questions were twofold. First, they were able to reassure clients that they had not been singled out for questioning because the same questions were being asked of everyone. Second, the standardization of questions made it easier to obtain the needed information.

Garcia-Moreno (2002) observed that there is insufficient agreement among those working on violence against women about which outcome indicators are appropriate for interventions focusing on this area, and there is very little information on the impact of screening practices on women and the role of different contexts on such impact. Similarly, Parsons, Goodwin & Petersen (2000) reported that a critical gap in current research in this area is in information about the effectiveness of routine screening for victims identified through reproductive health services. They pointed out that few studies have collected feedback on clinical interventions from victims themselves. Furthermore, it is not yet clear what specific outcome measures should be used to document improvements in the safety and well-being of women who receive interventions after screening. They cautioned that screening practices may lead women to have concerns about reprisal from their partners, confidentiality, mandatory reporting and restraints on their health insurance. Sullivan (2001) suggested indicators for the effectiveness of screening programmes for domestic violence in general, based on both their short-term and long-term outcomes and on measures of proximal change.

MacMillan & Wathen (2003) observed, "no studies have linked screening to treatment intervention in a way that allows us to determine whether routine screening for violence against women

does more good than harm." The authors' concerns stemmed from the possibility that women who have been identified as victims of violence may be referred to shelters – an intervention that has undergone inadequate evaluation. Looking at potential harm from another perspective, MacMillan & Wathen's review of the literature also noted that there have been no studies to document the harm associated with the failure of screening instruments to identify women who have experienced violence and who should have been identified using such tools.

In considering the impact of training on improving screening practices, Garcia-Moreno (2002) asserted that there had been inadequate formal evaluation of in-service training and screening programmes on violence against women in general. The studies included in her review indicated that there can be small, short-term increases in the number of cases identified when screening programmes are implemented, but that such improvements are difficult to sustain.

Acute, short- and long-term interventions

This section explores selected secondary intervention efforts implemented by community-based services. The literature provides descriptions of programmes, and also discusses the challenges faced by these models and practices.[1]

Briere & Jordan (2004) noted that survivors of sexual violence can experience victimization episodes very differently based on various factors such as characteristics of the assault and the victim, resulting in variations in social and clinical presentation. Therefore, social and clinical interventions must be tailored to the needs of each individual survivor's specific situation without making assumptions based on stereotypes or norms. Briere & Jordan further argued that there may not be a specific treatment for rape trauma, and called for clinicians to be ready to respond to a full range of victimization effects.

In addition to the challenge of varying experiences of victimization and the different responses of rape survivors, public health services are often hampered by the limited resources locally available to provide adequate support (World Health Organization, 2003). In developing countries, researchers have raised the issues surrounding the adequacy or quality of victim care, particularly when delivered by general health practitioners (Jewkes & Abrahams, 2002; Kim, Martin & Denny, 2003). Taking into consideration limitations resulting from resource constraints, the World Health Organization (2003) argued that it is important, especially for countries with sufficient resources, to understand the value of providing post-rape health care services by specialized providers rather than generalized services.

Bletzer & Koss (2006) stated, "effective interventions can assist women in the process of cycling through after-rape and improve participation in a world in which men and women share a co-presence, and the specific world of intimate relations that may have been curtailed by rape, or where first-time experience was postponed indefinitely." They emphasized the vital role of verbal disclosure and articulation throughout the recovery process, and the importance of attending to variability in how women recount their experiences of victimization while counselling and supporting women of different sociocultural backgrounds. Bletzer & Koss further recommended that every layperson be educated to know how to provide adequate assistance to family members and acquaintances in their recovery journeys.

As research has suggested that no woman is likely to be prepared for the psychological consequences of sexual violence, it is crucial that survivors come to understand what they may experience in the acute, short- and long-term aftermath of assault. Furthermore, it may also be beneficial for victims to understand relevant facts, and to be aware of their options regarding the various medical, mental health, legal and social services available. For example, through the work of the international nongovernmental organization Médecins Sans Frontières (MSF) (2004) with the survivors of rape in the Democratic Republic of Congo, MSF noted that it is beneficial to the recovery of most victims to know that rape in conflict contexts is considered legally as a crime punishable in international courts.

[1] Please refer to *Models of health service provision for victims of sexual violence* (WHO, 2007) for a more detailed review of current health-sector-based models of response to rape.

Research has indicated that early levels of distress may predict later development of psychopathology. Therefore, reducing early distress may serve to diminish the negative psychological consequences of rape. Various early intervention programmes have been designed and implemented with the goal of reducing early distress and post-traumatic stress symptoms. Researchers have evaluated these interventions aimed at preventing mental health sequelae and other problems such as major depression and substance abuse (Kessler et al., 1995; Kilpatrick et al., 1997; Resick, 1993; Rothbaum et al., 1992; Steketee & Foa, 1987). The findings of research on the appropriateness of early interventions to prevent psychopathology are inconsistent (Ehler & Clark, 2003). Specifically, doubts have been expressed about the usefulness of debriefing-type interventions as early intervention models (Ehlers & Clark, 2003; Litz et al., 2002; McNally, Bryant & Ehlers, 2003; Rose & Bisson, 1998; Rose, Bisson & Wessely, 2001; van Emmerik et al., 2002). There is little empirical support for the efficacy of debriefing interventions, but the specific components of debriefing have not been evaluated. Hence, its appropriateness as an early intervention strategy for rape victims is inconclusive (Acierno et al., 2003). In light of existing research, the World Health Organization recommends against psychological debriefing as an early intervention after trauma (WHO, 2004).

Hospital and clinic-based services

Most women who experience sexual violence do not seek professional treatment or other formal support. In the United States, of the 20% of all rape victims who report the crime to the police or other authorities, an estimated 70% receive medical care shortly after the incident (Resnick et al., 2000). In industrialized countries, for those who do seek help, hospitals and other clinic-based health services are often the first point of contact.

Within this context, there are three main mechanisms by which survivors of sexual violence obtain the support of hospitals and clinics. A rape survivor may present herself to the emergency department of a hospital; she may be referred to hospital or clinic services by a third party (e.g, a community-based organization); or she may be identified through screening by health professionals whom she has previously consulted on other health matters. In developing countries, there have been efforts to support reproductive health service professionals to strengthen practices for the identification and treatment of victims of sexual violence and other forms of violence against women. Acosta (2002) summarized the roles of the health sector in addressing violence against women as follows:

- designing mechanisms through which survivors of sexual assault and domestic violence are centralized in one or a few hospitals with adequate staffing, the necessary funding, private areas in which to conduct treatment and educational materials for survivors;
- providing clear roles and responsibilities for physicians including on the provision of medical treatment and the collection of forensic evidence;
- facilitating the coordination between various service-providing sectors as necessary, so that survivors do not have to unnecessarily repeat the story of assault;
- obtaining written consent from the survivors for examination and treatment;
- meeting immediate health care needs through the provision of as much care as possible by the survivors' first point(s) of contact.

The literature and programme descriptions listed the current efforts as follows:

- standardizing the treatment of sexual assault survivors when they are seen in hospital emergency departments;
- establishing specialized but integrated services within clinical settings;
- improving the screening skills of primary care personnel and other medical staff to enable them to identify survivors of sexual violence who may need some form of support;
- establishing referral practices.

The literature describing emergency department services for women who have experienced sexual violence emanates primarily from the United States. Beginning in 1992, hospitals in the United States have been mandated to develop an abuse protocol to meet national accreditation requirements for health care organizations. Since then, emergency department protocols have evolved to include treatments for physical injury, forensic rape examination, provision of treatment for STIs, emergency contraception and psychiatric care. However, there are several limitations to this comprehensive intervention approach. First, survivors of sexual violence may have to wait longer than other emergency department patients because many victims do not sustain physical injuries and very few require hospitalization. In a triage situation, where hospital staff attend first to patients with life-threatening conditions, survivors of sexual violence are not given priority. Second, because of the nature of their work, emergency department staff are frequently rushed and may not fully explain the forensic examination which is invasive and can re-traumatize the survivor. Thirdly, emergency department staff often do not receive adequate training on the proper responses to the needs of assault victims.

Garcia-Moreno (2002) noted that most doctors and nurses will finish medical training having received very limited information about violence against women in general. She referred to a review of texts for primary care, obstetrics and gynaecology, and nursing in the United States, in which less than half included a discussion of domestic violence. In other countries, where the public sector provides care to most victims of sexual violence, care providers often have no training in such care. Additionally, women who seek care at an emergency department, if not covered by health insurance, are often expected to pay out-of-pocket for the services received and to apply for reimbursement through various state compensation programmes in the United States (Ahrens et al., 2000), which can serve as a barrier to obtaining care.

Forensic rape examinations

Forensic rape examinations were designed with the primary purpose of collecting legal evidence from rape victims. During a forensic rape examination, a specific evidentiary protocol is followed, emergency contraception and prophylactic treatment for STIs, including HIV where appropriate, is administered, and treatment of physical injuries is provided (Young et al., & the New Hampshire Sexual Assault Medical Examination Protocol Project Committee, 1992, WHO, 2002). In the United States and Canada, Sexual Assault Nurse Examiner (SANE) programs were developed to overcome some of the shortcomings of simply having emergency department staff provide necessary services to rape victims by instituting specialized post-rape services in both hospital and non-clinical settings. These programmes offer specially trained nurses and physicians who conduct forensic rape examination; private rooms for survivors of sexual assault; concerted efforts at referral to link women to the full array of necessary services; courtroom testimony as needed; and in many cases, services are provided free of charge. Studies have indicated that nurses and physicians who have undergone SANE training and regularly attend to the needs of survivors are better able than non-trained nurses and physicians to undertake collection of higher quality evidence (Ahrens et al., 2000).

Although only a minority of rape survivors receive medical care shortly after victimization incidents, research has found this group of victims to be more vulnerable in terms of the development of rape-related psychopathology (Resnick et al., 2005). Therefore, researchers have suggested that early interventions targeting this population could be beneficial. An evaluation of a pre-forensic examination 2-part video intervention which described key aspects of the medico-legal examination, possible future emotional problems, and issues and interventions related to substance abuse, found the brief intervention was associated with reduced likelihood of substance use and abuse at 6 weeks post-assault (Acierno et al., 2003). Previous empirical studies have also supported the use of brief intervention strategies to prevent the development of post-rape substance abuse (Murphy et al., 2001; Stephens, Roffman & Curtin, 2000).

Integrated clinical care

In the international context, a number of efforts are under way to integrate care for victims of sexual violence into clinical practices. Schraiber & d'Oliveira (2002) described a counselling and support intervention programme that was planned for implementation in 15 health units and three hospitals in São Paulo, Brazil. The programme was intended to address issues of domestic violence in general, which encompassed issues of sexual violence. The key objectives of the programme were the development of screening tools, the enhancement of screening capacities of providers, the establishment of necessary responses appropriate for existing primary care services within the health system, the institution of systematic and formal record-keeping, the formulation of referral mechanisms, and the improvement of the quality of service procedure and service evaluation. The two main components of the programme were screening services and referral to counselling services within the health system. The intention of counselling services within this health system was to ensure that once victims of sexual violence have been identified, they are offered an hour-long counselling session, and continued support for up to four weeks. However, a review of the literature yielded no reports of the actual implementation or evaluation of the intervention programme.

In South Africa, the Western Cape Provincial Department of Health established a 24-hour rape management centre in a hospital in Cape Town. It was designed to offer comprehensive services to rape survivors, although an evaluation of its activities indicated a need for further attention to psychological support services (Morrison, Ellsberg & Bott, 2004).

In addition to efforts to integrate care for the victims of sexual violence into broader health care systems, the introduction of clinical treatment of victims of sexual violence into specialized programmes has also been proposed. Hague & Clarke (2002) described efforts to improve the response of the health service to victims of sexual and physical violence as part of the Woman Friendly Hospital Initiative in Bangladesh. This was a response to demographic studies indicating that 14% of maternal deaths in the area were associated with violence and injury. This initiative proposed the institution of clinical treatment programmes for victims of violence in 30 health facilities, and included the development of a health services protocol for the management of sexual and physical violence against women and the implementation of training activities for physicians and nurses. More specifically, the plan for the training course for nurses included the focus on psychosocial counselling for women affected by violence. Beyond Hague & Clarke's description of the plan for the integration initiative, however, no information on its implementation or evaluation was found.

Kerr and colleagues (2003) described the establishment of specialized services for victims of sexual violence in the sexual health department at a teaching hospital in London, England. The physical infrastructure of the Haven, as it was named, consisted of a large examination room with a private shower, a police interview space and an administrative office. The set-up provided an enclosed environment in which a full spectrum of services is offered 24 hours a day by on-site staff dedicated to serving the needs of victims of sexual violence. The Haven offered preliminary psychological support, and relied on referrals to community agencies to provide its patients with more comprehensive mental health services. The Haven also maintained close links with the police and legal referral services. In a review of the programme, Kerr and colleagues found that of those patients who returned to the Haven for various follow-up services, about 60% returned to seek psychosocial support and counselling. However, the study did not assess the outcome of services provided.

Jewkes, Sen & Garcia-Moreno (2002) highlighted the expansion of the One-Stop Crisis Center model in practice in Malaysia, which has grown from a pilot programme in the accident and emergency department of a Kuala Lumpur hospital to 34 centres throughout the country in three years. The centres were designed to coordinate medical, legal, psychological and social support in one location. Mental health services are provided by psychiatrists, counsellors and medical social workers, and trained social workers are on call 24 hours a day. Jewkes, Sen & Garcia-Moreno also documented some challenges faced by the programme in the early stages of implementation, including

the lack of sensitivity among staff, the insufficient staff of forensic medical officers and the lack of shelter for abuse victims. No formal evaluation however, has been done of this approach.

Grisurapong (2002) described a one-stop crisis centre in a provincial hospital in Thailand, which was in part, modelled on the Malaysian One-Stop Crisis Center. The centre addressed all forms of violence, including sexual violence, and employed a dedicated staff to provide 24-hour services to victims. Legal and mental health referral services were also provided by the centre. In addition, the programme developed and implemented training courses for intake staff, and made efforts to develop a local protocol for the clinical care of victims of sexual violence and to strengthen counselling practices. However, major barriers to service delivery were encountered by the programme. First, the hospital lacked trained psychologists or psychiatrists to provide counselling services for victims of sexual violence and training in counselling for nurses was inadequate. Grisurapong also noted the weak link between the programme and legal services, and the lack of community involvement to help victims remain in their communities. Grisurapong listed the following as lessons learned from the implementation of the one-stop centre in Thailand.

- Hospital administrators must be involved in the establishment of one-stop crisis centres.
- Teamwork between the various hospital departments was crucial – intake personnel represent key health care personnel in this endeavour as they are often the first point of contact and assistance for victims of sexual violence.
- Training for various hospital staff should focus not only on technical aspects of violence against women, but should also cover issues such as power relationships, gender and sexuality.
- Although the hospital-based programme focused on the training of health care workers, sensitization of police personnel on the same issues is also desirable.
- Visits to other crisis centres can be a useful starting point for designing similar services.
- Initially, health care providers may identify only the most obvious cases of abuse, but sharing of experiences between personnel in various department of the hospital can improve screening skills in general.
- Adherence to a standard protocol for each cadre of health care workers when handling cases of violence is necessary.

Pagaduan Lopez & Puno Bustos (2002) reviewed services provided to victims of sexual violence in the Philippines, and described two models of integrated clinical care. The first was a women's crisis centre, established in 1989, within a medical centre in Quezon City. The centre provided coordinated services to address counselling needs, health and medical concerns, legal issues and the need for shelter. However, no literature was found on the evaluation of this programme. The second model reviewed was The Women's Desk. This was situated in the Philippines General Hospital, and provided women victims of all forms of violence with a full range of services, including legal and psychosocial support. This programme enabled victims of sexual violence to utilize other services of the hospital where the programme was short-staffed or otherwise weak. However, the danger of over-reliance on outside departments was recognized, as this could lead to the programme becoming incapable of serving as a one-stop service point. Additionally, financial sustainability was noted as a concern affecting both programmes in the Philippines.

In Haifa, Israel, specialized services for victims of sexual violence were integrated into emergency department care at a general hospital in 1980 (Edlis, 1993). The model served to centralize the professional services needed to care for victims of sexual violence with links for referral services. The centre offered 24-hour integrated services provided by trained health care workers who are capable of handling a wide range of trauma-related needs. While the social work department took the lead in establishing the centre, and played a central role in the care of victims of sexual violence, the centre also involved other health care professionals whose services were vital for comprehensive treatment. The crisis intervention protocol began with emergency nurses who addressed

the immediate needs of victims of sexual violence. Following the triage situation, social workers provided victims with information about the procedure and on the potential consequences of filing complaints with the police. Concurrently, emergency department staff reported the incidents of sexual violence to the police as required by law. Nurses then explained to victims the details of the physical examination, which was conducted by gynaecologists using a special assault kit. After the physical examination, further immediate medical and psychological treatment was provided by other medical professionals according to need, the gynaecologists explained follow-up procedures of outpatient services, and victims were discharged with the approval of social workers and follow-up plans, unless physical needs necessitated hospitalization.

Although no specific evaluation measures were included in the study, Edlis (1993) reported that in the 13 years of the programme's operation, it had been nationally recognized as a success and had been used as a model for the establishment of rape centres in other hospitals. The specific advantages identified by Edlis included the promotion of professional teamwork and professional development which focused on the needs of victims, victims' families and the community, the ability to meet a wide range of victim needs by drawing on a variety of community services, the possibility of replicating the model, and the potential for collecting data as needed for studies. On the other hand, Edlis also documented several shortcomings of the model. First, the coordination with other agencies (types of agency not specified) was not sufficiently well-established to ensure continuity of care. Second, there was a heavy dependence on highly motivated staff to keep activities viable, which placed the centre in a vulnerable position of unstable quality of care given the high staff turnover and the general scarcity of qualified staff. Third, there was potential for tension between victims and social workers when recommendations for treatment made by the social work staff did not coincide with the desires of victims.

Referral programmes and coordinated service delivery

Many hospital and clinic-based services rely on referral networks to address the mental health needs of victims of sexual violence. Studies included in this review looked specifically at why referral programmes are necessary and the mechanisms through which coordinated services may effectively support survivors. One study focused specifically on sexual violence, whereas the others discussed these issues as they related to broader programmes to address violence against women.

Campbell & Ahrens (1998) observed that previous studies had indicated that coordinated community programmes can help survivors of sexual violence to gain access to mental health care and other forms of assistance more easily. Based on this assertion, they undertook a study of coordinated support programmes in the United States to examine the mechanisms at work. Coordinated support programmes included sexual assault response team programmes based in hospitals, programmes addressing drug and alcohol abuse, religious institutions, shelters for those affected by domestic violence, and crime reparation assistance programmes (i.e. programmes that help rape survivors to navigate through applications to the state-sponsored crime victims' fund). The authors found three main mechanisms for coordination: integrated service delivery; interagency training programmes; and community-level reform efforts designed to increase community awareness about sexual violence and improve the overall environment in which coordination occurs. Campbell & Ahrens also identified three means by which coordination of efforts bring about improved support for survivors of sexual violence: improving context (i.e. replacing hostility, confusion and miscommunication with greater interaction and support between different kinds of service providers); keeping the perspective of the rape survivor at the forefront; and promoting the understanding of rape as a social issue rooted in gender inequality and power differentials.

In examining at the effectiveness of referrals in addressing the needs of women experiencing domestic violence at a large managed health care organization in the state of California, United

States, McCaw & colleagues (2002) found that women accepted and followed through on referrals for specific reasons. These reasons included unhappiness with the situation at the time, a desire to change the situation at the time, worry about exposing children to abuse, worry about personal physical well-being, and health care provider's concern about stress-related symptoms. The study also found that comprehensive programmes within the health care system helped to increase the likelihood of identifying women living with domestic abuse including sexual violence, while a wide range of external services helped to meet other needs including assistance with legal issues and the availability of emergency housing.

Short, Hadley & Bates (2002) reviewed the operation of the WomanKind Program, implemented in three hospitals in Minneapolis, United States. The programme started in 1986 with the aims of addressing the needs of abused women through crisis intervention, case-management and advocacy services, and continuing support of clients going through health system services. The mission of WomanKind focused on helping survivors of domestic violence to gain access to necessary services, as well as providing training and education on domestic violence to health care providers. The study assessed health care providers' knowledge, attitudes, beliefs and behaviours with regard to the identification and referral of women experiencing domestic violence. It found that health care professionals in intervention hospitals were more comfortable and confident asking patients about domestic violence issues than those in comparison hospitals; they had a greater understanding of the ways in which intimate-partner violence could affect their patients; and they were more aware of their own role in addressing the needs of women living in violent situations. Total scores on measures of knowledge, attitudes, beliefs and behaviours were higher for staff at intervention hospitals than at comparison hospitals, and were significantly higher in the areas of self-efficacy for referral and services, self-reported behaviours, staff preparation and the autonomy of women experiencing violence. The study indicated that the improvements in knowledge, attitudes, beliefs and behaviours of the health care professionals enabled them to assist patients better, both by addressing the needs of survivors of violence as directly as possible, and in making appropriate referrals when necessary.

A related but somewhat different approach described in literature was that of women police stations (WPSs), which have been established in several Latin American countries. While the WPSs typically address the legal concerns of the survivors of sexual violence, they also have links with state agencies and/or nongovernmental organizations that provide other services such as psychological counselling. Evaluations indicated that women victims using WPSs have greater chances of receiving counselling and other services. However, it has also been observed that the women police officers do not necessarily exhibit more supportive attitudes towards survivors of violence than their male counterparts; there are serious funding shortages; and efforts to handle legal issues more effectively can be hampered by other parts of the system (Morrison, Ellsberg & Bott, 2004).

Community-based services

In many settings, especially in developing countries, the health care system lacks sufficient resources to provide hospital or clinic-based services to rape survivors. Jewkes & Abrahams (2002) noted that in most developing countries such support is provided almost entirely by nongovernmental organizations. Access to these services has been found to be uneven, however, and services can be particularly limited in settings where needs may be greatest. Amnesty International (2004a) observed, in the Democratic Republic of Congo, that therapeutic treatment for women and girls who had experienced sexual violence in the context of violent conflicts was virtually non-existent, and most of the work is being undertaken by local organizations, a limited number of psychologists and many non-psychologists. Human Rights Watch (2003) noted similar situations in Sierra Leone.

Rape crisis centres/programmes

The rape crisis centre (RCC) model originated in the United Kingdom and the United States in the 1970s and was associated with the emergence of feminist movements. Today, rape crisis centres are found in both industrialized and developing countries. Campbell & Martin (2001) noted that the basic services of RCCs include 24-hour hotlines, provision of counselling (individual, group or support groups), and legal and medical advocacy. Most of the direct services of RCCs are managed by licensed professionals with some centres employing paraprofessionals to offer short-term counselling. RCCs typically rely on rape victim advocates who are often volunteers with specific training to help survivors of sexual violence navigate through the legal and medical systems, with the goal of minimizing any potential for re-traumatization of the survivors. The Review identified four main types of RCCs (Campbell et al., 2001a):

- autonomous programmes that retain the character of the early feminist collectives typical of RCCs in the 1970s;
- autonomous programmes that are not feminist-based;
- programmes managed from within a social service or mental health agency;
- programmes located in hospital emergency departments.

In view of the financial constraints often faced by RCCs, O'Sullivan & Carlton (2001) stated that in the United States, "[t]he future of independent rape crisis centres is uncertain." They explained that funders of RCCs had urged autonomous programmes to increase revenues by offering additional types of service, or to reduce expenses by joining other agencies. However, a number of concerns have arisen regarding these recommendations. For example, rape crisis services that are embedded in other organizations tend to focus more on counselling, see fewer clients and to be less active in community education than autonomous rape crisis organizations.

O'Sullivan & Carlton (2001) undertook a study in the United States, examining the impact of organizational autonomy on the effectiveness of service delivery. They found that independent RCCs used more inclusive definitions of sexual assault, were concerned about cultural issues and the need to reach the full spectrum of clients, used volunteers as educators, and emphasized youth and males in their community education efforts. In contrast, combined programmes under-served survivors of sexual assault insofar as they were contacted by survivors less often, did not provide police or hospital referrals as regularly, and were not engaged in community education efforts. The study concluded that there was still an important role for autonomous RCCs, and that autonomy over budget, staffing and programme decisions are essential elements in the provision of community services for the victims of sexual assault.

Following their examination of the impact and effectiveness of RCCs, Campbell & Martin (2001) stated, "RCC advocates are quite successful in helping victims obtain needed services and buffering victims from victim-blaming personnel." More specifically, Matsushita-Arao (1997) reported three types of RCC counselling responses as being particularly important in addressing self-blame. These were supportive responses, responses including psycho-education, and responses that directly incorporated the issue of self-blame. Matsushita-Arao also found that the greater the number of contacts between the survivor and the RCC advocate, the less self-blame reported by victims.

While the RCC model originated in the United Kingdom and the United States, RCCs exist in various forms in many other countries. Though it is not clear that these organizations were established explicitly as RCCs, various features of the services provided by these community agencies are characteristic of the RCC model. Amoakohene (2004) highlighted the Crisis Response Center in Ghana, which started primarily as a counselling and referral organization in 1999, and has since expanded its services to include temporary shelter and rehabilitation services. In addition to providing services to rape survivors, it serves survivors of all forms of gender-based violence.

The International Rescue Committee, an international nongovernmental organization active

in gender-based violence programmes in countries affected by armed conflicts, documented the impact of its Drop-In Centers at four refugee camps in the United Republic of Tanzania. Services offered to survivors of gender-based violence included medical services, counselling and referral for emergency contraception, social support, assistance in gaining access to legal systems and temporary shelter. The centres are also active in community education through regular meetings with community leaders, role-playing exercises, dance and discussion (Nduna & Rude, 1998). The Drop-In Centers are located within the maternity wing of camp hospitals to reduce the potential for stigma and are staffed by women leaders in each camp. An evaluation report noted that the programme has helped survivors recover (Gurrola, 1999). Von Kerenshazy & colleagues (2002) highlighted some of the difficulties in establishing such services at a refugee camp in Eritrea. Most prominently, strong stigma surrounding sexual violence has made it difficult to gain the necessary support from certain segments of the society, including from parents of younger survivors of sexual violence and the husbands of married survivors.

Hotlines

Most hotlines are established as telephone banks to provide counselling and referral services to address a wide range of psychological needs. Although hotline centres may include a rape crisis component, the Review found no hotlines that specifically address the needs of survivors of sexual violence.

In Thailand, the Hotline Center Foundation is described as a small "original and pioneer in providing psychological counselling and psychotherapy through telephones for people...to get psychotherapy" (Ornanong Intarajit, Hotline Center Foundation, personal communication, 3 December 2004). The counselling aims to restore survivors' dignity and self-esteem, and to help survivors continue with their lives. Individuals who need additional help such as legal and medical services are also referred to the appropriate agencies. The foundation exists in part to fill the gap in formal services because many professional providers of both mental and physical health services are not educated enough on gender issues as necessary to enable them to provide effective counselling. Although no formal research or evaluation of the programme was available, the hotline centre leaders believed that their approach helped clients to recover more quickly from sexual violence than they would without the assistance.

Shelters

Shelters are typically designed to address the need for protection of individuals experiencing physical abuse alone or in combination with sexual abuse, and references to them are more common in the wider literature on domestic and intimate-partner violence. However, because sexual violence is commonly experienced as part of a wider spectrum of physical abuse, shelters are discussed briefly here.

In the United States, many shelters provide residential programmes and support groups. In addition, individual, group and family counselling may be offered (Sullivan & Gillum, 2001). Sullivan & Bybee (1999) studied the impact of shelter services by interviewing women who had been assisted by a shelter programme which focused on the use of advocates to help women develop safety plans and to gain access to the services they needed. They reported that the use of advocates in this setting was very effective; women in the intervention group reported a better quality of life and social support as well as less difficulty in obtaining other needed services than women in the control group.

An inherent limitation to the use of shelters as an intervention is the financial burden of the recurrent costs involved in operating residential programmes. Morrison, Ellsberg & Bott (2004) noted that many people working on domestic violence internationally had proposed that donors and governments fund such efforts although the cost-effectiveness of doing so in developing countries is questionable. Consequently, shelters are rare in middle- and low-income countries.

Support groups

Many organizations worldwide offer support groups to victims of sexual violence. In Venezuela, The Asociacion de Planificacion Familiar (PLAFAM), for example, (Moreno, Ramirez & Ramirez) offered support groups for three targeted groups of victims – victims of domestic violence, adult victims of sexual abuse and violence, and victims of childhood sexual abuse. The main objectives of the support groups included the building of solidarity among women in similar circumstances, helping women understand violence as a public problem rooted in gender inequities, and promoting empowerment, self-esteem, self-knowledge and knowledge of rights.

In the Democratic Republic of Congo the maisons d'écoute or maisons d'accueil offer victims of sexual violence a space in which to articulate their struggles with activists and to receive mutual support from fellow survivors (Amnesty International, 2004a). In addition to providing shelter and meeting other basic needs of survivors, the informal support groups are a crucial component of these centres.

A number of advantages of support groups have been documented, including the low cost, the ability to respond to more people than is possible with individual counselling, the provision of opportunities for solidarity among women victims, and the possibility of the management of groups by trained facilitators rather than sole reliance on mental health professionals (Morrison, Ellsberg & Bott, 2004).

Religion-based support

The Review identified a few references to religion-based support for survivors of sexual violence. The studies were mostly from Western industrialized countries, and pertained to the role of Protestant Christian churches, although it is possible that other religious institutions provide other mechanisms of support. The references cited below show a mixed picture of the role of religion-based support.

Campbell (2001) found that approximately 18% of women victims sought church-based counselling, and 85% of them reported the counselling experiences to be healing. In a study of the help-seeking experiences of women who had experienced various forms of violence in Ontario, Canada, Grasely and colleagues (1999) found that 18% of the women interviewed had sought support from members of the clergy. Over half (58%) reported that the clergy provided emotional support and that the overall experience was positive. However, 32% indicated that the experience had been negative because the clergy did not provide emotional support or seemed unwilling to provide pro-active help, and very few provided referrals.

Campbell & Ahrens (1998) observed that some survivors of sexual violence turned first to community organizations including churches before seeking assistance from legal or medical systems. In their study of innovative approaches to support women who have experienced sexual violence in the United States, they reported that staff at some rape crisis centres were concerned that religious counsellors may not be able to provide all the necessary information to women who seek their support. Rape crisis centres, therefore, created links with churches through a church outreach position. The outreach positions were staffed by members of the rape crisis centre and were based in different churches in the community. It was reported that although churches were generally supportive of this cooperative function, ideological conflicts based on differences in fundamental beliefs in areas such as gender roles and marriage sometimes arose, particularly with regard to marital rape. Such conflicts compromised the quality and consistency of services received by survivors of sexual violence.

Therapeutic approaches to survivors' mental health needs

Various frameworks have been adopted by service providers to address the mental health needs of women who have experienced sexual violence. The following section covers the major therapeutic approaches that have been adapted and applied to the treatment of survivors of sexual violence.

Cognitive behavioural therapies

Cognitive behavioural therapy (CBT) consists of various applications including systematic desensitization, flooding, psycho-education, prolonged exposure treatment (PE) and stress inoculation training (SIT), all of which are aimed at systematically managing the memory of the trauma and cognitively reinterpreting it to reduce anxiety. Other cognitive techniques, such as the challenging of automatic thoughts and cognitive restructuring, are sometimes used to decrease feelings of guilt, fear and depression.

Cognitive behavioural treatments administered shortly after the rape takes place have been found to significantly improve survivors' functioning and to decrease levels of anxiety and depression (Bryant et al., 1998; Bryant et al., 1999). A brief, intensive multi-session CBT intervention has also been found effective in accelerating the rate of improvement of rape-related psychopathology and reducing depression in rape survivors who received treatment within one month post-assault (Foa, Hearst-Ikeda & Perry, 1995).

Among the various approaches to CBT, PE and SIT have received the most empirical support for the treatment of PTSD among victims of sexual violence (Foa et al., 1991, 1999). PE involves psychoeducation, breathing control, behavioural exposure to feared environmental cues of the trauma, and imaginal exposure to the trauma memory. SIT includes components of education, skill building for relaxation, cognitive restructuring, and behavioural rehearsal (Kilpatrick, Veronen & Resick, 1982).

Foa et al. (1991) documented the use of different forms of CBT in a study undertaken in the United States. The study compared the effectiveness of three CBT approaches, PE, SIT and supportive counselling, with that of no treatment (people on a waiting list) as measured by PTSD symptoms. Immediately following the treatment all four sample groups had improved significantly. In terms of overall severity of symptomos of PTSD, the group that received SIT was found to have improved more than the group that received supportive counselling and the group that were on the waiting list. The study observed that immediately following treatment and at 3-month follow-up, the groups improved equally in the areas of fear, anxiety and depression. The study found that, SIT was more effective in relieving symptoms of PTSD in both the short-term and the long-term than PE.

Foa and colleagues (1999) compared PE, SIT and a combination of PE and SIT with a group on the waiting list. The study found that immediately following treatment and at 1-year follow-up, all three treatment groups experienced significant reduction in the severity of symptoms of PTSD and depression compared to the group on the waiting list. Immediately after treatment, the PE group indicated more improvement in the area of general anxiety than other groups.

Cognitive processing therapy

Cognitive processing therapy (CPT) was designed to treat PTSD resulting from sexual violence. It consists of two components: cognitive therapy and exposure in the forms of writing and reading about the traumatic event (Resick, 1992; Resick & Schnicke, 1992, 1993). Several studies have indicated the effectiveness of CPT in treating PTSD (Calhoun & Resick, 1993; Resick, 1992; Resick & Markway, 1991; Resick et al., 2002). In a study of effectiveness of CPT and PE treatment on chronically distressed rape victims, both approaches were found to significantly improve symptoms of PTSD and depression compared to delayed treatment (Resick et al., 2002). Resnick and colleagues also noted that outcomes for both treatment approaches were not affected by the chronicity of the trauma, and symptoms of PTSD and depression were reduced equally after treatment. In addition to the treatment of PTSD and depression, cognitions were affected by the therapies as well. Compared to PE, CPT was more successful in remediating guilt cognitions in areas of hindsight bias and lack of justification, but was not as effective in decreasing global guilt or a general sense of wrongdoing.

Post-traumatic stress disorder prevention therapy

A study by Foa, Hearst-Ikeda & Perry (1995) evaluated the effectiveness of a brief PTSD prevention programme consisting of information about the typical reactions to assault, breathing and relaxation techniques, reliving the event through imaginal exposure, confrontation of feared situations and cognitive restructuring. The results indicated that individuals who received this therapy experienced less severe re-experiencing and arousal symptoms than women in the control group at 2 weeks post-assault, and significantly less re-experiencing at 5.5 months post-assault. Of clinical importance, however, was the finding that none of the intervention group and 33% of the control group had more than six PTSD symptoms at the later assessment.

Feminist therapies

Building on a feminist perspective that sexual violence is a societal rather than an individual issue, the approaches of feminist therapies to recovery of mental health following the experience of violence revolve around helping the survivor to see her experience as part of a larger social problem. Campbell (2001) asserted that whereas CBT deals with the immediate symptoms of fear and anxiety, feminist therapies address victims' more long-term feelings of guilt, shame and self-blame. The underlying rationale is that by helping survivors to see the societal aspects of what they have experienced, it is possible to reduce the guilt, shame and self-blame which are pervasive and often socially influenced.

Campbell (2001) noted that group therapy was often used within feminist approaches to reduce self-blame, shame and guilt. Group members can support each other effectively in overcoming these feelings and can come to understand the social dimensions of their victimization experiences. According to Campbell (2001), the few studies that have evaluated feminist therapy approaches indicated that they may be effective, although more research is needed. She noted that many practitioners use elements of both CBT and feminist therapies in treatment interventions to reduce the short-term fear and anxiety resulting from sexual violence as well as to deal with the longer term issues of guilt, shame and self-blame. No research documenting the practice of integrating both forms of therapy was identified.

Relational therapy

Social support has been documented as a key component for successful recovery of the mental health of survivors of sexual violence. Although both individual and group therapies can include mechanisms to support women in interacting effectively with others in their social environments, rela-

tional therapies integrate the survivors' most immediate social network (i.e. family, friends and/or intimate partners) into the treatment. Bowling (2002) compared relational therapy with individual therapy, with outcome measures on symptoms of depression, PTSD and general family functioning, and found that women victims who received relational therapy were significantly more likely than those who underwent individual therapy to experience a decrease in symptoms of depression. Both groups showed similar decreases in symptoms of PTSD, and there was no significant difference between groups in family functioning.

Traditional healing practices

Non-professional individuals who are believed to possess healing powers, sometimes called traditional healers, are consulted in many part of the world for physical and psychological treatment in the aftermath of sexual violence. Describing the experience of survivors of sexual violence in Uganda, Bracken, Giler & Kabaganda (1992) stated, "[m]ost African societies also have an extensive network of traditional healers. As many forms of distress are perceived as having a supernatural dimension which cannot be adequately dealt with by western medicine, resort is very frequently made to such healers. The distress associated with trauma is often not conceptualized as a medical problem, and local family networks and traditional healers are felt to be the appropriate agents to deal with it. However, the impact of these type of approaches has yet to be evaluated.

Criminal justice system interventions

This section focuses on the interaction between victims of sexual violence and the personnel of the criminal justice system, in particular, the role that the criminal justice system plays in influencing the recovery processes of the victims of sexual violence in the aftermath of assault.

The criminal justice system can provide important services for victims of sexual violence. However, many studies have documented low rates of reporting of sexual violence offences as few women choose to disclose their victimization experiences to legal systems (Epstein & Langenbahn, 1994; Gilmore & Pittman, 1993; Gregory & Lees, 1999; Jaquier, Fisher & Killias, 2006; Kelly, 2002; Kilpatrick et al., 1987; Koss et al., 1987; Mack, 1998). Studies in the United States indicated that only 16% to 39% of rape victims reported the incidents to the police (Campbell et al., 2001; George, Winfield & Blazer, 1992; Kilpatrick, Edmunds & Seymour, 1992; Mahoney, 1999). Moreover, of those incidents of sexual violence that are reported, not all proceed through the system to the point of prosecution (Gregory & Lees, 1999; Harris & Grace, 1999; Holmstrom & Burgess, 1991).

While belief is central to investigations of sexual violence, several studies have documented that victims of sexual violence often face responses and attitudes of disbelief when interacting with criminal justice system personnel, which act as a major obstacle to victims' willingness to approach the police for assistance (Blair, 1985; Chambers & Millar, 1983; Jaquier, Fisher & Killias, 2006). In a study of the experiences of women rape victims with the police, one third of the study population reported encountering attitudes of disbelief in the police at some stage during the reporting process, and maintained the perception that they needed to persuade the police of the genuineness of their complaints in order for the investigation to proceed (Jordan, 1998). A number of studies have noted the perception of women victims that the disbelief response may be rooted in the adoption of rape myths regarding the behaviours and characteristics of rape victims (Jordan, 1998, 2001; Kelly, 2002; Kerstetter, 1990; LaFree, 1981; Shapcott, 1988). Furthermore, Jaquier, Fisher & Killias (2006) suggested, "police suspiciousness regarding rape allegations originates within a social environment characterized by a history of distrust towards women, and is exacerbated within the masculine ethos of police organizations".

A study found that many women residing in rural areas of the United States believed that the offences of violence against women were low priorities for the criminal justice system (Logan et al., 2005). In the same study, women in rural areas also indicated their perceptions that only victims with the necessary political connections were able to obtain justice through the legal system. Furthermore, they held the perception that it was unlikely that victims would receive assistance from the criminal justice system in cases where the perpetrators have the necessary political connections.

Jordan (2001) suggested that the potential differences in the focuses and goals of the police and the victims may contribute to low reporting rates as well as to the negative perceptions of the effectiveness of the criminal justice system in assisting rape victims. In depicting this inherent conflict within the interaction between victims of sexual violence and the criminal justice system, Jordan stated, "the victim is trying to manage the effects of trauma and regain a sense of personal equilibrium at the same time as the police are making excessive demands on her stamina and seeking to establish her veracity as a complainant.... The police focus is likely to be on the identification and

apprehension of the offender, which may or may not be something that the victim can assist with, and may or may not be the goal she shares" . The offender-oriented and crime-fighting focus of the police may manifest itself in the display of minimal or flawed understandings of various aspects of incidents of sexual violence, such as how and why they occurred and their effects on victims (Jaquier, Fisher & Killias, 2006). Moreover, the police are not trained to meet victims' needs to restore their sense of safety and control, and the procedures dictated by the criminal justice system may even work to disrupt and hinder victims' re-establishment and healing processes. Jordan (2001) suggested that the involvement of support workers and therapists can assist both victims and police in meeting their respective goals.

Herman (2003) examined the impact of legal intervention on the mental health of crime victims, focusing on survivors of sexual assault. She noted that in the United States, the legal system is structured to be an adversarial contest between prosecuting and defending parties in which tactics are used without regard for the inherent disparities in power that may exist between the parties, based on age, race, gender, and social or financial status. Based on the inherent structure of the legal system, victims of sexual violence may experience psychological benefits as well as psychological harms from their participation in legal procedures.

There have been studies on the psychological benefits that victims can derive from their participation in the legal process. They may feel safer if the perpetrators are found guilty and punished for their criminal acts. This in turn can lead to an enhanced sense of security for the victims themselves and for the community at large from the perspectives of victims. Herman (2003) suggested that if the legal prosecution is successful and victims' complaints are validated and acknowledged publicly, there is a greater possibility of victims receiving restitution and/or an apology from perpetrators, which may also enhance psychological healing through the restoration of the victims' trust in the community and its systems for protecting individuals.

On the other hand, victims can also suffer revictimization and other negative psychological consequences as a result of taking part in legal processes. Freedy and colleagues (1994) found victims' reports of inadequate services received from the criminal justice system to be related to heightened risks for developing PTSD. Jaquier, Fisher & Killias (2006) claimed, "a profound skepticism towards women rape complainants has historically been evident in criminal justice systems internationally". In accordance with such scepticism, the court system often demands that victims prove their credibility (often in the absence of extensive corroborative evidence) at a time when they may need support and acknowledgement of their accounts of their experiences of victimization. Additionally, at a time when victims may need to re-establish the sense of control and independence in their lives, the complex procedures and rules inherent in the legal system can be foreign and difficult to navigate. Similarly, the discourse styles adopted in the courtroom may not permit the victims to present what they themselves would perceive as complete and accurate stories. Finally, victims must often face and confront their perpetrators directly in court although many victims may rely on minimizing traumatic reminders as part of their psychological recovery process.

In describing the effects of the current relationship between victims of sexual violence and the legal system, Jordan (2001) stated, "if attitudes of disbelief and victim-blaming are encountered, not only will one woman's trauma be magnified and her sense of injustice heightened, but the credibility of the system itself and its commitment to protect and support victims generally is undermined". Until investigative officers can overcome the prevailing mindset of suspicion and disbelief, many victims will continue to refrain from reporting incidents of sexual violence (Jaquier, Fisher & Killias, 2006). In accordance with these observations, researchers have suggested that the greatest attrition in sexual violence cases occurs before they reach court (Jaquier, Fisher & Killias, 2006).

Conclusions and areas for future research

Research in the field of sexual violence is beset by the difficulties and barriers inherent in cross-national comparisons, and, "the ways to correct them remain largely unclear" (Cousineau & Rondeau, 2004). Bearing this in mind, this section identifies gaps in the current literature and makes recommendations for prioritizing and developing future research activities.

The Review has identified a need for additional research in all regions of the world, particularly in middle- and low-income countries, to examine women victims' perceptions of and responses to sexual violence. In addition, findings from high-income countries should be assessed for relevance to middle- and low-income countries, before the results are used to guide practices in these settings. The gaps in the current literature highlighted below serve as recommendations for future research initiatives.

In general, it is recommended that future research activities focus on women victims and intervention practices in middle- and low-income countries, with a cross-national and/or cross-cultural emphasis.

Perceptions of sexual violence by women victims

Although various studies have documented the perceptions of women victims of rape within intimate-partner relationships, less information is available on women's perceptions of the distinction among various forms of sexual violence. The Review also found that literature on potential differences in women victims' perceptions of sexual violence according to factors such as age and geographical locations was scarce. Much of the literature in this area comes from high-income countries, revealing large research gaps in middle- and low-income countries.

Key recommendations for future research

Future research on women victims' perceptions of sexual violence should include systematic documentation and analysis of the following:

- the definitions of sexual violence adopted by women victims from various demographic backgrounds;
- women victims' perceptions of the causes of various forms of sexual violence;
- women victims' perceptions of their needs as victims of sexual violence;
- women victims' perceptions of various intervention practices.

Women's responses to sexual violence

Although cross-cultural differences among women victims' responses to sexual violence were highlighted, the studies identified by the Review in this area of research were heavily dominated by western-based thinking. The use of the PTSD framework for understanding the psychological consequences of sexual violence is a prime example, as the appropriateness of its application to non-western cultures continues to be questioned and has not been extensively examined or validated.

Likewise, information on coping mechanisms comes largely from high-income countries. In addition, comparative studies of the impact of various forms of sexual violence on the recovery of women victims are needed. A small number of studies have been undertaken in the United States on the cumulative stress of living in an ongoing sexually violent relationship, compared to a single incident of rape, but little has been published on this subject in middle- and low-income countries.

Key recommendations for future research

Future research on women's responses to sexual violence should include:

- examination of the psychological consequences of sexual violence for women victims using standard measurements;
- analysis of the mental health outcomes of women victims according to the coping strategies employed, and mental health state prior to the incidents of sexual violence;
- review of the use of PTSD diagnostic guidelines as a framework for measuring the psychological impact of sexual violence on women victims;
- systematic documentation of the psychological effects of the responses of the criminal justice system on women victims;
- documentation of the processes of recovery experienced by women victims;
- examination of the disclosure process as it affects the recovery processes of women victims.

Intervention models and practices

The available literature on primary prevention practices mainly described and evaluated prevention education initiatives implemented in university settings in high-income countries, revealing the lack of research on other segments of society. The information on screening interventions and therapeutic approaches also relied heavily on studies based in western countries. It is clear that systematic evaluation of screening interventions is needed. The findings of research on therapeutic approaches to treating victims of sexual violence indicated that all major therapies contribute to the psychological recovery of patients, but no consensus has yet been reached on the superiority of any particular approach. Although there are descriptions of intervention plans and practices in developing countries, the Review identified virtually no systematic evaluation studies of intervention practices in these regions. Overall, research in the areas of intervention is inadequate in middle- and low-income countries.

Key recommendations for future research

Suggested areas of research on intervention models and practices are as follows:

- systematic documentation of primary prevention practices in general population settings,
- systematic evaluation of primary prevention programmes;
- systematic documentation of existing screening practices in various settings;
- documentation of the impact of screening interventions on women victims;
- evaluation of current screening intervention practices;
- evaluation of training programmes for health care providers in treating women victims;
- examination of the effects of receiving treatment (including medical, mental health and legal services) on recovery;
- systematic documentation of traditional healing practices in treating women victims;
- examination of the impact of traditional healing practices on the recovery processes of women victims;
- systematic documentation of services provided to women victims by religious institutions;

- examination of the impact of interventions provided by religious institutions on the recovery processes of women victims;
- evaluation of integrated clinical care practices in treating women victims;
- documentation and comparison analysis of the mental health outcomes resulting from the different types of therapeutic approaches used to treat women victims;
- systematic documentation and comparison analysis of criminal justice interventions and their impact on the recovery of women victims.

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ANNEX 1

Resource persons and organizations contacted

Resource persons and organizations successfully contacted for the purposes of this review are listed below:

Individuals

Abdi, Zeinab: ActionAid Kenya (formerly CARE International reproductive health programmes in Kenya)
Anderson, Victoria: Auckland Rape Crisis Centre
Bartel, Doris: CARE International Reproductive Health Programs (Washington, DC)
Billings, Deborah: Ipas (Mexico)
Campagna, Caroline: National Sexual Violence Resource Center (Pennsylvania Coalition Against Rape)
Campbell, Jacquelyn: Johns Hopkins University, School of Nursing
Ellsberg, Mary: Program for Appropriate Technology in Health (Washington, DC)
Guedes, Alessandra: Independent Consultant (formerly International Planned Parenthood Foundation (IPPF) – Western Hemisphere)
Hadi, Sahir Abdul: United Nations Population Fund
Heise, Lori: Program for Appropriate Technology in Health (Washington, DC)
Hynes, Michelle: US Centers for Disease Control and Prevention
Lopes Cardozo, Barbara: US Centers for Disease Control and Prevention
Malhotra, Anju: International Center for Research on Women
Maman, Suzanne: Johns Hopkins Bloomberg School of Public Health
Marsh, Mendy: Independent Consultant
Michau, Lori: Raising Voices
McCloskey, Laura: Harvard University School of Public Health
Navani, Sonia: The International Rescue Committee
Phung, Teresa: International Medical Corps
Read, John: The University of Auckland, Psychology Department
Reed-Hamilton, Sophie: The International Rescue Committee
Sen Gupta, Promita: United Nations Development Fund for Women (New York)
Shifman, Pamela: United Nations Children's Fund (New York)
Stines, Frederica: International Women's Health Coalition
Taft, Angela: La Trobe University (Melbourne)
Vann, Beth: Reproductive Health Response in Conflict (John Snow Research & Training, Inc.)
Ward, Jeanne: Independent Consultant
Yessirkegonova, Alma: United Nations Development Fund for Women (CIS)

Organizations

Auckland Rape Crisis: http://www.rapecrisis.org.nz/
CASA Amiga: casaamiga@terra.com.mx
Hotline Center Foundation (Thai language): http://www.hotline.or.th/

ANNEX 2

Internet resources consulted

Africa Regional Sexuality Resource Center: http://www.arsrc.org/en/index.htm
African Partnership for Sexual and Reproductive Health and Rights of Women and Girls (Amanitare): http://www.amanitare.org/home2.html
Asia-Pacific Resource Centre for Women (ARROW): http://www.arrow.org.my
Asia Foundation: http://www.asiafoundation.org/Women/violence.html
Australian Domestic and Family Abuse Clearinghouse: http://www.austdvclearinghouse.unsw.edu.au/
Institute of Development Studies, Sussex University (BRIDGE): http://www.bridge.ids.ac.uk/
Cambodian Women's Crisis Center: http://jinja.apsara.org/cwcc/eng.htm
Casa Amiga: http://www.casa-amiga.org/Information.html
Center for Reproductive Law and Policy: http://www.crlp.org/ww_searchbyreg.html
Centre for Research on Violence Against Women and Children: http://www.crvawc.ca/
CHANGE: http://www.genderhealth.org/Mission.php?TOPIC=ABT
Coalition on Violence Against Women – Kenya (COVAW): http://www.covaw.or.ke/
Collective for Research and Training on Development–Action (CRTD): http://www.crtd.org/profile.htm
End Violence Against Women (JHU-CCP): http://www.endvaw.org/
Fiji Women's Crisis Center: http://www.fijiwomen.com/
GBV Prevention Network: http://www.preventgbvafrica.org/
Gender Studies and Human Rights Documentation Centre: http://matrix.msu.edu/~mensah/gendercentre/documentation.html
Global Reproductive Health Forum (Research Library): http://www.hsph.harvard.edu/Organizations/healthnet/reprorights/topic10.html
Health Systems Trust: http://www.healthlink.org.za/
Hotline Center Foundation (Thai language): http://www.hotline.or.th/
Human Rights Watch: http://hrw.org/doc/?t=women_sexualviolence
International Center for Research on Women: http://www.icrw.org/
Rifka Annisa: http://www.insideindonesia.org/edit66/rifka1.htm
IPAS: http://www.ipas.org/
International Women's Health Coalition: http://www.iwhc.org/
Kvinno Forum: http://www.kvinnoforum.org/english/index.html; http://www.qweb.kvinnoforum.se/
Michigan Coalition Against Domestic and Sexual Violence: http://www.mcadsv.org/
Minnesota Center Against Violence and Abuse: http://www.mincava.umn.edu/library/dv/
Narika: http://www.narika.org/
National Sexual Violence Resource Center: http://www.nsvrc.org/
Novib: http://gbv.novib.nl/
US Department of Justice, Office on Violence Against Women: http://www.ojp.usdoj.gov/vawo/
Pambazuka News: http://www.pambazuka.org/
Program for Appropriate Technology in Health (PATH): http://www.path.org/
Rainbo: http://www.rainbo.org/

RAINN Counseling Centers: http://www.rainn.org/rccs.html
Raising Voices: http://www.raisingvoices.org/
Reproductive Health Gateway: http://www.rhgateway.org/
Saathi: http://www.saathi.org.np/
Sexual Violence Research Initiative: http://www.svri.org
Siyanda: http://www.siyanda.org/
South and Southeast Asia Resource Centre on Sexuality: http://www.asiasrc.org/
University of Illinois – Chicago Domestic Violence and Sexual Assault Evaluation: http://www.uic.edu/depts/psch/idhs/
United Nations – INSTRAW: http://www.un-instraw.org/en/index.html
USAID Development Experience Clearinghouse: http://www.dec.org/health_pop.cfm
Violence Against Women On-Line Resources: http://www.vaw.umn.edu/
Women's Health Project: http://www.wits.ac.za/whp/
Women Against Violence Europe (WAVE): http://www.wave-network.org/
Queensland Health: http://www.health.qld.gov.au/
World Health Organization (WHO): http://www.who.int/

ANNEX 3

Literature databases and search terms used

The literature review primarily relied on four literature databases: PubMed, PsycInfo, JStor, MedLINE and Sociological Abstracts. Bibliographies of key articles were reviewed to identify other papers of direct relevance regardless of publication date.

PubMed: Publications since 1 January 1995 were considered. Specific search terms included: "sexual violence women mental health", "sexual violence women health services", "sexual violence mental health", "sexual violence women developing countries", "sexual violence women responses", "rape hospital services", "women and rape in developing countries", "women and rape responses", "women rape victims", "women rape survivors", "counseling women after rape", "rape hotlines", "mental health services women rape", "mental health women rape", "mental health sexual assault" and "rape services".

PsycInfo: Publications from1994 to 2004 were included. The search terms were the same as those used in the search of PubMed (see above).

JStor: Literature from 1995 to 2004 was used. Types of journals selected included: African Studies, Anthropology, Asian Studies, General Science, Population Studies, Psychology and Sociology. Specific search terms included "sexual violence", "sexual violence and mental health", "rape and mental health", "rape services" and "rape responses".

MedLINE: Literature from 1994 to 2004. Specific terms included: "sexual violence women mental health", "sexual violence women health services", "sexual violence mental health", "sexual violence women developing countries", "sexual violence women responses", "rape hospital services", "women and rape in developing countries", "women and rape responses", "women rape victims", "women rape survivors", "counseling women after rape", "rape hotlines", "mental health services women rape", "mental health women rape", "mental health sexual assault" and "rape services".

Sociological Abstracts: Literature from 1994 to 2004 was searched. Specific search terms included "sexual violence", "sexual violence and mental health", "rape services", "rape and mental health" and "rape responses".

ANNEX 4. Empirical studies reviewed

AUTHOR(S) (YEAR)	STUDY POPULATION/ SAMPLE SIZE	SETTING(S)	RELEVANT KEY FINDINGS	FUTURE RESEARCH IDENTIFIED BY AUTHOR(S)	LIMITATIONS IDENTIFIED BY AUTHOR(S)
Acierno R (2003)	124 women rape victims Aged 15 years or older	Academic medical centre, United States	• The two-part video intervention developed for use in acute post-rape time frames was effective in reducing risk of marijuana abuse at 6 weeks		
Acierno R et al. (1999)	*National probability sample* 3006 women Aged 18 years or older	United States	• Risk factors for post-traumatic stress syndrome following rape included a history of depression, alcohol abuse, or injury experienced during the rape		
Agar K & Reed J (2002)	92 psychiatric clients (mean age 36.5 years)	Community mental health centre, Auckland, New Zealand	• Only about one third of clients sampled disclosed their abuse history to clinicians • Only 22% of the abuse clients received abuse-focused therapy • Response rate was lower if the clinician was male or a psychiatrist	• Interviewing local clinicians to investigate why they sometimes choose not to respond to abuse disclosures • Evaluation of the effectiveness of unit policies and training programmes • Including consumer groups in the development of policies and training programmes as well as evaluations	
Agbayani-Siewert P & Yick FA (2001)*	171 Filipino American undergraduate students (mean age approximately 20 years)	United States	• Males and females in the study held similar perceptions in: — physical, sexual and psychological definitions of dating violence; — perceptions of and attitudes towards intimate violence; and — experiences of dating violence		
Ahrens CE et al. (2000)	2 Sexual Assault Nurse Examiner (SANE) programmes	United States	• Several components were identified to be critical to the successful development of SANE programmes: — strong organizational history and foundation; — development in conjunction with community task forces or councils; — close collaboration with other community agencies; and — strategies for resolving differences	• Examination of the development of a larger number of SANE programmes and inclusion of a greater variety of initiating agencies to determine if the themes detected in the current study are applicable to alternative settings and if additional factors play a role in the development of SANE programmes • Inclusion of all relevant stakeholders in interviewing processes in the evaluation of SANE programmes	
Amoakohene M (2004)	50 married working women with at least secondary school education or its equivalent, with 56% possessing university qualifications	Accra and Kumasi, Ghana	• Respondents showed much greater concern for the psychological and emotional consequences of domestic violence than for any pain or injury that might result • The issue of sexual violence provoked a rather hostile reaction from respondents • Respondents did not consider sexual relations with their husbands an area that should be discussed with a "stranger". • Sexual offences such as harassment and rape within marriage are concepts unknown to Ghanaian traditions and cultures • There are a number of nongovernmental organizations and civil society organizations working in the area of violence against women, but direct support for abused women in the form of shelter is still largely inadequate, uncoordinated and informal • Irrespective of education, employment status and their socio-economic and professional positions, women in Ghana suffer violence		• Non-representative sample

* abstract only

AUTHOR(S) (YEAR)	STUDY POPULATION/ SAMPLE SIZE	SETTING(S)	RELEVANT KEY FINDINGS	FUTURE RESEARCH IDENTIFIED BY AUTHOR(S)	LIMITATIONS IDENTIFIED BY AUTHOR(S)
Anderson I (2004)	80 undergraduate psychology students 40 men, 40 women Aged 19 to 33 years (mean age of 20 years)	United Kingdom	• Men exhibited greater degrees of homophobia than women • Men's homophobic attitudes were significantly correlated with negative perceptions of male rape victims • A lack of significant differences was noted in perceptions of victims	• Further investigation of perceptions towards rape victims to ascertain whether they reflect a real phenomenon or an artefact of the present study's experimental methodology and design • The element of social desirability needs to be taken into account when executing rape perception research	• Lack of control • Inconsistent terminology used when describing the rape scenarios
Anderson I & Swainson V (2001)	120 undergraduate students 60 men, 60 women Aged 18 to 30 years (mean age of 20 years)	Birmingham University, England	• Respondents regarded rape, including male rape, to be motivated by the need for sex rather than by power • Men endorsed the view that rape is motivated by both sex and power to a greater extent than women	• Research to establish the veracity of these findings	• Unintended effects of chosen vignette
Arata CM (2000)	221 female undergraduate students Aged 17 to 47 years (mean age of 22.4 years)	United States	• Repeated victimization was associated with having experienced child sexual abuse involving physical contact, including intercourse and/or penetration • Women who experienced repeated victimization engaged in more self-blame, reported higher levels of post-traumatic symptoms, and reported more high-risk sexual behaviour	• Research on mediators leading to revictimization • Research on the development of interventions to prevent sexual revictimization	• Retrospective reporting • Convenience sample • Limited generalizability
Arata CM (1999a)	119 female undergraduate students Aged 17 to 47 years (mean age 23 years)	United States	• Rape victims with a history of child sexual abuse were found to have more trauma symptoms, to make greater use of nervous and cognitive coping strategies, and were more likely to blame themselves or society • The results suggest the importance of attributional and coping variables, as well as history of childhood sexual abuse, as mediators of postrape adjustment	• Investigation of the degree to which victims blame themselves and the variables that influence these attributions	• Retrospective reporting • Nonclinical convenience sample
Arata CM & Burkhart BR (1998)	299 female undergraduate students, all victims of sexual assault by nonstrangers Aged 17 to 34 years (mean age 19 years)	United States	• Attributions of blame and coping variable were each found to affect current functioning and to be affected to some degree by the level of victimization • Women who were currently symptomatic were significantly more likely to engage in characterological self-blame and were more likely to use coping strategies such as emotional expressiveness/social support-seeking and coping activity/ cognitive restructuring • Victims of rape were somewhat more likely to blame themselves than were victims of noncoital sexual assaults • Levels of distress were positively correlated with greater use of several coping strategies	• Prospective research on the effects of sexual assault, as only a prospective design could determine whether the victims had ever had clinically significant symptoms and, if so, what processes they had used in coming to some resolution • Further research to explore effects of coping and attributions on specific symptoms and/or mental disorders, such as depression and anxiety	• Retrospective reporting • Time elapsed between the assault and time of data collection

AUTHOR(S) (YEAR)	STUDY POPULATION/ SAMPLE SIZE	SETTING(S)	RELEVANT KEY FINDINGS	FUTURE RESEARCH IDENTIFIED BY AUTHOR(S)	LIMITATIONS IDENTIFIED BY AUTHOR(S)
Arata CM & Burkhart BR (1995)	316 undergraduate students, all reported coercive sexual experiences Aged 17 to 34 years (mean age of 19.3 years)	University of South Alabama, United States	• Victims of sexual assault by acquaintances displayed significant levels of symptoms of post-traumatic stress syndrome (PTSD) • Attributions of blame were significantly associated with PTSD symptoms – women who blamed themselves for the assault tended to report higher levels of PTSD symptomatology • PTSD symptoms were associated more by cognitive attributions than by features of the assault • Assault-related situational variables had very little effect on post-rape symptomatology – the level of victimization was not associated with whether an individual experienced PTSD-like symptoms • The events do not, by themselves, predict degree of distress, but rather the cognitive appraisals of the victim mediate the degree of emotional distress	• Research to understand the nature and origin of cognitive appraisals, as well as victims' responsiveness to treatment	• The measure of PTSD symptoms used (the CR-PTSD scale) is not sufficient to diagnose PTSD – the study only suggested possible correlates of PTSD symptoms and not the actual diagnostic category • Failure to obtain more data on life history and personality
Arnow BA et al. (1999)	206 women recruited from a health maintenance organization primary care clinic waiting area Aged 20 to 63 years	United States	• Psychological distress is associated with higher utilization of outpatient services		• Retrospective reporting (accurate reports of the incidences are limited by such factors as inaccurate recall, stigmatization, and repression, which could lead to false results, causality cannot be established) • Biased sample
Atkeson BM et al. (1982)	115 female rape victims Aged 15 to 71 years (mean age of 25.6 years)	Rape crisis centre, Atlanta, Georgia, United States	• Victims of rape exhibited depressive symptoms following the traumatic event of the assault, and these symptoms were significantly greater than those exhibited by nonvictims • The average duration of victims' depressive symptoms is similar to that of outpatient reactive depressions • The level of trauma experienced in a rape situation is not predictive of continued problems with depressive symptoms. Instead, the extent of the victim's immediate problems following the assault and the response of friends and family to the victim are important • Twelve months postrape, the demographic variables of age and socioeconomic status are predictive of depressive symptoms, with older and poorer women experiencing more problems • Women with psychological problems prior to the rape, and in particular problems with anxiety, obsessive–compulsive behaviours, and depression, are more likely to experience a slower recovery from depressive symptoms • Problems with sexual relationships and poor physical health prior to the rape may adversely affect the duration and severity of depressive symptoms		• Potentially biased sample
Austin RL & Kim YS (2000)	Crime data of rates of murder and rape for 1991 and 1992 from the International Criminal Police Organization	Cross-national (89 countries)	• There is no evidence that gender equality is negatively associated with rape – when an indicator of gender equality is significantly associated with rape, the incidence of rape increases as women and men move toward equality		

AUTHOR(S) (YEAR)	STUDY POPULATION/ SAMPLE SIZE	SETTING(S)	RELEVANT KEY FINDINGS	FUTURE RESEARCH IDENTIFIED BY AUTHOR(S)	LIMITATIONS IDENTIFIED BY AUTHOR(S)
Baker CK et al. (2005)	2509 adults 907 men, 1602 women Aged 16 to 92 years (mean age of 39.3 year)	Oaxaca, Guadalajara, Hermosillo, Mérida, Mexico	• Almost all forms of violence were associated with a moderate-to-high probability of PTSD, but victims of sexual and domestic violence may be particularly vulnerable to developing symptoms associated with PTSD • Women had a higher probability of meeting DSM-IV criteria for lifetime violence-related PTSD than men		• Under-representation of men in the study • Retrospective reporting • Small sample sizes • Complex sampling design
Banyard VL, Williams LM & Siegel JA (2001)	174 women 87 with documented histories of sexual abuse during childhood and 87 without (mean age of 31.55 years)	United States	• Adult sexual assault was associated with high levels of mental health symptoms	• Examine trauma exposure more broadly to understand: — the chain reactions of risk that may be set in motion across the lifecycle by childhood events including ways that childhood traumas co-occur; — factors that contribute to resilience and recovery; — interventions that may work to stop or interrupt such a chain; — how particular traumas, risk, and protective factors interact with both individual and family development beyond childhood • Examine the relationships between different components of trauma exposure and outcomes specifically to improve understanding of both the unique effects of various traumas as well as their interconnections • Assess exposure to traumas at different points in the lifecycle and their subsequent impact • Study on the factors that contribute to recovery	• Retrospective reporting • Unique sample- findings cannot be generalized • Small sample size
Becker JV et al. (1986)*	471 women aged 18 years and over 372 sexual assault survivors and 99 women with no history of sexual assault	United States	• 71% of women survivors of sexual assault reported that their sexual assaults were related to their development of sexual problems; only 17.2% of nonvictims reported experiencing any sexual problems		
Becker JV et al. (1982)*	83 victims of rape/ incestuous assault (mean age of 29.5 years)	United States	• 56% experienced sexual dysfunctions postassault • 71% reported that the sexual assault precipitated the dysfunction • Fear of sex and arousal or desire dysfunction were the most common sexual problems found		
Becker JV et al. (1984)*	371 female survivors of sexual assault Aged 18 to 67 years	United States	• Most prevalent problems were fear of sex, arousal dysfunction, and sexual desire dysfunction • Almost 60% of the sample who reported assault-related sexual problems had been assaulted more than 3 years prior to their evaluation • Suggested that treatment of sexual-assault survivors should address the sexual aspects of the assault and that the therapist should be aware of and anticipate the possibility of chronic problems in a survivor's sexual life		

* abstract only

AUTHOR(S) (YEAR)	STUDY POPULATION/ SAMPLE SIZE	SETTING(S)	RELEVANT KEY FINDINGS	FUTURE RESEARCH IDENTIFIED BY AUTHOR(S)	LIMITATIONS IDENTIFIED BY AUTHOR(S)
Beckham JC et al. (1997)	129 Viet Nam combat veterans with PTSD recruited at an outpatient PTSD clinic (mean age of 48 years)	United States	• 80% reported chronic pain • Compared to PTSD combat veterans without chronic pain, PTSD veterans who reported chronic pain reported significantly higher somatization • Increased PTSD re-experiencing symptoms were related to increased pain level, pain disability, and overall pain index		• Correlational study design, therefore does not establish causality • Lack of physical examination
Bifulco A, Brown GW & Adler Z (1991)*	286 working-class mothers Aged 18 to 50 years	England	• Sexual abuse was related to other earlier stressful experiences such as parental indifference, violence to the child, and institutional stay, and was associated with an increased risk of depression over and above these factors		
Bletzer KV & Koss MP (2006)	62 female rape survivors 25 Native Americans, 13 Mexican Americans and 24 Anglo women (mean age of approximately 35 years across three groups)	Southern Arizona and western Oklahoma, United States	• There are variations across the three populations for narrative conventions and linguistic devices that women of distinctive backgrounds utilized to talk about their experiences, which pointed to a need to consider differences when planning, designing and assessing programmatic initiatives that provide counselling for women of different populations		
Bletzer KV & Koss MP (2004)	62 female rape survivors 25 Native Americans, 13 Mexican Americans and 24 Anglo women (mean age of approximately 35 years across three groups)	Southern Arizona and western Oklahoma, United States	• Despite variations in how Cheyenne, Mexican and Anglo women chose to report rape, nearly all the women framed and staged their account(s) as a narrative – the incident each experienced was sufficiently significant to elevate its telling to story status • Description of physical contact varied for the three populations • These women generally emphasized scripts of coercion, with little recourse to scripts of consent • Exceptions to structured narratives appeared among women in strained and abusive relationships, where routine abuse simulated the terror of social erasure, inhibiting a woman's capacity to produce a coherent meaningful narrative		
Bohner G (2001)	67 university students 38 male, 29 female (median age 23 years)	University, Germany	• Participants used the passive voice more frequently, in both absolute and relative terms, when they described the perpetrator's actions during the rape itself, as opposed to any of the perpetrator's other actions or the victim's actions • The use of the passive voice was independent of sex of participant • Participants who used more passive constructions perceived the incident as less severe and ascribed more responsibility to the victim • Individuals who were generally more accepting of rape myths used more passive forms to describe the actions of a rapist during the rape than did individuals who rejected rape myths	• Identification of the linguistic categories that could be instrumentalized in the assessment of attribution of responsibility • Further studies on the perception of sexual violence might address additional text features that have been shown to correlate with causal attributions so as to further explore non-reactive alternatives to direct judgements	
Bolstad BR & Zinbarg, RE (1997)	117 female undergraduate students Aged 17 years or older	University of Oregon, United States	• Diminished generalized perception of control is associated with greater severity of PTSD symptoms following adult sexual victimization when experienced on a single occasion or involving force • Adult sexual victimization experienced on multiple occasions is related to greater severity of PTSD symptoms when compared to adult sexual victimization experienced on one occasion • Adult sexual victimization involving force resulted in greater severity of PTSD symptoms when compared to adult sexual victimization not involving force	• Research to determine if the relationship between externality and PTSD symptoms generalizes to other symptom clusters such as depression • Assess the direct and indirect relations between locus of control and PTSD following sexual victimization by including measures of coping strategy, threat appraisal, and other potential mediating variables	• Small sample size • Retrospective • Cross-sectional design • Narrow focus on PTSD symptoms to the exclusion of other possible emotional sequelae of trauma

* abstract only

AUTHOR(S) (YEAR)	STUDY POPULATION/ SAMPLE SIZE	SETTING(S)	RELEVANT KEY FINDINGS	FUTURE RESEARCH IDENTIFIED BY AUTHOR(S)	LIMITATIONS IDENTIFIED BY AUTHOR(S)
Bondurant B (2001)	109 female undergraduate students, all rape victims Aged 18 to 25 years	Medium-sized south-eastern university, United States	• The majority (64%) of the women did not acknowledge their rape experiences • A combination of a belief in specific elements of blitz rape scripts and relatively nonviolent sexual assault experiences appear to be the most important factors hindering women from acknowledging rape • Perceived violence of a rape (indicated by physical harm experienced, and verbal and physical resistance) was the best predictor of acknowledgement – women who perceived their rapes as more violent were more likely to acknowledge the rapes • Acknowledged rape victims exhibited both more behavioural and characterological self-blame after controlling for the amount of violence in the rapes • Behavioural self-blame was a stronger predictor of acknowledgment than characterological self-blame		• Convenience sample, primarily white and middle-class women between the ages of 18 and 25 years • Correlational nature of study
Botta RA, Pingree S (1997)	123 women undergraduate students Aged 17 to 23 years (mean age 19 years)	Large midwestern university, United States	• Interpersonal communication about acquaintance rape such as gaining information about acquaintance rape from friends and knowing someone who has been a victim of acquaintance rape, significantly predicted acknowledging rape above and beyond situational and demographic variables		• Convenience sample, primarily white, middle-class college freshmen and sophomores
Bowling SW (2002)*	37 females who consented to treatment for sexual victimization	Rape crisis centre, San Antonio, Texas, United States	• Clients who participated in relational therapy were significantly more likely to have decreases in symptoms of depression • The participants in relational therapy showed similar decreases in PTSD symptoms to those of participants in the individual treatment group • Family therapy approaches are as successful as individually based treatment approaches in the treatment of post-traumatic symptoms and more helpful in treating the symptoms of depression among a population of female survivors		
Bownes IT, O'Gorman EC & Sayers A (1991)*	51 female rape victims Aged 16 to 47 years	Northern Ireland	• PTSD is likely to be a long-term problem for rape victims • The incidence of rape by strangers, of use of physical force, of weapons being displayed, and of injuries sustained by the victim were all higher in survivors who had PTSD		
Bownes IT, O'Gorman EC & Sayers A (1991)*	51 female rape victims Aged 10 to 47 years	Northern Ireland	• The incidence of depression, anxiety, emotional liability, restlessness, irritability, and guilt were higher in the PTSD group • The incidence of rape by strangers, of use of physical force, of weapons being displayed, and of injuries sustained by the victim were all higher in survivors who had PTSD		
Breitenbecher KH & Gidycz CA (1998)	406 women undergraduate students	Large midwestern university, United States	• A prevention programme designed to target women with histories of sexual assault was found to be ineffective in reducing the incidence of sexual assault among participants • The prevention programme was also ineffective in altering dating behaviours, sexual communication or awareness about sexual assault among participants • The ineffectiveness of the programme was unrelated to participants' histories of sexual assault • Consistent with previous research indicating that one-shot interventions are not effective in producing lasting behavioural change	• Prospective research to investigate the mechanisms of revictimization	• Results are generalizable only to women in the college population • Focus on women's behaviour, neglecting acts of sexual aggression by men

* abstract only

AUTHOR(S) (YEAR)	STUDY POPULATION/ SAMPLE SIZE	SETTING(S)	RELEVANT KEY FINDINGS	FUTURE RESEARCH IDENTIFIED BY AUTHOR(S)	LIMITATIONS IDENTIFIED BY AUTHOR(S)
Bremner JD et al. (1996)	61 Viet Nam combat veterans with PTSD (mean age of 45.5 years) 92% white, 5% black, 3% Hispanic	West Haven Veterans Administration Medical Center, West Haven, Connecticut, United States	• Onset of PTSD symptoms typically occurred at the time of exposure to combat trauma in Viet Nam and increased rapidly during the first few years after the war • Symptoms plateaued within a few years after the war, following which the disorder became chronic and unremitting • Hyperarousal symptoms developed first, followed by avoidant symptoms, and finally by symptoms from the intrusive cluster • The onset of alcohol and substance abuse was associated with the onset of PTSD symptoms, and the increase in use paralleled the increase of symptoms • Specific substances have specific effects on PTSD symptoms		
Breslau N et al. (1999)	2181 individuals Aged 18 to 45 years	Detroit area, Michigan, United States	• Compared with previous exposure to trauma that did not involve assaultive violence, previous exposure to trauma involving assaultive violence was associated with a higher risk of PTSD from subsequent trauma • The effect of previous assaultive violence on the risk of PTSD from subsequent trauma persisted over time with little change • Compared with no history of previous exposure to trauma, a history of two or more traumatic events involving assaultive violence in childhood was associated with a nearly fivefold greater risk that a traumatic event in adulthood would lead to PTSD • Even a single previous event involving assaultive violence, either in childhood or later on, was associated with a higher risk of PTSD from trauma in childhood • There was no evidence that the subject's age at the index trauma influenced the risk of PTSD		
Breslau N et al. (1991)*	1007 members of a health maintenance organization Aged 21 to 30 years (median age of 26 years)	Detroit, Michigan, United States	• PTSD was not randomly distributed in the population; some people were at higher risk than others		
Breslau N et al. (1997)*	1007 members of a health maintenance organization Aged 21 to 30 years (median age of 26 years)	Detroit, Michigan, United States	• There were no sex differences in lifetime prevalence of exposure to traumatic events or in number of traumatic events • Sex differences in PTSD could be partially explained by preexisting anxiety disorder or major depressive disorders, but were unrelated to family history or early separation from parents		
Breslau N et al. (1998)	2181 individuals Aged 18 to 45 years	Detroit area, Michigan, United States	• Sex comparisons of exposure to specific traumas within the assaultive violence class showed that women were more likely than men to report rape (9.4% versus 1.1%) and other sexual assault (9.4% versus 2.8%) • Assaultive violence had the highest risk of PTSD (20.9%) • Women were at higher risk of PTSD than men, controlling for type of trauma • In most cases (74%), PTSD persisted for more than 6 months; the duration of PTSD was longer in women than in men	• Further research on combat, rape, and sexual or physical assault as causes of PTSD • Continued investigation of vulnerability factors to understand why some of those who experience trauma develop PTSD	

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Bryant RA et al. (1999)	45 survivors of motor vehicle accidents or industrial accidents with acute stress disorder	PTSD Unit, Westmead Hospital, Sydney, New South Wales, Australia	• Chronic PTSD in the supportive counselling condition was characterized by greater avoidance behaviours than in the prolonged exposure alone or plus anxiety management conditions • Findings suggest that PTSD can be effectively prevented with early provision of cognitive behaviour therapy and that prolonged exposure may be the most critical component in the treatment of acute stress disorder	• Comparison of the efficacy of prolonged exposure and prolonged exposure combined with cognitive therapy	• The diagnosis of acute stress disorder is a recent development, and its validity has yet to be firmly established • The study's use of combined prolonged exposure and cognitive therapy did not permit delineation of the relative effects of imaginal exposure and cognitive therapy • Modest sample size • The sample only included survivors of motor vehicle accidents and industrial accidents, thus, results cannot be generalized to the general population • Comorbidity issues were not indexed
Bryant RA et al. (1998)	24 survivors of motor vehicle accidents or industrial accidents with acute stress disorder 10 men, 14 women (mean age approximately 33 years)	PTSD Unit, Westmead Hospital, Sydney, New South Wales, Australia	• Fewer participants receiving cognitive behavioural therapy (CBT) than receiving supportive counselling (SC) met criteria for PTSD post-treatment • There were greater statistically and clinically significant reductions in intrusive, avoidance, and depressive symptomatology among the CBT participants than among the SC participants • The relative ineffectiveness of SC suggests that early intervention that attempts to provide support and problem-solving advice will not substantially reduce PTSD • Findings suggest that immediate treatment effects may not be long-lasting	• Comparison of the efficacies of different components of CBT in treating acute stress disorder • Future treatment studies of acute stress disorder should index the role of post-trauma stressors on relapse following treatment • Address the finding that CBT did not reduce anxiety more than SC did • Index the effect of brief interventions on coexisting disorders such as major depression and substance abuse	• Small sample size • The sample only included survivors of motor vehicle accidents and industrial accidents, thus, results cannot be generalized to the general population • Study procedure did not include interrater reliability checks of the acute stress disorder diagnosis • Comorbidity issues were not indexed
Burgess AW & Holmstrom LL (1979)*	81 adult rape victims	Boston, Massachusetts, United States	• Victims recovering fastest used more adaptive strategies such as positive self-assessment; defence mechanisms of explanation, minimization, suppression, and dramatization; and increased action • Victims who had not yet recovered at the follow-up interview used more maladaptive mechanisms, such as negative self-assessments, inaction, substance abuse, and acting on suicidal thoughts		
Burgess AW & Holmstrom LL (1979)*	81 adult rape victims	Boston, Massachusetts, United States	• Most victims who had been sexually active were found to experience changes in frequency of sexual activity and in sexual response		

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Burnam MA et al. (1988)	3132 household adults 40% Mexican Americans, 6% Hispanics of other cultural origins, 42% non-Hispanic whites, 13% persons of other ethnic and racial backgrounds	Los Angeles, California, United States	• The study suggests that the experience of being sexually assaulted is associated with increased risk for later onset of major depression, substance use disorders, and three anxiety disorders (phobia, panic disorder and obsessive–compulsive disorder) • There was no significant relation between sexual assault and later onset of manic episodes or schizophrenic disorders • No increased risk for developing antisocial personality as a result of an earlier experience of sexual assault • Although women are at greater risk of becoming victims of sexual assault, the impact of assault on mental health status does not differ considerably between the sexes • Victims assaulted in childhood were more likely than those first assaulted as adults to report later onset of major depression, drug abuse or dependence, alcohol abuse or dependence, and phobias • Major depression, substance abuse or dependence, antisocial personality, and phobia are associated with higher probability of reporting later sexual assault	• Prospective studies to illuminate the causal relations between sexual assault and disorder	• The study failed to cover some disorders that would be expected on the basis of prior literature to be associated with sexual assault, particularly sexual dysfunctions • Retrospective data
Burt MA & Katz BL (1988)*	113 adult women rape victims	Washington-Baltimore area, United States	• Of the five coping techniques (avoidance, expressive, nervous/ anxious, cognitive, and self-destructive) derived, only the use of expressive coping strategies increased among victims at follow-up interviews, while use of all other strategies decreased		
Burt MA & Katz BL (1987)	113 adult women rape victims 81% white, 17% black, 1% Asian, 1% Hispanic	Washington-Baltimore area, United States	• No significant associations were found between most measures of recovery and the length of time since the rape		
Butterworth P (2004)	*National representative sample* 2232 women with children	Australian National Survey of Mental Health, Australia	• Lone mothers were more likely to have psychiatric disorders and to have experienced physical and sexual violence than partnered mothers • The measures of physical and sexual violence were better predictors of psychiatric disorders than either lone parent status or the sociodemographic measures	• Further analysis is needed to explore the co-occurrence and interrelationships between characteristics and experiences • Longitudinal or prospective studies to determine causal relationships between trauma and psychiatric disorders	
Campbell JC & Soeken KL (1999)	159 battered women (mean age 31.6 years) 76.6% African Americans, 6.1% white, 0.6% Mexican American, 0.6% Asian American, 0.6% Arab American, 5.5% other or mixed	Baltimore, Maryland, United States	• Those who were sexually assaulted had higher scores on negative health symptoms, gynaecological symptoms, and risk factors for homicide even after controlling for physical abuse and demographic variables • The number of sexual assaults (childhood, rape, and intimate partner) was significantly correlated with depression and body image		• PTSD was not measured as a mental health consequence related to forced sex • Nonrepresentative volunteer nature of the sample • Relatively small sample size • Incomplete mental health measurement • Lack of data on previous experiences of rape for part of the sample • Relatively few specific gynaecological questions

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Campbell R (1998)	168 rape victim advocates Aged 22 to 65 years (mean age 37.25 years) 88% white, 5% African American, 4% Latina, 2% Native American Indian, 1% Asian American, 1% Arabic American	United States	• The findings suggest that for rape victims to receive desired services, their cases may need to fit a rather constricted mould – when certain characteristics of the victim, the assault, and the community are in careful alignment, the likelihood of an outcome that is consistent with victims' needs is most probable • As these factors start to deviate from this narrow path, the number of services may decrease, the fit with victims' wishes may be compromised, and the advocacy needed to bring about beneficial outcomes may rise. • The legal system may be the least flexible of such deviations – cases that do not conform to the mould were often filtered out of the system • The medical system often responded in a manner consistent with victims' needs • Many women received the short-term help they desired, but longer term help was not as readily available, resulting in relatively negative experiences for women in two of three of the clusters		• Collection of data from rape victim advocates raises issues of the reliability and validity of these reports • The study did not include a comparison group of victims who did not work with advocates
Campbell R & Ahrens CE (1998)	44 communities: 22 with coordinated community-based programmes to assist rape victims, 22 with fewer coordinated programmes	United States	• High coordination communities had three types of programmes to address sexual assault: coordinated service programmes, interagency training programmes, and community-level reform groups • The explanatory model developed proposes that three factors explain why coordinated community programmes are beneficial to rape survivors: — these programmes reflect an understanding of the context of social service delivery from the perspective of the providers; — the perspective of the victim was reflected in this new system of care; — the programmes take into consideration the larger social context of rape		• Complete validity data were not collected from all stakeholders in all communities • Few of those sampled were rape victims • Not all of the service providers were involved in the analysis of data and the building of the explanatory model
Campbell R et al. (2001)*	102 rape survivors (mean age 34.29 years)	United States	• The overall contribution of positive social reaction to victims' recovery is negligible, but negative social reactions hindered recovery • 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 emotional and physical health problems than victims who considered these reactions hurtful, or victims who did not experience these reactions at all		
Campbell R & Raja S (1999)*	415 mental health professionals Aged 26 to 75 years	State of Illinois, United States	• Most of those sampled believed that some community professionals engage in harmful behaviousr that are detrimental to the psychological well-being of rape survivors		

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Campbell R, Raja S & Grining PL (1999)	415 licensed mental health professionals Aged 26 to 88 years (mean age 46.17 years) 75% female, 25% male 93% white	State of Illinois, United States	• Although many of those sampled were trained with regard to at least one form of violence against women, 14% had received no training on any issue • Training on violence against women was related to contact and experience with victims of violence • Mental health professionals who were women and people of colour were more likely to have received training on sexual assault, domestic violence, and child sexual abuse/incest • Mental health professionals who endorsed a feminist orientation were more likely to be trained on sexual assault, domestic violence and child sexual abuse/incest		
Campbell R et al. (1999)	102 female rape survivors Aged 18 to 52 years (mean age 34.29 years) 51% African American, 37% white, 6% Latina, 5% multiracial, 1% Asian American	Detroit area, Illinois, United States	• Although none of the women interviewed felt that their experience with community systems was worse than the rape itself, many discussed how negative encounters compounded the effects of the assault • Of the 40% who had contact with the legal and/or medical systems, most received only minimal services from these agencies • Very few cases in the legal system went beyond the stage of filing a police report; the detectives and prosecutors did not pursue these cases, even though the rape victims wanted to press charges • In the medical system, rape survivors received more services than in the legal system but were still infrequently advised about testing for sexually transmitted diseases and for pregnancy, or methods of preventing pregnancy. • Of the women who had contact with the mental health system, most were able to obtain either short- or long-term counselling • No direct relationship between services received and post-traumatic symptom outcomes was substantiated • Significant main effects were found for the relationship between legal secondary victimization and post-traumatic symptoms • Significant main effects were found for the relationship between medical secondary victimization and post-traumatic symptoms • The actions of community system personnel can affect rape survivors' outcomes; experiences of doubt and blame were associated with increased psychological distress • The type of rape significantly affects how community contact impacts well-being: nonstranger rape victims who received minimal help from their communities and had negative experiences with system personnel		• Sample may not be representative due to sampling design • Retrospective reporting • Relatively small sample size • Self-report data • Considerable variability in the sample as to time elapsed since sample as to time elapsed since the assault
Campbell R et al. (2001)	102 female survivors of rape Aged 18 to 52 years (mean age 34.29 years) 51% African American, 37% white, 6% Latina, 5% multiracial, 1% Asian American	Detroit area, Illinois, United States	• The majority of women who reported their assault to the legal or medical system did not received the services they needed • Difficulties with service delivery were associated with both perceived and objective measures of negative health outcomes • Contacts with the mental health system, rape crisis centres, or religious communities were generally perceived by victims as beneficial • Women from ethnic minorities and victims of non-stranger rape are at particular risk of experiencing difficulties when trying to obtain needed services		

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Campbell R (2006)	81 female rape survivors (mean age of 26.12 years) 52% African Americans, 37% white, 8% Latina, 3% multiracial	Hospitals in a major metropolitan city, United States	• Rape survivors who worked with advocates reported receiving more services from the legal and medical systems • Survivors who had the assistance of an advocate were significantly more likely to have police reports taken and were less likely to be treated negatively by police officers • Survivors who worked with an advocate during their emergency department care received more medical services, including emergency contraception and prophylaxis against sexually transmitted diseases, reported significantly fewer negative interpersonal interactions with medical system personnel, and reported less distress from their experience with medical contacts	• Evaluation studies on the effectiveness of rape victims' advocates	• As random assignment was not possible, a quasi-experimental design was used • Given the scope of the study, no follow-up assessments were conducted • Specific actions taken by the advocates were not identified
Cann A, Calhoun LG & Selby JW (1979)*	128 undergraduate students	North Carolina, United States	• Respondents perceived the victim who refused to discuss her sexual experience as sexually active and as more responsible for the rape than in other circumstances (the judge refused to allow testimony, or no mention was made of sexual experience) • When the judge prohibited testimony, the victim was held less responsible for the rape than the sexually inactive and no-information victims		
Carmody M (2005)	25 individuals of diverse sexualities 5 men, 20 women Aged 21 to 58 years (mean age 51 years for men, 35 years for women) Predominantly Anglo-Australian	Australia	• About 20% of the sample had experienced unwanted sexual practices, but were able to develop pleasurable sexual intimacy with others later on, in which self-care was crucial to their pleasure • This review of anti-rape education strategies suggests a current failure to address the kinds of information and skills that especially young people need to negotiate pleasurable ethical sexual intimacy • Many programmes are reinforcing heteronormativity and are limited to attempts to "police" unethical behaviour and continue to place the primary responsibility for this on women		
Cascardi M et al. (1996)	107 women rape victims (mean age 29.76 years)	United States	• Assaults in safe environments led to more severe post-trauma symptoms and greater number of lifestyle changes than do assaults in dangerous environments • Assaults by dangerous assailants, rather than those by safe assailants, led to more severe overall symptoms • Assaults occurring in a safe situation by a dangerous assailant led to more severe PTSD symptoms than assaults in dangerous situations by a safe assailant • Women assaulted in a safe location by a dangerous assailant reported the greatest number of lifestyle changes following the rape – most changes are made in an attempt to increase security or personal safety • Brutality of assault and violation of safety expectations may represent two distinct aspects of assault, both influencing the severity of post-trauma reactions	• Comparison of a victim's post-assault perception with objective ratings • Investigations including both subjective perceptions of safety and women assaulted by the safest assailants	• The sample did not include women assaulted by individuals who would be considered the most safe, for example, spouses or boyfriends • African American women were overrepresented compared to the general population • All women were self-identified rape victims who sought medical and/or legal assistance

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Castro R, Peek-Asa C & Ruiz A (2003)	914 pregnant women (mean age of 25 years)	Prenatal health clinics, Morelos, Mexico	• For all women, and especially women who experience violence during pregnancy, emotional abuse increased over the course of pregnancy, whereas physical and sexual violence generally decreased	• Population-based studies to corroborate and refine the findings reported here • Investigation of violence during postpartum period • Develop innovative methods to examine the dynamics of the family and the generational potential for violence, with a focus on the men who commit violence	• Self-reported information about violence – potential recall bias • Cluster analysis was omitted
Chandra PS et al. (2003)	146 female psychiatric patients Aged 18 to 58 years (mean age 30 years)	Southern India	• Sexual coercion was reported by 34% of women interviewed • Women presenting to psychiatric hospitals with acute psychological distress or disorder frequently have a history of one or more types of interpersonal victimization • Women revealed a sense of helplessness, fear, and secrecy related to their experiences of sexual victimization • The problem of sexual coercion is seldom addressed in mental health care in India • 60% of respondents reported not having disclosed their experience of sexual abuse to anyone and had not sought any help. The reasons for non-disclosure included fear of, or threat from, the perpetrator, resignation based on the belief that abuse is common and happens to all women, and fear of being blamed for the incident instead of finding sympathy and understanding	• Research using matched control groups and longitudinal designs to investigate the temporal relationship between mental illness and coercive experiences, particularly related to severity of symptoms or acute exacerbation • Investigation of the relationship of psycho-pathology among women with severe mental illness to either childhood or adult coercive experiences • Investigation of the factors related to help-seeking in the context of mental illness itself • Comparison of the context and pattern of sexually coercive experiences of the mentally ill with women in the general population to delineate factors that might increase the vulnerability of severely mentally ill women	• Absence of a matched control group • The exclusion of women who were too mentally ill to participate • Cross-sectional study
Chasteen AL (2001)	90 women	Ypsilanti township, Michigan, United States	• Women do not define rape in a uniform way, and they do not understand it in a homogeneous way • The varying life experiences and social positions of women influence their understandings of sexual assault	• Investigation of everyday constructions of sexual violence – how people define and interpret sexual assault, and the connections between large-scale changes and everyday assumptions	
Chilcoat HD & Breslau N (1998)	1007 adults Aged 21 to 30 years	South-east Michigan, United States	• Post-traumatic stress disorder signalled an increased risk of drug abuse or dependence on prescribed psychoactive drugs, but no significant increase in the risk for more commonly used drugs, such as marijuana and cocaine • Exposure to traumatic events in the absence of PTSD did not increase the risk of drug abuse or dependence • The risk for abuse or dependence was the highest for prescribed psychoactive drugs • There was no evidence that preexisting drug abuse or depen-dence increased the risk of subsequent exposure to traumatic events or the risk of PTSD after traumatic exposure		• Restricted age rage of the sample • Underrepresentation of the extreme ends of the socioeconomic distribution
Choquet M et al. (1997)	8140 students, grades 8–12 48.7% boys, 51.3% girls (mean age 16.2 years)	Public secondary school, France	• Rape victims, especially boys, have more behavioural problems than nonvictims – they ran away more often, had suicidal thoughts, attempted suicide and behaved violently • For both boys and girls, there was a relationship between rape and current sleep difficulties, depressive symptoms, somatic complaints and tobacco consumption • The majority of victims hac not consulted a mental health professional or a social worker		• Sample only included individuals enrolled in schools

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Christofides NJ et al. (2005)	124 health care providers in 31 hospitals 64.5% women 50.8% doctors	South Africa	• 32.6% of health workers in hospitals did not consider rape to be a serious medical condition • A total of 30.3% of providers had received training in caring for rape survivors • 76.9% of regional hospitals had a private examination room designated for use in caring for rape survivors • Better quality of care was associated with practitioners being older than 40 years, having cared for a higher number of rape survivors before, working in a facility that had a clinical management protocol for caring for rape survivors, having worked for less time in the facility and perceiving rape to be a serious medical problem		• Staff were not randomly selected for interview within facilities • Information on training could have been subject to recall bias • Self-reported data
Clum GA & Calhoun KS, Kimerling R (2000)*	57 sexually assaulted female undergraduate students	United States	• Symptoms of PTSD and depression were significantly associated with global health perceptions and severity of self-reported health symptoms • Only PTSD symptoms were significantly associated with reproductive health symptoms		
Cohen L & Roth S (1987)*	72 women victims of rape who had been raped an average of 8 years prior to the study	United States	• Rape continued to be a serious trauma for the women, resulting in fairly high levels of symptoms across a wide range of problem areas • Individual differences in severity of symptoms were related to age, socioeconomic status, time since rape, force used during the rape, and prior history of sexual assault • Current levels of functioning were related to whether rapes were reported to the police and the amount of time that had passed before the women confided in another person • Both approach and avoidance coping strategies were negatively related to recovery		
Coker AL et al. (2000)	556 individuals 243 males, 313 females Aged 18 to 64 years	South Carolina, United States	• Women were significantly more likely to report physical or sexual violence (17.8% of women versus 4.9% of men) • Women were significantly more likely than men to report forced sex both within and outside an intimate relationship • Most women (57.5%) did not seek professional services following experiences of interpersonal violence • Women who experienced more severe violence were significantly more likely to seek professional help from mental or physical health care providers or community-based agencies for victims of interpersonal violence • Higher level of education was the only demographic factor associated with increased likelihood of seeking professional services		• Low response rate • Self-reported data • Since the study used a telephone-based survey, those without telephones were not included in the sample • Relatively small sample size
Coker AL & Richter DL (1998)*	144 women	Sierra Leone	• 50.7% of women reported ever having been forced to have sexual intercourse • 76.6% of women reported either forced sex or intimate-partner violence • Circumcised women were most likely to report intimate-partner violence and forced sexual intercourse		

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Coker AL et al. (2000)	1401 women Aged 18 to 65 years	University-associated family practice clinics, Columbia, South Carolina, United States	• 7.7% of the women currently involved in a relationship and 17.7% in their most recent relationship, experienced sexual violence • Sexual violence may be a marker of more severe violence and, perhaps, a marker of escalation of violence • More violence is reported for past than current relationships • 33.6% of women who had experienced physical and/or sexual violence had a disability preventing work, as compared with 15.5% of women who had not experienced violence	• Assessment of short- and long-term mental and physical health consequences of intimate-partner violence by type and timing, as well as the health care costs of such violence • Longitudinal studies to clarify the natural history of intimate-partner violence by type	• Findings cannot be generalized to non-clinical populations or to women in same-sex relationships
Culbertson KA & Dehle C (2001)	96 female undergraduate students/ sexual assault survivors Aged 18 to 51 years (mean age 25.27 years) 91% Caucasian	University, western United States	• Women who were acquainted with, married to or cohabiting with the perpetrator reported more hyperarousal symptoms than individuals who were dating or sexually intimate with the perpetrator • Individuals assaulted by a spouse or cohabiting partner reported more hyperarousal and intrusive symptoms than did other victim groups • Women sexually assaulted by an acquaintance reported more hyperarousal and intrusive symptomatology than did women assaulted by a date or a sexually intimate partner • Sexual assault by a spouse, cohabiting partner or an acquaintance had a more adverse impact on the victim than did sexual assault by a date or sexually intimate partner	• Replication of current study in a more demographically diverse sample • Determination of the influence the number of sexual assaults by a perpetrator has on ratings of impact of event • Examination of the correlation between relationship investment and type of perpetrator • Examination of the impact of current relationship status of victims and perpetrators on responses to study questionnaires	• Sample included only a small number of victims of assault by strangers • The sample consisted of primarily white female students, thus, generalizability of findings is limited • Potentially misleading wording of the questions assessing sexual assault • Poor response to a particular research question • No measure of physical violence by the perpetrator outside of the assault • No questions included to determine if the sexual assault victim was still in a relationship with the perpetrator
Darves-Bornoz JM (1997)	83 rape victims, 55 of whom were victims of recent rape Aged 13 to 50 years (mean age 20.3 years) 90% women 98% French	Centre for Victims of Sexual Abuse, University Hospital, Tours, France	• Rape leads to a high proportion of PTSD • In general, the psychopathology following rape is severe • PTSD at 6 months is associated with phobic and dissociative disorders, as well as a cluster of borderline personality disorder symptoms arising after rape which the authors called *borderline-like traumatic syndrome* • The intra-family nature of rape is the best predictor of chronic PTSD at 6 months		• Sample limited to victims involved in the legal process or who had sought help
Darves-Bornoz JM et al. (1998)	285 rape victims Aged 13 to 50 years (mean age 22.5 years) 92% women 70% with PTSD	Centre for Victims of Sexual Abuse, University Hospital, Tours, France	• Use of the General Health Questionnaire (GHQ-28) in screening for psychologically traumatized rape victims in order to refer them to psychotraumatology care specialists is methodologically appropriate		• Sample limited to victims involved in the legal process or who had sought help
Davidson JR et al. (1991)*	2985 individuals Aged 18 to 95 years	United States	• PTSD was associated with greater psychiatric comorbidity, attempted suicide, social phobia, obsessive–compulsive disorder, generalized anxiety, and major depression • Compared with acute cases, chronic PTSD was accompanied by more social phobia and somatization disorder, impairment of subjective social support, and greater likelihood of physical attack with regard to initiating trauma		

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Davidson JR et al. (1996)*	2918 individuals	United States	• There was a significant relationship between history of sexual assault and attempted suicide, even when other potential risk factors were controlled for • Women who reported a history of sexual assault that occurred before 16 years of age were at an increased risk of suicide attempt		
Davis CG, Nolen-Hoeksema S & Larson J	205 individuals 74% female (mean age 51.2 years)	Hospices, San Francisco Bay area, California, United States	• Those who were able to make sense of their loss of a loved one typically did so by seeing the death as predictable or as a natural condition of life or by suggesting that the death was comprehensible within the context of their religious or spiritual beliefs • Those who were able to find benefit in the experience tended to report that they had learned something important from it, about themselves, about others or about the meaning of life. • Whether or not the respondent was able to make sense of the event was consistently unrelated to whether he or she was able to find something positive in the experience • Higher levels of optimism were associated with the greater likelihood of finding something positive in the experience, which was predictive of lower levels of subsequent distress • Whereas making sense of the loss is important in the early phases of adjustment to a loss, perceiving benefit may be a more long-term process that unfolds over time, affecting adjustment	• Identification of the mechanisms by which construal of meaning influences adjustment	• The selective recruitment procedure resulted in a non-representative sample, which limits the generalizability of the findings • The reliance on single-item variables to assess making sense of and finding benefit in the experience
Davis RC, Brickman E & Baker T (1991)*	105 women victims of rape, attempted rape or aggravated sexual assault Aged 18 to 81 years	United States	• Unsupportive, but not supportive behaviour, was found to be significantly associated with victim adjustment • There was no indication that victims who received high levels of supportive behaviour from others adjusted better to rape than victims who received little support		
Deitz SR, Littman M & Bentley BJ (1984)*	190 undergraduate students 93 male, 97 female	United States	• In addition to significant sex differences in attributions of responsibility for the incident, respondents' pretrial empathy towards rape victims and rapists was predictive of their perception of the rape victim, the defendant and the rape incident • Victim resistance and attractiveness effects were significant in that subjects responded least favourably to the unattractive rape victims, particularly when the victim had resisted the rape by fighting with her attacker • Males and subjects who exhibited low empathy towards the rape victim were more responsive to subtle manipulations of victim resistance and attractiveness than were females and subjects who exhibited high empathy towards the rape victim		

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Dickinson LM et al. (1999)	252 women selected by somatization in primary care	3 family practice outpatient clinics, United States	• A history of sexual abuse is associated with substantial impairment in health-related quality of life and a greater number of somatized symptoms, medical problems, and psychiatric symptoms and diagnoses • A linear relationship exists between the severity of sexual abuse and impairment in health-related quality of life, both before and after controlling for the effects of a current psychiatric diagnosis	• Clarification and further study of the relationship between specific risk factors and long-term consequences of abuse, the mechanism through which the effects occur, an assessment of subthreshold psychiatric diagnoses, symptom patterns that span numerous diagnostic categories, and possible mediating factors • Repeating this study with different selection criteria with primary care or general medical patients to shed light on the overall spectrum of the effects of sexual abuse on health and illness behaviour	• Selection criteria potentially resulted in a non-representative sample • Retrospective reporting
Downey G, Silver RC & Wortman CB (1990)	*Wave 1* 228 parents who had lost an infant to sudden infant death syndrome 3 months post-loss: 163 parents 18 months post-loss: 124 parents	Cook County, Illinois and Wayne county, Michigan, United States	• There was no indication that attributions influence subsequent adjustment • Attributions to oneself or others appeared to be symptomatic of distress	• Determining whether the attributional process differs when the outcome of an event is uncertain • Identification of the factors that explain why a sizeable minority of parents were unconcerned with attributional issues and never became concerned with them • Clarification of the process through which some individuals can relinquish concern with understanding the past, and instead begin to invest energy in subsequent life tasks	• Due to the nature of Sudden Infant Death Syndrome, the results may only be generalizable to events that are serious, unexpected, and irrevocable and that have no known cause • The wording of the attribution questions may have limited the comparability of the results with those of other studies • Timing of the interviews may not have been optimal
Draucker CB (1999)	33 women survivors of sexual assault by male intimates Aged 19 to 62 years 24 White, 7 African American, 1 Asian American, 1 ethnicity unknown	United States	• Psychotherapeutic needs identified included: — to focus on feelings and problem solving while relying on subjects' own strengths and resources to make decisions; — making the treatment goal to live in a violence-free environment rather than to leave the battering relationships; and — exploring issues in depth • Subjects expressed a need for quality therapeutic relationships that facilitate their own healing powers	• Consideration of more complex and clearly delineated types of sexual violence	• The assignment of subjects to groups did not follow consistent criteria of types of sexual violence • No attempt was made to assure interrater reliability
Draucker CB & Stern PN (2000)	23 women rape victims Aged 19 to 62 years 16 Caucasian, 5 African American, 1 Asian American, 1 unknown ethnicity	United States	• Women victims' returns to normal life were fraught with obstacles they identified as the stigma associated with being a victim of sexual assault, the continuing threat of violence, insensitive treatment by health care workers, a criminal justice system that did not meet their needs, or in some cases, little or no support from significant others • The nature of the violence relationship(s) and the extent of the violence influenced how women forged ahead • Three themes were found in the descriptions by individuals of their experiences post-rape: — getting back on track; — starting over again, through telling others, discovering strength, and acknowledging the poor choice of a partner; — survival • Most individuals did not accept blame for the violence, as a way of moving on, but retained some regrets about their actions • Many continued to believe they had been vulnerable to bad relationships for a variety of reasons, or attributed a pattern of abuse to injurious childhood experiences		• The sample does not represent all women who experience intimate sexual violence

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Edmonds EM & Cahoon DD (1986)*	143 undergraduate students 52 male, 91 female	United States	• Responses indicated that wearing sexually oriented clothes was seen as more likely to be rape, more likely to provoke such an attack, and more likely to be responsible for the attack if she were to be assaulted • The assailant was held to be less accountable if the victim was assaulted while wearing sexy clothes than while wearing sexually conservative clothes		
El-Bassel N et al. (1998)*	143 women aged 18 to 55 years, all were sexually active in the 90 days prior to interviews, sought medical care at the hospital emergency department, and were triaged to non-emergency care Predominantly Latina and African American	Hospital emergency department, New York City, New York, United States	• Abused women were more likely than non-abused women to report having had an STD, engaging in sex with a risky partner, having more than one sexual partner, and having been tested for HIV • Abused women were almost five times more likely than their counterparts to have reported an STD and four times more likely to engage in sex with a risky sexual partner		
Ellis EM, Atkeson BM & Calhoun KS (1982)	50 victims of sexual assault Aged 15 years and older 25 multiple-incident victims (mean age 24.2 years) 52% white, 48% black 25 single-incident victims (mean age 28.6 years) 28% white, 72% black	Atlanta, Georgia, United States	• Multiple-incident victims reported more suspiciousness and hostility towards others than single-incident victims • Multiple-incident victims had fewer and less satisfying social relationships and fewer and less enjoyable sexual relationships • Multiple-incident victims reported more problems with depression and a history of many more suicide attempts		
Ellis EM, Atkeson BM & Calhoun KS (1981)	27 female rape victims at least 1 year post-assault 92% aged 20 to 39 years 93% white	Metropolitan Atlanta area, Georgia, United States	• Women who had been victims of sudden violent attacks by complete strangers showed the most severe reactions, being even more depressed, fatigued, and fearful and getting less satisfaction from activities than victims of other types of assaults • The study placed an emphasis on the severity and duration of emotional and sociosexual problems that may result from rape		• Small sample size • Authors were not able to determine how representative the sample was
Ellsberg MC et al. (1999)	488 females Aged 15 to 49 years 360 ever-married women	León, Nicaragua	• The lifetime prevalence of spousal violence was 52% among ever-married women • A cohabiting relationship greatly increases the risk of physical abuse • Wife abuse constitutes a major public health problem in Nicaragua, in terms of its high prevalence as well as the frequency and severity of abuse		• Cross-sectional study design
Ellsberg M et al. (1999)	488 women Aged 15 to 49 years	León, Nicaragua	• Women reporting abuse were 6 times more likely to experience emotional distress • An estimated 70% of all cases of emotional distress found among ever-married women were attributable to wife abuse		• Cross-sectional study design • Possible recall bias

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Epps KJ, Haworth R & Swaffer T (1993)	27 males convicted of rape, attempted rape or indecent assault against women Aged 14 to 20 years (mean age 17.3 years)	Youth treatment services, Glenthorne Centre or St Charles Centre, Birmingham, England	• Adolescents convicted of serious sexual assaults on women do not differ from adolescents convicted of nonsexual violent crimes in their attitudes towards women or in the extent to which they endorse rape myths	• Larger scale studies need to be conducted on adolescents of all ages and from a variety of settings	• The measures used lack the sensitivity to detect attitudinal differences between groups of adolescents • Sample was restricted in age groups
Faravelli C et al. (2004)	72 women: 40 women victims of rape during the previous 9 months and who were not sexually abused previously (mean age 34.5 years), and 32 women who experienced severe, nonsexual, life-threatening events	United States	• Compared with the nonraped group, the following psychiatric diagnoses were found to have significantly greater prevalence among raped women: PTSD, sexual disorder, major depression and eating disorder		• This group cannot be assumed representative of all adult women who were raped for the first time, but only of the subjects who were instating legal proceedings against the rape perpetrator and chose to contact an association dedicated to the assistance of abused women • It is possible that questions on some symptoms or psycho-pathological areas were not fully answered by the interviewees
Feild HS (1978)	1448 adult rapists, police, female rape crisis counsellors, and citizens	United States	• Sex, race, and marital status were the most important characteristics in predicting attitudes to rape • Significant differences were found among the groups in their perceptions of rape • The counsellors differed from the police, citizens, and rapists in their views of rape, while citizens and police were most similar • No differences were found between the police and rapists on half of the attitudinal dimensions	• Systematic evaluation of the relations between police officers' attitudes towards rape and their behaviour towards a rape victim	
Feldman PJ, Ullman JB & Dunkel-Schetter C (1998)*	128 female under-graduate students	United States	• Perceived vulnerability did not directly or indirectly predict blame • Similarity directly predicted less blame and indirectly predicted greater social support through associations with blame, perceived vulnerability and empathy • World assumptions directly predicted greater blame and indirectly predicted less social support through blame		
Feuer CA, Nishith P & Resick P (2005)	272 female rape victims seeking treatment Aged 18 to 72 years (mean age 32.71 years) 72% Caucasians, 28% African Americans	United States	• Hyperarousal and numbing are functionally related mechanisms • Intrusions and avoidance are functionally related • Arousal explained the majority of the variance in numbing beyond that explained by avoidance and intrusion • Intrusive symptoms explained the majority of the variance in effortful avoidance beyond that explained by numbing and arousal		

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Fikree FF et al. (2004)	100 obstetricians	Karachi, Pakistan	• Obstetricians generally perceived domestic violence to be very common in Pakistan. Most mentioned that more than 30% of Pakistani women are victims of domestic abuse • Senior obstetricians perceived the prevalence to be lower, whereas most junior and trainee obstetricians reported a higher perceived prevalence • Perceived prevalence of domestic violence for patients were significantly lower as compared to those for the general community • Only 8 obstetricians mentioned that they had ever received any training on identification or management of victims of domestic abuse • Professional barriers such as lack of time during antenatal or gynaecological clinics or lack of awareness of referral services or resources to support routine screening were cited as major barriers • Patient-related barriers such as patient's fear of police or of retaliation by spouse or marital family were perceived as major barriers to instituting routine screening in clinical practice • Obstetricians' personal concerns regarding inability to control or cure the problem and fear of police involvement for themselves were regarded as major barriers to instituting routine screening in clinical practice	• Formative and operations research that tests the effectiveness of screening protocols with the involvement of health care providers	• Potential recall bias • Study findings may not be generalizable to obstetricians in other areas of Pakistan • Small sample size
Filipas HH & Ullman SE (2006)	577 female undergraduate students 35.1% Caucasian, 26.4% Asian American, 17.6% Latina, 15.7% African American, 5.2% other	University, United States	• Individuals who reported both childhood sexual abuse and adult sexual assault had more PTSD symptoms, were more likely to use drugs or alcohol to cope, act out sexually, withdraw from people, and seek therapy services • The revictimized group reported more self-blame at the time of the abuse and at the time of the study • Greater number of maladaptive coping strategies used, greater severity of childhood sexual abuse, and greater self-blame predicted revictimization • Individuals who were sexually abused by someone they knew experienced more PTSD symptoms than those individuals abused by someone less familiar	• Research on self-blame and maladaptive coping responses to use empirically validated measures to support or refute the present findings • Further research on the role of PTSD in child sexual abuse and revictimization in other populations	• Convenience sample • Retrospective reporting • The measures used to assess attributions of blame and maladaptive coping strategies are not standard measure • Other forms of childhood abuse were not assessed • The role of PTSD in child sexual abuse and revictimization maybe underestimated because of the reported low PTSD rate in this high-functioning college sample
Filipas HH & Ullman SE (2001)*	323 victims of sexual assault (mean age 30 years)	United States	• Both positive and negative reactions were commonly experienced by victims disclosing their assaults to others • Victims seeking help from formal support sources were more commonly faced with negative reactions of victim blame, stigmatizing responses and controlling reactions from others • Reactions of friends were particularly important for recovery – positive reactions from friends appeared to be more helpful, whereas negative reactions appeared to be harmful from both informal and formal support sources		

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Finkelhor D et al. (1989) 2626 adults	*Nationally representative sample* Aged 18 years or older	United States	• Individuals who were victims of childhood sexual abuse involving penetration were more likely to report a disrupted marriage, dissatisfaction in their sexual relationship and a tendency to be a religious nonpractitioner • Victims of childhood sexual abuse were more likely to have read or talked about the problem recently and tended to see it as a more common occurrence than nonvictims		
Fischer GJ (1987)*	190 undergraduate students 90 Hispanic, 200 nonethnic majority	United States	• Hispanic individuals had more traditional attitudes towards women than individuals from the nonethnic majority • Hispanic individuals had less rejecting attitudes toward forcible date rape than individuals from the nonethnic majority • These effects were not a simple function of ethnicity		
Foa EB et al. (1991)	45 female rape victims with post-traumatic stress disorder (mean age 31.8 years) 25% black, 72.7% white, 2.3% Hispanic	United States	• Stress inoculation training was the most effective treatment in reducing PTSD symptoms immediately after treatment • Prolonged exposure was found to be an effective treatment • Supportive counselling and no treatment conditions improved arousal symptoms of PTSD, but not intrusion and avoidance symptoms • 3½ months after termination of treatment, prolonged exposure appeared to be the superior treatment	• The findings that SIT produced superior immediate reduction in symptoms and PE seemed to produce superior improvement at follow-up suggest that an optimal programme should combine both treatments • Evaluation of the relative efficacy of SIT procedures	• The use of only female therapists in the study limits its generalizability • The provision of training and supervision in all of the treatments may have introduced experimental bias effects
Foa EB et al. (1999)	96 female victims of assault with post-traumatic stress disorder (mean age 34.9 years) 63% Caucasian, 36% African American	United States	• Prolonged exposure (PE), stress inoculation training (SIT), and combined PE–SIT were superior to no treatment in ameliorating severity of PTSD – many participants in active treatment lost their PTSD diagnosis and reached clinically improved end-state functioning compared with participants who had no treatment • All three treatments reduced depression symptoms • The immediate effects of all three active treatments were maintained at the 12-month follow-up • In the intent-to-treat sample, PE was superior to SIT and PE–SIT in measures of post-treatment anxiety and global social adjustment at follow-up and had a greater effect on severity of PTSD, depression and anxiety		• The study did not conduct assessments during the active-treatment phase and therefore provided no information on the status of drop-outs at the time of termination • The study did not valuate interrater reliability systematically
Foa EB, Hearst-Ikeda D & Perry KJ (1995)	10 female victims of recent assault	Center for the Treatment and Study of Anxiety, Medical College of Pennsylvania, Pennsylvania, United States	• A brief cognitive-behavioural programme administered shortly after the assault accelerated improvement of trauma-related psychopathology • The brief cognitive-behavioural programme was effective in reducing depression	• Further examination of the helpfulness of the brief cognitive-behavioural programme with trauma survivors	• Small sample size • Victims were not randomly assigned to groups • All the participants were female victims of assault and the generalizability of the results to victims of other types of traumas is unknown
Foa EB, Riggs DS & Gershuny BS (1995)	158 female victims of assault Aged 17 to 65 years (mean age 31.19 years)	United States	• Numbing and effortful avoidance represented separate phenomena and related differently to other post-trauma symptoms • Anger may serve to ameliorate anxious arousal when effortful avoidance fails • Very few of the victims without PTSD endorsed the numbing symptoms, whereas many with non-PTSD symptoms endorsed symptoms of intrusion, arousal and effortful avoidance • The presence of numbing symptoms best identified individuals with PTSD		• The generalizability of the results to victims of other trauma, male victims and victims with long-term PTSD is unclear

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Foley LA et al. (1995)	70 undergraduate students 53 females, 17 males 58 white, 12 black	Medium-sized south-east public university, United States	• Respondents were less likely to define the incident as date rape and a crime and were less likely to indicate that the incident should be reported and that the assailant should be held legally accountable if the victim was a black woman than they were if the victim was a white woman • A black woman was not as likely to be perceived as a victim of date rape or of a crime as was a white woman • Black women's perception that their reports of being sexually assaulted will be disbelieved is accurate • Females were more likely to define the forced sexual encounter as date rape and as a crime and were more in favour of prosecuting the perpetrator than were males • Females were more likely than males to think the incident should be reported to the proper authorities and that the assailant should be held legally accountable, be found guilty, and receive a longer sentence	• Examination of the stereotypes held by participants to determine whether different extents of belief in rape myths and attitudes towards racial groups would predict subjects' reactions to date rape	
Follette VM et al. (1996)*	210 females aged 17 to 52 years recruited from psychological clinics and community advocacy agencies, and a non-clinical sample of under-graduate students	Psychological clinics, advocacy agencies and university, United States	• The level of trauma-specific symptoms is significantly related to the number of different types of victimization experiences reported		
Fonow MM, Richardson L & Wemmerus VA (1992)	582 undergraduate students 45% males, 55% females 86% white, 10% black, 4% other minorities	Ohio State University (large midwestern university), United States	• Mostly white, young American college students have some knowledge about rape but are not aware that rape is embedded in a larger social structure and culture, one that associates sexuality with violence • Women were more knowledgeable about rape, less likely to blame the victim, and less accepting of adversarial sexual beliefs and gender-role conservatism • Students who received rape education had lower rape-myth acceptance scores than the students who were given no education or only the pretest	• Development, implementation and evaluation of strategies to alter the deeper attitudes underlying the misperceptions about rape • Design and evaluate culturally sensitive rape education	
Forbes BG & Adams-Curtis LE (2001)	438 undergraduate students	Millikin University (small midwestern university), Decatur, Illinois, United States	• Significant relationships were found between aggression in the family of origin and experience of sexual coercion for both males and females • Personality and attitude measures, including acceptance of rape myths, were not related to sexual aggression in males • Small relationships were found between extroversion and childhood self-esteem and experience with sexual aggression	• The relationship between experiences with dating and exposure to college culture, and the transmission of rape myths and promotion of the sexual exploitation of women	

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Forbes GB et al. (2005)	428 undergraduate students 208 males (mean age 18.76 years), 220 females (mean age 18.59 years) 85% European Americans	Millikin University (small midwestern university), Decatur, Illinois, United States	• For both men and women, scores on the Rape Myth Acceptance Scale were related to getting even		• The results need to be generalized with caution because the participants were relatively young college students who probably had little direct experience of betrayal, particularly of sexual infidelity • The use of only one type of nonsexual betrayal and a very narrow range of potential aggressive or vengeful responses limited the research
Frazier PA (2003)	171 female victims of sexual assault Aged 16 to 52 years (mean age 27 years) 77% Caucasian	7 emergency rooms, Midwestern metropolitan area, United States	• Survivors who report more behavioural self-blame also report more distress at all postrape interviews • Decreases in behavioural self-blame over time are associated with decreases in distress over time • Victims who engage in more behavioural self-blame do not report engaging in more behaviours to try to avoid future assaults • Both behavioural self-blame and the belief that future assaults are more likely are associated with more distress • Blaming the rapist is associated with more distress at all postrape interviews • Increases in perceived control over the recovery process are associated with decreases in distress over time • Perceived control over the recovery process is more strongly related to lower distress levels than even the belief that future assaults are unlikely	• Identification of the predictors of different patterns of recovery, especially factors that are potentially modifiable in clinical settings • Identification of factors that facilitate a sense of present control as well as factors that may mediate the positive relations between present control and adjustment • Various aspects of future control, including the belief that future events are controllable, and perceived likelihood of future events, and engaging in precautionary behaviours • Longitudinal studies to assess changes in control and distress over time and predictors of different patterns of recovery	• Limited representativeness of the results due to sample selection • Self-reported data • The measurement of control beliefs may be inadequate • The belief that future assaults are controllable was not assessed • The study was unable to establish causal relationships
Frazier PA (2000)	*Study 3:* 104 rape survivors Aged 14 to 64 years (mean age 25.55 years) 80% Caucasian	Sexual Assault Resource Service, Minneapolis, Minnesota, United States	• Both behavioural and characterological self-blame are associated with poorer recovery immediately as well as several years post-rape • Attributions do not predict future PTSD symptoms • The only factor that predicted later PTSD symptoms was a sense of control over being assaulted again • Victims tended to attribute more blame to external than to internal factors • Blaming external forces is associated with poorer recovery and is more strongly related to higher levels of symptoms than is self-blame • Thinking more often about why the rape occurred is associated with more p sychological distress		

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Frazier PA & Burnett JW (1994)	67 rape victims (mean age 27 years) 81% Caucasian	Sexual Assault Resource Service, Minneapolis, Minnesota, United States	• Social support was a frequently used coping strategy • Although the overall support ratings are high, men are rated as slightly less supportive than are women • Rape trauma nurses and victims' sisters were most supportive • Male friends and boyfriends were least supportive • Taking precautions and thinking positively were frequent coping strategies • Expressing feelings, seeking social support, counselling and keeping busy were most often found helpful • Staying home and withdrawing were associated with higher symptoms levels • Keeping busy, thinking positively, and suppressing negative thoughts were associated with lower levels of symptoms • Coping strategies that are emotion- rather than problem-focused and that are approach- rather than avoidance-focused appeared most helpful	• Identification of coping strategies that victims use • Evaluation of the effectiveness of these strategies	• Limited generalizability due to sample selection • Symptoms were assessed 3 days post-rape; this excluded many victims who seek counselling months or years following the rape • Measurement of coping strategies was problematic • The identification of a coping strategy as helpful was not necessarily adaptive
Frazier PA, Conlon A & Glaser T (2001)	171 female sexual assault victims Aged 16 to 52 years (mean age 27 years) 77% Caucasian	Sexual Assault Resource Service, Midwestern urban area, United States	• Even 2 weeks after the assault, many survivors reported some positive changes, particularly increased empathy, better relationships and greater appreciation of life; those who retained those changes over time reported the least distress 1 year post-assault • Most survivors' beliefs about the goodness of other people and the safety and fairness of the world continued to be negatively affected even 1 year after the assault • A sexual assault, which involved intentional harm, seemed particularly likely to create negative changes in basic beliefs about others • Positive changes generally increase and negative changes generally decrease over time • Some kinds of change appear to be more sudden (e.g. increased empathy), whereas others may take more time to emerge from the recovery process (e.g. recognizing strengths, sense of purpose in life) • There was significant individual variability in both the number of changes reported and patterns of self-reported positive and negative changes over time • Positive changes in self and spirituality were associated with less distress, whereas negative changes were related to more distress • Those who lose positive changes were as distressed as those who never found them	• More representative sample	• Limited generalizability of results due to sample selection • Small sample size for some of the longitudinal analyses • Recent standardized measures of post-traumatic growth were not available at the time of the study • The data did not address whether survivors' reports of positive change reflect actual life changes or positive illusions created to cope with the trauma

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Frazier PA, Mortensen H & Steward J (2005)	*Study 1:* 171 female sexual assault victims Aged 16 to 52 years (mean age of 27 years) 77% Caucasian *Study 2:* 131 non-recent sexual assault victims Aged 18 to 78 years (mean age of 39 years)	Midwestern urban area, United States	• Individuals who engaged in more behavioural self-blame were more likely to use social withdrawal and problem avoidance as coping strategies • Perceived control over the recovery process was associated with less distress because it was associated with less use of social withdrawal and greater use of cognitive restructuring • Social withdrawal mediated the relation between behavioural self-blame and distress, and also between perceived control and distress • Survivors who engaged in more avoidant coping, particularly social withdrawal, reported higher distress levels	• Comparison of the relations among measures of control, coping, and distress between men and women who have experienced the same stressor • Examination of these relations among different racial or ethnic groups	• Results can only be generalized to female, white survivors of sexual assault • The study assessed a limited number of coping strategies • Sample size was too small to have sufficient power to detect mediator effects • Samples were too small to conduct structural equation modelling analyses • Correlational data – cannot determine the direction of the relations among variables
Frazier PA & Schauben LJ (1994)*	282 female undergraduate students Aged 17 to 56 years	United States	• Among rape survivors, both behavioural and characterological self-blame, and thinking more often about why the rape occurred were associated with poorer recovery • The belief that future rapes are less likely was associated with better recovery		
Frazier PA et al. (2004)	171 female sexual assault victims Aged 16 to 52 years (mean age of 27 years) 77% Caucasian	Sexual Assault Resource Service, Midwestern urban area, United States	• The factors most strongly related to reporting positive life changes soon after the assault were social support, approach and religious coping, and perceived control over the recovery process – increases in these factors were also associated with increases in self-reported positive life changes over time • The relations between social support and positive change were mediated by coping strategies and control appraisals, particularly perceived control over the recovery process	• Examination of ethnic differences in responses to trauma, and assessment of potential mediators of these differences • Identification of the role of support providers in the positive change process • Attention on control appraisals in theory and research on positive change, and particularly to present control • Examination of more complex models of the relations between psychosocial resources, positive life change and distress and their temporal sequence	• Missing data from participants who dropped out • Correlational data • There are many other variables that may be associated with positive change that the study did not assess • Some of the measures were not as extensive as they could have been • Self-reports • Results can only be generalized to female survivors of sexual assault who seek help in an emergency department
Frazier PA, Valtinson G & Candell S (1994)	192 undergraduate students Aged 19 to 27 years (mean age 21 years) 117 sorority members, 75 fraternity members 97% Caucasian	Large midwestern university, United States	• Men and women who participated in the coeducational acquaintance-rape prevention programme were less likely to endorse the kinds of attitudes and beliefs that are associated with acquaintance rape • The intervention group was more likely than the control group to agree with statements endorsing respect and equality between men and women, assertive communication and safety precautions for women • Differences between the intervention and control groups were no longer evident 1 month after the programme ended • Participants' evaluations of the programmes were quite positive, with the majority stating that they had enjoyed the programme and would recommend it to other fraternities and sororities	• Assessment effectiveness of longer term interventions	• Measures used did not have established reliability and validity • Measures of change were outdated and not sufficiently sensitive

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Freedy JR et al. (1994)	251 crime victims and family members involved in the criminal justice system 63.3% female Aged 17 to 75 years (mean age 38.2 years) 62.5% Caucasian, 35.5% African American	South Carolina, United States	• Victims of more violent crimes including sexual assault, victims who sustained physical injuries, perceived that they would be seriously injured, or perceived their lives to be threatened, were more likely to suffer from PTSD than victims who did not have these characteristics • Most victims believed that the criminal justice system should provide a range of services for victims • Victims who were involved with the criminal justice system for longer periods of time did not report more access to services • Most victims reported inadequate access to services including mental health services • Receipt of psychological counselling and diagnostic status were significantly associated with crime type		• There were unmeasured variables that could have produced informative results if assessed • Some unknown selection bias may exist due to sample selection • Cross-sectional data • Retrospective reports
Garcia, LT (1998)	171 undergraduate students 89 male, 82 female	United States	• The more salient and direct responses were less likely to be interpreted as token resistance by both men and women • More salient and direct responses resulted in less positive feelings and more negative feelings being attributed to the woman in that situation • Men whose scores on the Rape Myth Acceptance Scale indicated beliefs consistent with rape myths were more likely to interpret a woman's response as token resistance		
George LK, Winfield I & Blazer DG (1992)	*North Carolina sample:* 1157 women Aged 18 to 64 years 60.3% white, 39.7% black	North Carolina and Los Angeles, California, United States	• Study participants who were 18 to 44 years old, lived in an urban environment, and had some college education were more likely to be victimized than older, rural and less educated respondents • Assault was considerably more prevalent in the sample from Los Angeles • Respondents from North Carolina were more traumatized by the assault and more likely to seek help afterwards	• Examination of the role of sociocultural factors in differences in definitions of sexual assault and correlates of acknowledged versus unacknowledged rape	
Gibson LE & Leitenberg H (2001)	1050 female undergraduate students (mean age 18.4 years) 95% Caucasian Analyses based on 106 female undergraduate students who had experienced sexual assault within the past year	State university, New England, United States	• Sexually assaulted young women with a history of childhood sexual abuse used more disengagement methods of coping to deal with the adult sexual assault than women without such a history • The relationship between prior sexual abuse and the use of disengagement coping strategies was mediated by feelings of stigma, but not by feelings of betrayal and powerlessness or beliefs in the meaningfulness and benevolence of the world	• Examination of whether other sorts of traumatic events during childhood are associated with an increased use of disengagement methods of coping with a variety of adult stressors	• There is conceptual and possible measurement overlap between the construct of disengagement coping and Cluster C of the Diagnostic and Statistical Manual of Mental Disorders definition of Post-traumatic Stress Disorder • Sample of predominantly Caucasian undergraduate students from relatively high socioeconomic backgrounds can be considered a methodological limitation

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Gidycz CA, Hanson K & Layman MJ (1995)	178 female undergraduate students 92.1% Caucasian, 3.4% black, 1.7% Hispanic, 2.2% Asian, 0.6% Native American	United States	• A woman's chances of being victimized were dependent upon victimization in the preceding time period • Women who had a history of victimization were twice as likely as those women without such a history to be victimized again during the 3-month follow-up period	• Inclusion of additional mediating variables that may account for the links between victimization experiences including such factors as coping skills, the availability of social support post-assault, and involvement with the legal system	• Subjects were functional college students, thus the results should not be generalized to other samples • Longitudinal designs are subject to certain difficulties (i.e. sample attrition) • More victims than nonvictims returned for the 9-month follow-up
Gidycz CA et al. (2001)	1108 undergraduate students 17% men, 73% women 93% Caucasian, 5% African American, 1.3% Asian, 0.6% Hispanic, 0.1% Native American	Large university, Ohio, United States	• The programme for prevention of sexual assault did not have a significant effect on attitudes towards women, rape empathy, or rates of sexual aggression or victimization • Participants showed less acceptance of rape myths at post-test than the comparison group • Participants rated the programme highly, although they did not find the information personally relevant • The programme was not powerful enough to affect sexually aggressive behaviour by men or to reduce a woman's risk of victimization		• Assessment of behavioural changes as a result of participation in the programme is inherently very difficult
Gidycz CA et al. (2001)	762 female undergraduate students	Ohio University, Ohio, and State University of New York at Binghamton, New York, United States	• Women who were not victimized during the 2-month follow-up period tended to be those who had no history of victimization and who, thus, were at the lowest risk of being victimized • If participants were victims of rape during the 2-month follow-up period, the programme did not reduce their risk for sexual revictimization during the 6-month follow-up period • Rape empathy interacted with the women's level of prior victimization		• Despite the large-scale multisite nature of the study, the size of some cells was small, thereby limiting the likelihood of making meaningful between-group comparisons
Gold SR et al. (1994)	654 female undergraduate students Aged 17 to 36 years (mean age 18.95 years) 74% Caucasian, 15.1% African American, 4.7% Hispanic, 5.2% Asian American, 1% other	United States	• Sexual abuse was associated with more symptoms and more recent assaults • Revictimized women reported the most symptoms • Mediating variables were predictive of scores on the Dissociation, Anxiety, Depression, Sexual Abuse Trauma Index, and Sexual Problems subscales • The interaction of low levels of parental support and a non-expressive coping style was predictive of Anxiety and Depression scores • There was no correlation between Trauma Symptoms Checklist scores and measure of severity of abuse		
Golding JM (1994)	1610 women Aged 18 years or older 673 non-Hispanic white, 758 Hispanic, 3 American Indian, 75 Asian American, 5 Pacific Islanders, 69 African American, 27 other ethnicities	Los Angeles, California, United States	• Sexually assaulted women were more likely than women who had not been assaulted to report poor health perceptions, functional limitation, several chronic diseases, medically explained somatic symptoms and medically unexplained somatic symptoms • Sexual assault was associated with increased risk of symptoms in a variety of organ systems rather than solely reproductive or sexual symptoms • Diabetes, arthritis and physical disability were associated with history of sexual assault	• Research using medical record data to objectively document specific diagnoses	• The use of lifetime time frames for sexual assault, disease and somatic symptoms – order of onset could not be determined • The association of history of sexual assault and physical conditions may be attributable to a third variable not assessed • The results may not be generalizable to all populations

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Golding JM, Cooper ML & George LK (1997)	*Pool of 7 independent population surveys:* 10001 individuals 2451 men, 7550 women	United States	• History of sexual assault was associated with poor subjective health regardless of gender, ethnicity or sample • Depression did not account for or mediate the association between assault and health perceptions • Multiple assault and assaults by a stranger or spouse were most strongly associated with poor subjective health • Degree of physical threat or force, type of sexual contact, and disclosure were not significantly related to health perceptions	• Examination of the extent to which repeated victimization may affect general health	• Health perceptions were assessed by using one-item measures, which are likely to have low reliability. • Limited representation of men and the lack of representation of many ethnic groups
Golding JM et al. (1989)	3132 adults Aged 18 years or older 1428 Hispanic, 1310 non-Hispanic white, 394 other	Los Angeles, California, United States	• About two thirds of the sexually assaulted respondents had told someone about the assault: over half had talked to a friend or relative, 10.5% consulted police, 16.1% mental health professionals, 9.3% physicians, 3.9% clergy, 1.9% rape crisis centres and 1.6% legal professionals • Assault by a stranger, physical threat, fighting against the assailant, a high degree of sexual contact and emotional distress concerning the assault were associated with talking about the assault, especially with the police and physicians • 73.8% of those who told someone found at least one person helpful • Rape crisis centres (94.2%) and legal professionals (82.7%) were most frequently described as helpful, followed by mental health professionals (70.1%), friends and relatives (66.6%), clergy (63.1%), physicians (55.6%) and police (38.2%)	• Study the helpfulness of specific sources by surveying clients or patients who have used them • Data about timing of support-seeking, the kind of help respondents needed and received from each source, and specific behaviours that respondents found helpful, and more detail about the helpfulness of specific support sources • Complement the present study's strength in estimating rates of help-seeking with more detail about the quality of help received	• Reporting of both sexual assault and support-seeking may be subject to biases due to difficulty with recall of events from the distant past • Evidence that sexual assault is associated with psychopathology suggests that psychopathology may affect reporting • Small numbers of people using each support source limited the dependability of inferences about predictors of helpfulness of the sources
Golding JM et al. (1988)*	1560 community residents Aged 18 years or older	United States	• Sexual assault was associated with seeking mental health care and medical services • Sexual assault increased use of both forms of care indirectly, through poor mental and physical health • Uninsured, assaulted respondents were especially likely to consult medical providers • Sexual assault was more common among users of mental health services than nonusers, and among women using medical services than among women who were not patients		
Golding JM, Wilsnack SC & Cooper ML (2002)	*Pool of 6 independent population surveys:* 9865 individuals	United States	• History of sexual assault was associated with relatively low levels of social support • Compared to nonassaulted persons, people with a history of sexual assault were less likely to be married, reported less frequent contacts with friends and relatives, and reported receiving less emotional support from friends, relatives and spouse • Assault was associated with network size (not being married), relationship structure (low frequency of network contacts) and relationship function (low emotional support form friends, family and spouse) • Sexual assault during adulthood was associated with a lower likelihood of being married • Sexual assault by spouse was related to less emotional support from friends and family; assault by a stranger was related to more support from friends and family	• Investigation of the possibility that support might also mediate or moderate (or both) the associations of history of sexual assault with mental and physical health problems	• Correlational data - causal relationships cannot be inferred • Some constructs were assessed using single-item measures in at least some of the data set, limiting their reliability • There were relatively few significant associations of assault circumstances with support

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Green BL et al. (2000)	2507 female second-year undergraduate students Aged 17 to 24 years (mean age 19.4 years) 63% white, 19% African American, 9% Asian American, 4% Latina, 5% other	United States	• Multiple interpersonal exposure was the category associated with the highest risk for current symptom distress • Individuals who have experienced multiple events have worse outcomes than those who have experienced fewer events or a single event • Individuals who have experienced interpersonal traumas, especially multiple traumas, are more distressed than those who have experienced only noninterpersonal events	• Assessment of history of trauma and analyses that take into account the patterns of exposure that are prominent in the samples and populations that are studied and treated	• Restricted sample: it is not clear to what extent the findings would be generalizable to a more representative community sample • Only a subsample of the women surveyed actually responded, and this is likely to be a selected group • The study was only able to address general current symptom distress in self-reported trauma survivors
Green CR et al. (2001)	90 women patients presenting for management of chronic pain Aged 18 to 82 years 82% white, 14% black, 4% other	Multidisciplinary Pain Center, Ann Arbor, Michigan, United States	• Women describing long-term abuse reported a significantly greater number of symptoms of physical pain and anxiety and were more likely to report a history of substance abuse and cigarette smoking than women reporting abuse during childhood or adulthood alone	• Research using a longitudinal design that follows people with and without a history of abuse to help determine the influence of abuse on future health problems • Exploration of whether certain personality characteristics or socioeconomic factors differentiate women who are abused during childhood only from those who experience lifetime abuse	• Possible self-report bias • Correlational data • Possible self-selection bias • Nonresponse
Greendlinger V & Byrne D (1987)	114 male undergraduate students	State University of New York at Albany, New York, United States	• The likelihood of rape was correlated with reports of coercive sexual fantasies, acceptance of rape myths, and general aggressive tendencies, although coercive sexual behaviour and the likelihood of rape were not significantly related		
Hanson KA & Gidycz CA (1993)	360 female undergraduate students 94% white, 4% black, 1% Hispanic, 1% Asian or Pacific Islander	Large university, United States	• The prevention programme was effective in reducing the incidence of sexual assault among women who had not been victimized before their participation in the study • The prevention programme was not effective in reducing the incidence of sexual assault among women with a history of victimization • The prevention programme appeared to increase subjects' knowledge about sexual assault and to reduce the likelihood of experiencing situational factors associated with acquaintance rape • The prevention programme did not appear to be effective in increasing subjects' perceptions of the clarity of their sexual communication	• Continual assessment of the mechanisms through which victimization experiences become linked	• The prevention programme targeted women only • Self-reported data • The generalizability of the results is limited to female college students, particularly first and second-years
Harrison PJ, Downes J & Williams MD (1991)*	96 undergraduate students 45 male, 51 female	United States	• On the victim-blaming or denial scale, men showed a significantly greater change in responses from pretest to posttest • For men, both treatments raised scores on both scales compared with a control group that had no intervention		

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Hattendorf J, Ottens AJ & Lomax RG (1999)	18 battered women who killed abusive partners Aged 24 to 60 years (mean age 39.9 years) 11 African American, 6 white, 1 African American-Native American	Illinois, United States	• Before killing male partners, these battered women suffered moderate to high levels of frequency and severity of PTSD symptoms, except for an inability to recall important aspects of the trauma • Significant canonical correlations were found between the frequency and severity of PTSD symptoms and the severity of types of abuses inflicted	• Inclusion of women who are not incarcerated to provide insights into how they re-empower and re-story lives once dispossessed by partner abuse and imprisonment	• The lack of an instrument for the assessment of PTSD specifically for the population of battered women • Participants in the study were incarcerated women, limiting the generalizability of the results
Heppner MJ et al. (1995)	257 first-year undergraduate students 105 male, 152 female (mean age 17.39 years)	Large, public, Midwestern university, United States	• Both men's and women's scores on the Rape Myth Acceptance scale dropped significantly immediately after the rape prevention intervention, but both showed a rebound effect after 2 months, when men's scores were virtually the same as before the intervention	• Examination of the more long-term impact of rape prevention interventions • Examination of the relationship between male sex role socialization and belief in rape mythology	• The sample consisted of first-year college students from one university, limiting the generalizability of the results • There was no control group • Missing data
Heppner MJ et al. (1995)	258 undergraduate students 50% men, 50% women (mean age 18.5 years) 93% Caucasian, 2% African American, 2% Hispanic, Puerto Rican, or Mexican American, 2% Asian American or Pacific Islander	Large, public, Midwestern university, United States	• Both men and women in the interactive drama rape prevention programme reported greater motivation to hear the message, believed the quality of information presented to be better, felt that the level of complexity was more appropriate and generated more issue-relevant thinking, than did participants in the didactic-video intervention or the control group • Interactive drama participants were more able to differentiate between consent and coercion • The didactic-video intervention was more effective than the control intervention at altering men's acceptance of rape myths at 1 month, but change was not stable	• Diversification of samples for future evaluations of rape prevention programmes	• The sample consisted only of college students • Several of the instruments used in the study are new and need further psychometric development
Hickman SE & Muehlenhard CL (1997)	139 female undergraduate students (mean age 19 years) 84.1% European American/white, 6% African American, 6% international students, 2% Asian Americans, 1.3% Hispanic Americans, 0.6% biracial	University of Kansas (large, public, Midwestern university), United States	• Subjects reported being more fearful of rape by strangers than by acquaintances • Subjects reported engaging in more precautionary behaviours because of fear of stranger rape than of acquaintance rape • Subjects considered that acquaintance rape was more common • Precautionary behaviours were best predicted by level of fear • A history of acquaintance rape had no effect on women's responses	• Investigation to determine if women fear acquaintances differently and how this fear affects their precautionary behaviours • A between-subjects design to evaluate women's fears of acquaintance rape without implicit comparison with stranger rape and vice versa • Exploration of whether women's reported precautionary behaviours are similar to their actual precautionary behaviours	• A broad definition of "acquaintance" was used
Hill JL & Zautra AJ (1989)*	36 female survivors of rape Aged 18 to 62 years	United States	• Subjects' ratings of their ability to change several sources of self-blame attributions failed to predict postrape demoralization • Frequency of characterological self-blaming and unique vulnerability were significant predictors of adjustment to rape • Feelings of control over sources of self-blame attributions do not adequately explain the impact of characterological self-blame and unique vulnerability on postrape adjustment		

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Idisis Y, Ben-David S & Ben-Nachum E (2007)	72 individuals 50% men, 50% women 50% therapists, 50% non-therapists (university students)	Israel	• Both therapists and non-therapists showed a slight general tendency to blame the victim • There was a consistent tendency to attribute more blame to female victims than to male victims • Men attributed less blame to male victims than did women • Women attributed less blame to female victims than did men • Therapists judged the rapes as slightly more severe • The severity of rape scenarios and accompanying judgement of deserved punishment are dependent, among other factors, on the degrees of blame attributed to the rapist and to his victim – the greater the degree to which the victim is seen as contributing to the rape, the lower the judgement of severity of the rape and the lesser the degree of punishment deserved by the rapist, and vice versa		
Janoff-Bulman R (1989)*	338 undergraduate students	United States	• People's assumptive worlds are affected by traumatic events, and the impact on basic assumptions is still apparent years after the negative event		
Janoff-Bulman R (1979)	*Study 1:* 120 female under-graduate students *Study 2:* 38 rape crisis centres	*Study 1:* Large public university, United States *Study 2:* Rape crisis centres through-out the United States	*Study 1:* • Depressed subjects engaged in more characterological self-blame than nondepressed subjects, whereas behavioural self-blame did not differ between groups • Depressed subjects were characterized by greater attributions to chance and decreased beliefs in personal control *Study 2:* • Behavioural self-blame, and not characterological self-blame, emerged as the most common response of rape victims to their victimization		
Jordan J (2001)	48 women Aged 16 years to mid-70s 92% New Zealand European/European	New Zealand	• Initial reporting experience is a critical determinant of whether complainants will be able to develop sufficient trust in the police to feel able to proceed with an investigation • Overall level of satisfaction with the doctors who performed the medical examinations was reported to be high • A lack of significant improvement in the reporting process was found		• Only women were included in the study • Cases with a history of childhood abuse were excluded • No attempt was made to verify the women's accounts • Recruitment of the sample was dependent primarily on referrals from counseling agencies • Geographic constraints of the sample
Kahn AS et al. (2003)	89 female under-graduate students, all victims of rape 33 acknowledged victims, 56 unacknowledged victims	Medium-sized, south-eastern public university, United States	• Compared to unacknowledged victims, acknowledged victims, were older, knew their assailants less well, experienced more forceful assaults, and had stronger negative emotional reaction to the experience • Women were most likely to acknowledge their experience as rape when the assailant was not their boyfriend and they woke up with a man penetrating them or the assailant used force and dominated them to obtain intercourse • When the assault involved a boyfriend, or if the woman was severely impaired by alcohol or drugs, or if the act involved oral or digital sex, the women were unlikely to label their experiences as rape		• Small sample size

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Kahn AS, Mathie VA & Torgler C (1994)	198 female undergraduate students (mean age 20.5 years) 152 nonvictims, 24 acknowledged victims, 22 unacknowledged victims	James Madison University, Harrisonburg, Virginia, United States	• Unacknowledged rape victims possessed more violence, stranger rape scripts than do acknowledged rape victims, who were more likely to have an acquaintance rape script • Compared to acknowledged victims, unacknowledged victims had a sexual history which involved less force • Most unacknowledged victims do not define their rape experience as rape because they have a rape script of a violent, stranger, blitz rape which does not match their experience of being raped in a less forceful manner by someone with whom they were acquainted		• The data are purely correlational • The sample was composed almost exclusively of victims of acquaintance rape
Kalra M et al. (1998)	115 women Aged 18 to 85 years (mean age 37.56 years)	Canada	• Women from both age groups reported being the target of negative dating experiences and being concerned about these experience; older women expressed slightly more concern • Older women (aged 40 years or older) endorsed rape myths to a greater extent • Adherence to rape myths was not tied to actual experiences of dating violence	• Life-span research of dating experiences and attitudes towards dating violence	
Kanekar S & Kolsawalla MB (1980)	320 graduate students	University of Bombay, India	• Males tended to attribute greater responsibility to the rape victim than did females • The difference in attribution by males and females seemed to hold primarily for marginal or intermediate cases where respectability and provocativeness were not consistent in giving a completely positive or negative picture of the rape victim • Provocativeness of the victim affected her responsibility in an expected direct manner • Males recommended a shorter sentence for the rapist than did females in the provocative condition		
Kerr E et al. (2003)	676 complainants of sexual assault 6% male Aged 11 to 66 years (mean age 26 years)	Department of Health, King's College Hospital, London, England	• Requirements following sexual assault included forensic examination, first aid, postcoital contraception, prevention and management of sexually transmitted infections and psychosocial support • Provision of these services within a sexual health setting is feasible		
Kessler RC et al. (1995)*	5877 noninstitutionalized, civilians Aged 15 to 54 years	United States	• PTSD is a highly prevalent lifetime disorder that often persists for years • The qualifying events for PTSD are also common, with many subjects reporting the occurrence of several such events during their lifetimes • There is variability in the associations of these different events with PTSD, none is such that virtually everyone exposed to it develops this disorder • The relative odds of other lifetime disorders was significantly elevated among subjects with lifetime PTSD, and the majority of these subject also had a least 1 other lifetime DSM-III-R disorder		

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Kilpatrick DG et al. (1997)	*National probability sample* 3006 women (mean age 35.9 years) 82% white, 8.2% African American, 5.8% Hispanic, 2.2% Native American, 1.8% other racial groups	United States	• Active drug use was associated with increased risk of victimization • Risk of new victimization was greatest in women who used drugs and had been previously assaulted • Lifetime assault was associated with increased odds of alcohol abuse and drug use	• Clarification of the temporal sequence of assault and substance use • Studies of risk of victimization among women should include measures of substance use–abuse together with measures of other variables that have been shown to increase likelihood of assault • Fine-grained contextual information about victimization experiences and events that preceded these experiences should be obtained to provide a better understanding of possible mechanisms by which substances use–abuse might increase risk of assault • Focus on the extent to which risk of developing substance use–abuse might be mediated by violence-related mental health problems, such as PTSD or major depression	• This report demonstrated increased risk, not causation per se
Kilpatrick DG et al. (1989)*	391 adult females	United States	• Life threat, physical injury and completed rape were factors that made significant individual contributions to explaining crime-related post-traumatic stress disorder		
Kilpatrick DG et al. (1987)	391 adult females Aged 18 years or older (mean age 39.8 years) 72.9% white, 26.6% black non-Hispanic	United States	• 53% of the sample had been victims of at least one sexual assault, consisting of completed rape (23.3%), attempted rape (13.1%), completed molestation (18.4%), attempted molestation (4.6%), aggravated assault (9.5%) and sexual assault (3.0%) • Reporting rates were extremely low for sexual assaults • Reporting rates for completed rapes were no higher than those for other sexual assaults • Arrest rates were lowest for cases of sexual assault and aggravated assault • Only 3% of completed rape cases resulted in an arrest • Lifetime and current crime-related PTSD rates were highest for victims of completed rape		
Kimerling R & Calhoun KS (1994)	202 individuals 115 women victims Aged 15 to 71 years (mean age 25.9 years) 87 nonvictims (mean age 28.6 years)	Atlanta, Georgia, United States	• Women who experienced sexual assault reported more somatic complaints, poorer perceptions of physical health, greater psychological distress and increased use of medical services • Victims did not show a significantly higher use of mental health services • Victims continued to seek medical attention at the end of the year after the assault, when health perceptions and somatic symptoms were no longer significantly elevated	• Investigation of factors other than physical health that contribute to medical service utilization – inclusion of comprehensive psychological assessment of features that have been correlated with health complaints and somatization in women, including post-traumatic stress disorder, negative affect and objective measures of health	
Klaw EL et al. (2005)*	University students	United States	• College student participants in campus education on acquaintance rape developed rape consciousness, and this shift involved cognitive, emotional and behavioural changes similar to those involved in the development of feminist identity		

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Koss MP (1985)	231 women undergraduate students: 82 not sexually victimized, 37 low-sexually victimized, 50 moderately victimized, 62 highly sexually victimized	Midwestern university, United States	• While personality variables and attitudes did not differentiate the groups of subjects, numerous situational variables did: the relationship of the victim and offender, the violence of the assault, the resistance of the victim, the emotional response of the victim and the sexual history of the victim • Low and moderately sexually victimized women had encountered less force by the offender and their resistance had a greater impact than that of the raped women		• Generalizability of the results is restricted because the study was based on a population of hidden rather than identified rape victims from a population of college students • The range of psychological measures employed was limited
Koss MP et al. (1988)	489 undergraduate female rape victims	Universities, United States	• Compared with rape by strangers, rape by acquaintances was more likely to involve a single offender and repeated episodes, was less likely to be seen as rape or to be revealed to anyone, and was similar in terms of subjects' resistance • Compared with victims of acquaintance rape, victims of rape by strangers were more likely to tell someone about their experience, to seek crisis services, to report to the police, to believe that they should have sought therapy and to view their experience as rape • Assaults by strangers were perceived as more violent than assaults by acquaintances with the exception of rapes by family members • Rapes by husbands or other family members were rated equally violent to stranger rape, but were much less likely to occur in a context of drinking alcohol or use of other drugs • The combined use of drugs and alcohol was most often reported by women who were raped by strangers and casual dates • Women hesitated or were less well-prepared psychologically to use active avoidance when assaulted by someone they knew than women who were assaulted by strangers • No differences were found among any of the subjects in their levels of psychological symptoms	• Consideration of whether traumatic assaults can be resolved adaptively without discussing them with others • Addressing the possibility that the cherished beliefs or assumptions shattered by a rape could differ depending on the relationship of the victim to the offender and that these differences could influence the shape and or the course of resolution	• Retrospective data were used • Although the general level of psychological symptoms was equivalent, the sources of the emotional pain could vary • The results are limited in application to college students
Koss MP, Figueredo AJ & Prince RJ (2002)	253 rape survivors (mean age approximately 38 years)	United States	• Self-blame and maladaptive beliefs predicted greater psychological distress, which strongly and negatively influenced all health outcomes • Self-ratings of rape memory characteristics contributed little to predicting postrape distress	• Further development of cognitive–experiential reprocessing interventions aimed at assessing and consciously managing the modification of beliefs	• Cross-sectional data • The study focused on female rape survivors only • The sample consisted primarily of urban, employed, white women, with higher-than-average levels of education • The rapes discussed occurred an average of 16 years prior to the study, and the passage of time is well known to ameliorate the effects of trauma: no effort was made to statistically control for the effect of time
Koss MP, Gidycz CA & Wisniewski N (1987)	6159 individuals 2972 men, 3187 women (mean age of 21.4 years) 86% white, 7% black, 3% Hispanic, 3% Asian, 1% Native American	32 institutions of higher education, United States	• Since the age of 14, 27.5% of college women reported experiencing, and 7.7% of college men reported perpetrating, an act that met legal definitions of rape, which included attempts • Men did not admit enough sexual aggression to account for the number of victimizations reported by women • Rape is much more prevalent than previously believed	• Compare violence and resistance attributions among sexually aggressive and sexually nonaggressive men • Analysis based on ethnicity controlling for region • Analysis based on region controlling for ethnicity	

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Koss MP, Koss PG & Woodruff WJ (1991)*	390 adult women 74 nonvictims of crime, 316 victims of crime	United States	• Compared with nonvictims, severely victimized women reported more distress and less well-being, visited a physician twice as frequently in the index year, and had outpatient costs that were 2.5 times greater • Severity of criminal victimization was the most powerful predictor of physical visits and outpatient costs • Victims' visits to physicians increased by 15% to 24% during the year of the crime compared with a change of less than 2% among nonvictims		
Koss MP et al. (1985)*	143 individuals: 50 sexually non-aggresive (mean age 21.2 years), 17 sexually assaultive (mean age 24 years), 23 sexually abusive (mean age 21.1 years), 53 sexually coercive (mean age 21.5 years)	United States	• The findings support a social control/social conflict explanation of nonstranger sexual aggression		
Koss MP, Woodruff WJ & Koss PG (1990)	2291 women Aged 19 to 69 years (mean age 36.5 years) 25% black, 72% white, 3% other ethnic groups	United States	• Criminal victimization was an important predictor of health perceptions even after accounting for the contributions of demographics and other stressful life events with known links to illness	• Determine whether the results can be generalized to women who differ from those studied	• Male crime victims were not included in the sample • The amount of variance in health that was accounted for in this study was not large • The assessment of health in the study was limited to subjective perceptions of current health • The assessment of crime victimization was retrospective
Koss MP & Figueredo AJ (2004)	59 rape victims Aged 18 to 57 years (mean age 29.5 years) 81% white, 7% Hispanic, 7% African American, 5% Asian American or Pacific Islander	United States	• Both characterological self-blame and behavioural self-blame were unhelpful • Recovery occurred when any type of preoccupation with attributing causes became less intense • There was significant contribution of maladaptive beliefs to the prediction of psychosocial distress and to the prediction of the specific forms of mental and social problems • Improvement in the first 5 months was most rapid, but after that improvement slowed down and recovery flattened out before survivors declined to the levels of distress that characterize population means • The present results, based on observation of recovery from sexual assault, suggest that: — over time habituation to traumatic images did occur as reflected by reductions in PTSD; — preoccupation with blame, both directed at the self and others, decreased; and — sense of control and other core beliefs were repaired		• Comparison between rape survivors who volunteered for the study and those survivors who chose not the volunteer • The sample underrepresented Hispanic and American Indians • The sample size may not have provided enough power to detect weak effects

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Koss MP et al. (2003)	1660 individuals from seven Native American tribes 41% male, 59% female Men: mean age 40.5 years; Women: mean age 39.5 years	United States	• For women, sexual abuse increased the odds of alcohol dependence • For men, combined physical and sexual abuse significantly increased the odds of alcohol dependence • Effects of childhood exposures on high-risk behaviours emphasize screening for violence in medical settings and development of social and educational programmes for parents and children living on and near tribal reservations	• Expand measurement of tribal characteristics to include measures of tribal integration, ancestry, lifestyle characteristics, gender roles and values, attitudes and expectations about alcohol	• Underestimation of the prevalence of alcohol dependence and childhood exposure as a result of reporting bias • Cross-sectional design • Possibility of correlations between exposure variables and unmeasured variables
Krakow B et al. (2002)*	187 sexual assault survivors with PTSD (mean age 37 years)	United States	• Compared with subjects without sleep-disordered breathing, subjects with diagnosed or suspected sleep-disordered breathing reported significantly worse nightmares, sleep quality, anxiety, depression, posttraumatic stress and impaired quality of life • Despite suffering from sleep problems for an average of 20 years, which had not responded to repeated use of psychotropic medications or psychotherapy, few subjects had been referred to sleep specialists • Sleep-disordered breathing appears widespread among survivors of sexual assault seeing help for nightmares	• Clarification of the associations between sleep-disordered breathing, distress, and physical and mental health impairment in trauma patients	
Krakow B et al. (2002)	142 female survivors of sexual assault with PTSD (mean age 37.5 years) 16% Hispanic, 3% Native American, 81% Anglo	New Mexico, United States	• Retrospective frequency of nightmares was extremely high, averaging occurrences every other night and an estimated number of nightmares greater than five per week • Retrospective assessment of nights and nightmares using the Nightmare Frequency Questionnaire is a convenient and reliable way to quantify nightmares • There appears to be little clinically meaningful difference between retrospective and prospective assessment of nightmare frequency • Nightmare frequency correlates moderately with anxiety, depression, nightmare distress, and more strongly with posttraumatic stress and nightmare impairment	• Assess the distinction between symptoms of PTSD and anxiety dreams with awakenings versus anxiety dreams without awakenings	• Correlation between frequency of nightmares and distress and impairment may be valid, but only for this sample of survivors of sexual assault • Prospective recording without adequate monitoring may affect experimental design and confound subsequent results
Krause ED et al. (2006)	405 women seeking services for violence at the hands of a current or former male partner (mean age 33 years)	A battered women shelter, a domestic violence protection order court, a domestic violence criminal court, United States	• PTSD is one factor that may increase the likelihood of further abuse by a partner over time • Although both hyperarousal and numbing symptoms were higher at baseline among women subsequently abused again, only numbing symptoms increased the odds of further abuse after controlling for the covariates • Avoidance symptoms were found to be protective against further abuse • Greater severity of interpersonal violence and shorter duration of relationship increased the risk of further abuse	• Identification of additional ecological factors (e.g. individual, relationship, systemic, perpetrator variables) that may increase or decrease risk of further abuse by a partner • Examine prospectively the impact of the separate PTSD symptoms on other forms of revictimization among survivors of interpersonal violence and survivors of other types of violence while accounting for their ecological differences	• The sample was composed mostly of low-income, minority women seeking interpersonal violence-related services, thus, the findings may not be generalizable to other groups • 19% of the original sample were not included in the final analyses • The study only examined further abuse by an index partner
Kushner MG et al. (1993)*	140 female victims of assault Aged 17 to 65 years	United States	• Perceived controllability over aversive events was associated with severity of PTSD symptoms • The association between controllability and PTSD was not mediated or moderated by measures of severity of assault		

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L'Armand K & Pepitone A (1982)	650 undergraduate students Approximately 60% men, 40% women	Urban university, United States	• Rape within either a dating or an intimate context was judged to be less serious than rape by a stranger • Rape was judged less serious when the victim's sexual history was described as either limited or extensive than when this information was not given • Females judged the rape to be more serious than did males • There were no sex differences in victim blame	• Testing of two additional mediating principles that would affect judgements of rape in a victim–rapist relationship as well as victim nonchasity: — victim damaged; and — violation of victim's rights • Test the hypothesis that sex differences in judgements of crime are general rather than specific to rape	
Laws A & Golding JM (1996)	6125 individuals: 514 victims of sexual assault (mean age 36.6 years), 5511 non-victims (mean age 42.2 years)	Los Angeles, California and North Carolina, United States	• Statistically significant associations were found between symptoms of eating disorder and history of sexual assault • After controlling for age, gender, ethnicity, income, socio-economic status and study site, persons with a history of sexual assault were more likely than those not assaulted to report thinking they were too fat, weight loss to 85% of normal, one or more anorexia symptoms, and sudden weight change (ethnicity and income modified the associations) • The circumstances of assault most strongly associated with symptoms of eating disorder were assault during childhood, assault by parents, repeated assault, coercion by threat of withdrawal of love and completed sexual contact	• Examination of the basis for the associations found in this study	• Some eating disorders that may be related to sexual assault were not assessed (e.g. bulimia and obesity) • Causality cannot be determined from the cross-sectional study
Layman MJ & Gidycz CA, Lynn SJ (1996)	83 undergraduate students: 40 unacknowledged rape victims, 20 acknowledged rape victims, 23 nonvictims	Ohio University, Columbus, Ohio, United States	• In comparison to unacknowledged victims, acknowledged victims reported more forceful assaults and indicated more resistance and clearer refusal • Acknowledged victims reported that they would be more likely to press charges against the attacker in the future • Acknowledged and unacknowledged rape victims did not differ in terms of sexual practices • Both victim groups endorsed more sexual practices than non-victims and were less likely to be involved in steady (6 months or more) relationships than nonvictims • Acknowledged victims exhibited more symptoms of PTSD and rape-related stress than unacknowledged victims, who exhibited more symptoms than nonvictims, as measured by clinical interview	• Investigation to ascertain whether features of the situation lead to construal of the event as rape or, alternatively, whether recollections of the situation are affected by the construal of the event as rape • Prospective research within individuals in the general population to examine the degree to which pre-assault differences distinguish acknowledged and unacknowledged victims • Tracking perceptions of rape over time • Examination of the processes by which sexual assault and domestic violence victims explain their assault-related experiences and come to blame themselves, others, or the situation	• Because of the low rate of acknowledged rape victims in college populations, the statistical power of this study is low • Definitional issues associated with the term rape
Lea S & Auburn T (2001)	1 convicted rapist	Prison-based Sex Offender Treatment Programme, United Kingdom	• The practical ideologies the offender drew on in recounting his versions of the rape served to construct the incident as ambiguous		
Lee MY & Law PFM (2001)*	186 Asian Americans of Chinese, Japanese, Korean and south-east Asian ethnicity	United States	• Results showed varied opinions among the four groups of subjects regarding the perceived severity of the problem • There was a perceived insignificant role of family members in inflicting sexual violence, a general tendency not to choose an immediate, confrontational stance against the perpetrator to stop sexual violence, and a preference for using help from the private domain in situations of sexual victimization • The role of shame in deterring individuals from seeking outside professional help was affected by ethnicity		

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Leserman J et al. (1996)	239 female patients from a referral gastroenterology clinic (mean age 39.4 years) 83.7% white, 16.3% nonwhite	University of North Carolina, North Carolina, United States	• Subjects with a history of sexual abuse had more pain, non-gastrointestinal somatic symptoms, bed disability days, lifetime surgical operations, psychological distress, and functional disability than those without a history of sexual abuse • Subjects who experienced physical abuse had a worse health outcome on most health status indicators • Rape (intercourse) and life-threatening physical abuse seemed to have worse effects on health than less serious physical violence and sexual abuse involving attempts and touch • Subjects first abused in childhood did not appear to differ in health from those who were first abused as adults		• The results may not be generalizable to patients seen outside referral gastroenterology practice • Potential recall bias
Letourneau EJ et al. (1996)	391 individuals: 228 with history of sexual problems (mean age 41.2 years), 165 without history of sexual problems (mean age 42.7 years)	United States	• Variables significantly related to sexual problems included having experienced: — some form of criminal victimization; — completed rape; — physical injury during the crime; — depression; and — PTSD	• Investigation to determine whether the sexual symptoms are related to the trauma, or whether they represent a more long-term pattern of sexual behavior • Determine whether individuals with PTSD-related sexual problems have different needs from other clients with sexual problems	• Retrospective reporting • A brief measure of sexual problems that was used in the study cannot substitute for a thorough assessment for sexual dysfunction
Levine-MacCombie J & Koss MP (1986)	82 female university students Aged 18 to 25 years 26 acknowledged victims of acquaintance rape, 21 unacknowledged victims, 35 avoiders	United States	• Compared to rape victims, avoiders: — were less likely to have experienced passive or internalized emotions at the time of the assault; — perceived the assault as less violent; and — were more likely to have used active response strategies • Acknowledged rape victims could be differentiated from unacknowledged rape victims by the extent to which the pattern of responses characterized their behaviour • The minimal presence of emotions such as fear, helplessness, guilt, shock, hurt and unhappiness was a powerful determinant of rape avoidance		
Lewis SF et al. (2005)	*National probability household sample* 4009 women Aged 18 to 34 years 80.2% Caucasian, 11% African American, non-Hispanic, 5.4% Hispanic, 1.7% Native American, non-Hispanic, 1.1% Asian American, non-Hispanic	United States	• Increased likelihood of seeking informal help was associated with younger age, history of sexual assault, and post-year diagnoses of PTSD and major depressive episode • Increased likelihood of seeking formal help was associated with younger age, Caucasian racial/ethnic status, history of sexual assault, history of physical assault, and past-year diagnoses of PTSD and major depressive episode	• Prospective analysis of the impact of sociodemographic, assault history, and mental health variables on seeking of formal and informal help	• Retrospective assessments • Diagnostic information based on a nontraditional telephone interview procedure and not confirmed by face-to-face diagnostic interview • It was not possible to assess events that directly impacted or drove help-seeking behaviour

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Lira LR, Koss MP & Russo NF (1999)	17 Mexican immigrant women Aged 22 to 55 years (mean age 31.8 years)	Rural Arizona, United States	• Participants made a clear distinction between *rapto* and *violación* that underscores the necessity of translating research instruments in ways that capture the language usage of the culture for whom they are designed • Child rape was a concern in these women's communities, and it provoked more expressions of disgust, horror and anger than did sexual violence perpetrated on older victims • Rape was defined mainly in terms of three dimensions: the specific behaviours involved, the nonconsent of the victim and the level of force exerted by the perpetrator • The explanations that emerged for rape motivation focused on the perpetrator, including the ideas that rapists need to satisfy their sexual needs, are sick or mentally ill, are under the influence of drugs, or have something wrong inside • Participants recognized that husbands frequently exhibited behaviours towards their wives that could be labelled as rape • Keeping silent was a consistent theme, particularly when talking about the experiences of childhood sexual abuse and date rape. Fear, shame, and self-blame were mentioned as the main motives for silence in these contexts		
Litz BT et al. (1992)*		United States	• The PTSD subjects reported more current health problems, but no more physician-diagnosed disorder than the non-PTSD cohort		
Litz BT et al. (1997)	457 Viet Nam combat veterans	United States	• Hyperarousal symptoms were the most robust predictor of emotional numbing symptoms of PTSD (disinterest, detachment and restricted range of affect) • There was an absence of an association between a diagnosis of major depressing and emotional numbing related symptoms • No significant relationship was found between emotional numbing and the diagnosis of substance abuse	• Examination of the specific relationship between all PTSD symptom clusters and other types of symptoms and disorders commonly reported by traumatized individuals • Examination of the causal relationship between hyperarousal and emotional numbing related symptoms	• The assessment procedures required participants to make highly general judgements about their emotional behaviour
Logan TK et al. (2005)	30 women (mean age 37 years)	18 rural and 12 urban rape crisis centres, United States	• Survivors of rape experienced many barriers to service utilization • There were some barriers to service utilization that were mentioned only in rural areas and some that were mentioned only in urban areas • Barriers to health and mental health services overlapped with barriers to criminal justice system services • Many rural women indicated they believed that the crimes of violence against women in their communities are low priorities for the criminal justice system	• Comparing women's perceptions with more objective data or other data sources to improve understanding of barriers to service use	• The results are likely to be biased due to the methodology, sample selection, and small number of participants • There were characteristics that differentiated rural and urban situations that could not be controlled
Logan TK et al. (2004)*		United States	• Women faced many barriers to service use including affordability, availability, accessibility and acceptability • It took an inordinate level of effort to obtain all kinds of services, however, women with victimization histories faced additional barriers over and above those faced by women without victimization histories • Barriers to health and mental health service utilization overlapped with barriers to utilizing the criminal justice systems • There were many similarities in barriers to service use between rural and urban women, but also some important differences		

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Lonsway KA & Kothari C (2000)	361 first-year undergraduate students	Large midwestern university, United States	• Results indicated that First Year Campus Acquaintance Rape Education had a positive impact on participants' attitudes to and judgements of a hypothetical scenario, but only when assessed immediately following workshop participation • Increases in knowledge were maintained for a period of up to 7 weeks, and telephone survey responses revealed an increase in the level of support for rape prevention efforts 4 to 6 months following programme participation • Superior outcomes were observed among students involved in more than one educational programme	• Investigation into questions of programme content and format manipulating various elements to determine which are most effective for achieving desired outcomes • Continual innovation in designing behavioural outcome measures for rape prevention education	• The study focused on issues of methodology and design rather than the content of the educational programme • The study failed to address the effect of participation in the programme on behavioural sexual aggression • The study relied on two telephone survey questions as an assessment of behavioural outcomes
Lothian J & Read J (2002)*	74 members of mental health consumer groups	New Zealand	• Two thirds of the participants reported sexual, physical or emotional abuse at some point in their lives, but only 20% had been asked about abuse on assessment • The likelihood of being asked about abuse was higher the more recently the assessment had been made • 69% of those who reported abuse believed there was a connection between having been abused and their mental health problems, but 17% thought the clinician saw such as connection • Those reporting abuse were more likely than other participants to believe that their diagnosis was not an accurate description of their difficulties and to be dissatisfied with their treatment		
Lown EA & Vega WA (2001)	1155 women with current male partners Aged 18 to 59 years	Fresno County, California, United States	• Women reporting physical or sexual violence by an intimate partner in the previous year were more likely to report fair/poor overall health, physical health and mental health, as well as worse comparative health, a history of heart problems, persistent health problems, and numerous somatic symptoms • Physical or sexual interpersonal violence was associated with a poorer self-assessment of health and many health symptoms among this Mexican American population		• The study relied on self-report of chronic medical problems and health symptoms • The study's use of a brief measure to assess abuse may have resulted in an undercount of incidents of abuse • Cross-sectional design
Mahoney P (1999)	201 survivors of sexual assault Aged 18 years or older	United States	• Survivors of marital sexual assault were significantly more likely than survivors of assault by an acquaintance or stranger to experience multiple assaults • Survivors of marital sexual assault were less likely to seek medical, police, or agency help	• Refinement of the measurement of level of acquaintance to better explore the impact of victim/offender relationship in sexual assault • Examination of the effect of rape chronicity on the physical and psychological consequences of sexual assault	• The level of chronicity found in the study could have been inflated as a result of reporting uncertainties • The survey design may have influenced the different rates for help-seeking found • Husband and ex-husband offenders were included in the same group • Some survivors had more than one record in the data set • Subjects overall had a low total household income

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Major B, Mueller P & Hildebrandt K (1985)	247 women who underwent 1st trimester abortion 41.8% 19 years of age or younger, 37.3% aged 20 to 24 years, 20.9% aged 25 years or older 88% white, 11% black	Private abortion clinic, large metropolitan area, United States	• Subjects who blamed their pregnancy on their character coped less well than those who did not blame their character • Self-behaviour blame was unrelated to coping • Subjects who had high coping expectations before the abortion coped much better than those with low coping expectations		
Maker AH, Kemmelmeier M & Peterson C (2001)	131 women Aged 18 to 43 years (mean age 22.2 years) 69% Caucasian, 15% African American, 4% Asian American	Three Midwestern universities, United States	• Childhood sexual abuse before the age of 16 years was the only predictor of later sexual assault among comorbid risk factors • Sexual abuse by peers, number of perpetrators, age at time of sexual abuse and severity of sexual abuse did not increase the risk for later sexual assault • Adult victims of sexual assault showed lower levels of mental health functioning than did survivors of childhood or peer sexual abuse	• Assessment of multiple stressors in different samples to better clarify risk factors for revictimization in varied populations • Exploration of peer sexual assault as a separate phenomenon from childhood sexual abuse to better assess its unique predictors and psychological consequences • Exploration of the characteristics and behaviours related to childhood sexual abuse, such as victim identity, high-risk sexual behaviours, learned helplessness and incorrect attributions that might place survivors of childhood sexual abuse at higher risk for sexual assault during adulthood • Exploration of the relationship between childhood sexual abuse and sexual assault during adulthood and their ramifications in different populations	• Retrospective self-reports were used • Caution should be used in drawing causal inferences from these data • The study did not examine the underlying mechanisms for the increased risk for sexual revictimization • The study did not allow for a systematic comparison of various ethnic groups
Malamuth NM et al. (1991)	2652 male undergraduate students who behaved aggressively towards women either sexually, nonsexually or both	United States	• The model identifies key characteristics of sexual aggressors, with four latent constructs of attitudes, delinquency, hostile masculinity and sexual promiscuity • The findings supported the model in which a hostile home environment affects delinquency, which in turn influences the sexuality and hostility paths		• Cross-sectional data were used • Retrospective data were used
Marhoefer-Dvorak S et al. (1988)	52 rape victims who had been assaulted from 3 months to 34 years previously Aged 17 years or older	St Louis metropolitan area, Missouri, United States	*Part 1:* • Victims of single and multiple rapes did not differ in terms of psychological functioning postrape *Part 2:* • Rape victims with prior history of major victimization were more assertive than victims without such a history • Rape victims with a prior history of major victimization had more problems with somatic symptoms than victims without such a history	• Address possible shifts in attribution as a result of repeated victimization	

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Martin K, Vieraitis LM & Britoo S (2006)	Census data from 238 cities with a population of 100 000 or more in the year 2000	United States	• In cities with higher levels of deprivation, rape rates were significantly higher • Cities with a higher percentage of young members of the population (ages 18 to 34 years) reported significantly higher rape rates • The strongest predictor of rape rates was percentage of divorced females • A negative relationship was found between population density and rape rates	• Incorporation of these data into longitudinal studies to examine changes in correlates of rape across the past 30 years	• There are limitations associated with using the UCR rape rate for the dependent variable
Mason GE, Riger S & Foley LA (2004)	157 female undergraduate students Aged 18 to 49 years (mean age 22.4 years) 78% white, 10% African American, 4% Asian American, 3% Hispanic American, 5% other	United States	• Unacknowledged victims attributed more responsibility to the victim than either acknowledged victims or nonvictimized participants (the differences were not significant) • Acknowledged victims rated the level of violence in their assault as significantly higher than the rating given by unacknowledged victims • Acknowledged victims were significantly younger at the time of their assault than unacknowledged victims • Participants who were more accepting of rape myths attributed more responsibility to the victim than did those less accepting of rape myths • Participants, regardless of their level of acceptance of rape myths, did not differ significantly in their view on whether the incident was date rape		• The use of scenarios restricts how realistic the described assault may be for participants • There were indications of a ceiling effect for the Likert-type ratings statements • The sample subjects may differ from the general population in their perception of the scenario due to their exposure to sexual assault education programmes
Matsushita-Arao Y] (1997)*	42 women survivors of adult forcible rape identified by rape crisis centres	United States	• Survivors identified by rape crisis centres reported experiencing less total, behavioural, and characterological amounts of self-blame currently than they retrospectively reported experiencing immediately after they were raped • The best predictor of current total amount of self-blame using pre-assault, assault and post-assault variables was the relationship to the assailant(s) – survivors who knew their assailant(s) reported experiencing more self-blame • The best predictor of current severity of depression was the amount of time since the rape – as the amount of time increased, the survivors reported experiencing less depression • Three types of rape crisis centre counselling responses were judged to be helpful in reducing feelings of self-blame: — supportive responses; — psychoeducational responses; and — those responses addressing the issue of blame • There was an inverse relationship between the number of contacts with rape crisis centre counselling for the rape and the current total amount of self-blame – as the number of contacts increased, the survivor reported experiencing less self-blame		

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McCauley J et al. (1997)*	1931 women Aged 18 years or older	Community based, primary care practices, United States	• History of childhood abuse was reported more commonly among the youngest subjects • Regardless of age, women who reported childhood abuse were less likely to be married • Subjects reporting childhood but not adult abuse had levels of physical symptoms and psychological problems that were as severe as those of adult subjects experiencing current abuse • Symptom and complaint levels were highest for subjects reporting both current and past abuse		
McCaw B et al. (2002)*	177 female victims of domestic abuse Aged 17 to 81 years	United States	• The most cited reasons for victims to accept referrals were unhappiness with current situation, wanting to leave or change the situation, concern about children who witness abuse and the suggestion by a health care practitioner that the patient's symptoms could be related to the abuse • Most victims reported having symptoms of depression in the previous year		
McGrath ME et al. (1997)*	207 physicians, nurses, social workers	United States	• 68% of the staff members indicated that they never/rarely screen for sexual assault • 63% had knowledge of existing protocols for sexual assault • Providers trained in sexual assault were more likely to screen for sexual assault • Barriers that the majority of staff experienced in the care of victims of sexual assault included: frustration that the victim would return to an abusive partner, concerns about misdiagnosis, lack of time, personal discomfort, reluctance to intrude into familial privacy, and lack of 24-hour social service support		
McMillen JC, Smith EM & Fisher RH (1997)	195 survivors of disasters	United States	• Perceived benefit 4 to 6 weeks after a disaster predicted post-traumatic stress disorder 3 years later • Perceived benefit moderated the effect of severity of disaster exposure on mental health diagnosis change over time • Without perceived benefit, as exposure severity increased, the amount of recovery decreased • If benefit was perceived, as exposure severity increased, the amount of recovery increased	• Longitudinal studies concentrating on disentangling the relationships among coping strategies, benefits perceived and adjustment	• The use of a single item to assess rates of benefit • Limited range of dependent variables • It is not possible to draw causal conclusions
Mechanic MB & Resick PA (1998)	92 rape victims Aged 18 to 51 years (mean age 29.2 years)	United States	• Deficits in reported memory for parts of a traumatic event were relatively common when assessed shortly after the trauma • Memories for rape did not operate like memories for ordinary events – women reported improvement in the completeness of reported memories of the trauma over time • Recall deficits were associated with decreased perception of life threat		• The test of the simple forgetting model was a crude one • Reports of memories were studied, and their accuracy was not verified • The measures of reported amnesia and general memory were limited by their brevity

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Messman-Moore TL, Brown AL & Koelsch LE (2005)	339 women undergraduate students Aged 18 to 22 years (mean age 19.18 years) 90% Caucasian, 1.8% African American, 0.6% Hispanic, 1.2% Native American, 2.1% Asian American, 2.4% bi-racial, 0.9% other	Miami University, Oxford, Ohio, United States	• Both post-traumatic symptomatology and self-dysfunction were found to be associated with a history of childhood and adult sexual victimization • A history of adult victimization was associated with greater self-dysfunction than a history of childhood victimization • Both post-traumatic symptomatology and self-dysfunction predicted revictimization during the study; however, self-dysfunction also predicted victimization in the absence of prior victimization • Sexual victimization (as a child or adult) prior to the study predicted post-traumatic symptomatology, which predicted self-dysfunction, which predicted victimization during the study	• Examination of PTSD symptom clusters rather than PTSD as an entity to determine whether certain aspects of the disorder impact vulnerability more than others • Prospective and longitudinal studies with more diverse samples to further examine post-traumatic symptomatology and self-dysfunction • Study to determine what factors relevant to self-dysfunction appear salient to issues regarding vulnerability to rape and revictimization	• The sample comprised mostly Caucasian, upper class, young women – thus, findings may not be generalizable to other populations • Examination of clinical phenomena in college students may be problematic • Findings should be considered in light of the number of women (re)victimized during the study
Meyer CB & Taylor SE (1986)	58 females who had been raped within the past 2 years Aged 16 to 76 years	6 rape crisis centres in Southern California, 1 rape crisis centre in New York, United States	• High levels of behavioural and characterological self-blame for rape were found • Both behavioural and characterological self-blame were associated with poor post-rape adjustment • Societal blame was the only causal attribution for rape that was not associated with adjustment • Remaining at home and withdrawing from others were both associated with poor adjustment • The used of stress reduction techniques was associated with good adjustment		• Respondents in the study were recruited from rape crisis centres, which makes them different from other populations of rape victims • The use of factor analysis with so small a sample
Millar G, Stermac L & Addison M (2002)*	1118 female victims of sexual assault who presented for treatment to a specialized sexual assault care centre Aged 14 to 83 years	Canada	• The severity of the attack prompted women to seek treatment earlier • Women who were assaulted by a known perpetrator were more likely to delay seeking assistance		
Moeller TP, Bachmann GA & Moeller JR (1993)*	668 middle-class females	Gynaecological practice, United States	• In comparison to women not abused during childhood, those who had been abused reported significantly more hospitalizations for illnesses, a greater number of physical and psychological problems, and lower ratings of their overall health • The greater the number of childhood abuses, the poorer the adult health and the more likely that subjects experienced abuse as adults		
Monto MA & Hotaling N (2001)	1286 males arrested for attempting to hire street prostitutes Aged 18 to 88 years (mean age 38 years) 60% white, 17% Hispanic, Chicano, or Latino, 13% Asian, 5% black, 5% other	San Francisco, California, Las Vegas, Nevada, Portland, Oregon, United States	• Results showed low levels of acceptance of rape myths among subjects, but a small number expressed higher levels • The strongest predictors of acceptance of rape myths were attraction to violent sexuality, regular use of prostitutes, sexual conservatism and thinking about sex less frequently • There was no relationship between acceptance of rape myths and the experience of sexual and physical abuse as a child		

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Muehlenhard CL & Hollabaugh LC (1988)	610 women undergraduate students (mean age 19 years)	Texas A&M University, College Station, Texas, United States	• 39.9% of the women had engaged in token resistance at least once • The women's reasons for engaging in token resistance fell in three categories: practical, inhibition-related and manipulative reasons • Women who had engaged in token resistance were more likely than other women to believe that token resistance is a common behaviour among women, that male–female relationships are adversarial, that it is acceptable for men to use physical force in male–female relationships • Sexually inactive women who had not engaged in token resistance were the most erotophobic • Women who had emotional, religious or moral concerns had more traditional gender role attitudes than other women • Women who engaged in token resistance for game-playing reasons seemed to endorse a forceful approach to sexuality – their acceptance of male dominance seemed to be specific to physical force in sexual situations		• The study was conducted in an environment where men tend to endorse traditional gender role attitudes
Muehlenhard CL & Linton MA (1987)	635 undergraduate students 294 men, 341 women	Texas A&M University, College Station, Texas, United States	• Risk factors for sexual aggression were found: the man's initiating the date, paying all the expenses, and driving; miscommunication about sex; heavy alcohol or drug use; "parking"; and men's acceptance of traditional sex roles, interpersonal violence, adversarial attitudes about relationships, and rape myths		• Causality cannot be inferred from the data
Mulugeta E, Kassaye M & Berhane Y (1998)*	1401 female high school students	Addis Ababa, Western Shoa, Ethiopia	• 78% of respondents believed that rape was a major problem • Social isolation, fear and phobia, hopelessness and attempted suicide were reported by rape victims		
Murphy CM et al. (2001)	303 heterosexual couples with an alcoholic male partner Aged 21 to 65 years 94% Caucasian, 3% African American, 1% Hispanic, 2% unknown	Addictions treatment programmes, Massachusetts, United States	• Several distinct mechanisms involving antisocial personality characteristics, severe early onset alcohol problems, use of other drugs, relationship distress, and cognitive variables were important correlates of partner violence among alcoholic patients	• Investigation into the potential protective effect of cessation of drug use on partner violence in substance-dependent populations • Further investigation of the role of substance abuse in partner violence, with studies designed to examine complex models that include both distal variables in the personality, relationship, and cognitive domains, as well as proximal influences of acute intoxication from alcohol and other drugs	• Cross-sectional data
Murphy SM et al. (1988)	391 adult females Aged 18 years or older 72.9% white, 26.6% black, 0.6% other	United States	• Victims of childhood sexual abuse could be distinguished from nonvictims by a pattern of elevated anxiety, heightened interpersonal sensitivity, increased anger problems, more paranid ideation, and increased obsessive–compulsive symptoms • The age at which the sexual assault took place was related to current adult functioning – subjects assaulted in adolescence displayed more elevations in hostility, interpersonal sensitivity, obsessive compulsive symptoms, anxiety and paranoid ideation than nonvictims	• Identification of the mechanisms whereby adult revictimization leads to so much poorer long-term adjustment	

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Murphy WD, Coleman EM & Haynes MR (1986)*	208 males Aged 18 to 69 years	United States	• Acceptance of rape myths showed a significant zero-order correlation with coercive sexual behaviour • Both self-reported sexual arousal and penile tumescence measures were significantly related to attitudinal measures, social perceptions measures, and self-reported likelihood to rape		
Mynatt CR & Allgeier ER (1990)*	125 female under-graduate students	United States	• 42% of the subjects had experienced at least 1 episode of sexual coercion • The majority of the victims had been coerced by people they knew, and only 6% of the incidents were reported to authorities		
Neville HA & Pugh AO (1997)	29 African American survivors of sexual assault Aged 18 to 59 years	Predominately white, medium-sized, midwestern community, United States	• Both general and culture-specific factors contributed to women's decisions not to report assault to the police • The majority of participants disclosed the last incident to significant and generalized others • The majority of the disclosing participants reported receiving, on average, positive reinforcement from the confidant(s)		• Small sample size • The method used to recruit participants may limit the generalizability of the results • The study only focused on the last incident experienced
Newman MB et al. (2000)	608 adult female members of a large health maintenance organization Aged 18 to 88 years (mean age 45 years)	California, United States	• Results showed significantly more self-reported health symptoms and more self-reported visits to the doctor by abused participants than among those who reported no childhood history of sexual abuse • Abused participants made more visits to the doctor related to outpatient surgery and outpatient internal medicine • People who were both sexually abused and depressed tended to visit the emergency department frequently and to make more inpatient internal medicine and ophthalmology visits than sexually abused participants who reported less depressed mood and non-abused controls		• Participants were recruited from waiting rooms, thus, could be biased towards those who make greater use of medical services in general • Due to the low return rate after completion of the initial survey, emphasis was placed on recruiting sexually abused participants, which may have skewed the subsample • Cross-sectional design
Nixon RDV, Nishith P & Resick PA (2004)	73 rape victims seeking treatment for rape-related PTSD (mean age 32.29 years)	United States	• Performance on a short-term and delayed verbal memory was strongly associated with the degree of prior traumatic experience rather than PTSD or depressive symptomatology	• Further investigation of the effects of accumulative trauma experiences and memory functioning	• The lack of a trauma-exposed, non-PTSD comparison condition prevented investigation of the separate influence of level of traumatic exposure and PTSD symptomatology on memory • Potential ceiling effects on psychopathology scores • Interpretations were based upon findings on a single measure
Norris FH (1992)	1000 adults 50% black, 50% white	4 medium-sized south-eastern cities, United States	• Of the 10 events (robbery, physical assault, sexual assault, tragic death, motor vehicle crash, combat, fire, other disaster, other hazard, any event) evaluated, sexual assault led to the highest rate of PTSD • Lifetime exposure to the 10 potentially traumatic events was higher among whites and men than among blacks and women; exposure during past year was highest among younger adults • Black men appeared to be most vulnerable to the effects of events, but young people showed highest rates of PTSD		• Self-reported data • A sample more precisely representative of the general population, pre-event measures of stress, and more detailed data on the vents experiences are all features that would have improved the study

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Norris FH & Kaniasty K (1994)	522 individuals 105 victims of violent crime, 227 victims of property crime, 190 nonvictims	State of Kentucky, United States	• Over the course of the study, victims of violent crime remained more distressed than did victims of property crime who, in turn, remained more distressed than nonvictims • The effects of crime could not be accounted for by differences between victims and nonvictims pre-crime in either social status or psychological functioning • Lasting effects were often contingent on the occurrence of subsequent crimes		
Norris FH, Kaniasty KZ & Scheer DA (1990)	392 victims of crime	State of Kentucky, United States	• 12% had contact with mental health professionals within the first few months post-crime • Use of mental health services was most prevalent when depressive symptoms were present and the crime involved violence • Among victims of violence, urban residence, high level of social support, internal locus of control, and prior experience of crime were associated with use of mental health services • The need for assistance was most pronounced when the recent incident followed other victimization experiences • The greater the support received, the more likely were victims of crime to seek help from mental health professionals • The victims who recovered from the event most rapidly were those who reported receiving mental health services at both study interviews • Sociodemographic factors were not particularly important in predicting use of mental health services		• The crudeness of the dependent measure – the measure used does not reveal anything about the nature of the service received
Norris FH et al. (2003)	Probability sample 2509 adults 907 men, 1602 women Aged 18 to 92 years (mean age 39.3 years)	Oaxaca, Guadalajara, Hermosillo, Mérida, Mexico	• The results of this investigation in Mexico were broadly similar to results of previous investigations in North America • Lifetime prevalence of exposure and PTSD were 76% and 11.2%, respectively • Risk for PTSD was highest in Oaxaca (the poorest city), persons of lower socioeconomic status and women • The impact of trauma was greater for women, and they were twice as likely as men to meet all criteria for PTSD (15% versus 7%) • Conditional risk for PTSD was highest following sexual violence • Of lifetime cases, 62% became chronic; only 42% received medical or professional care		• The study lacked the capacity to draw a truly nationally representative sample or to include small villages or indigenous communities in the design • Women were overrepresented in the psychological-interview sample • The male sample was biased in the direction of an over-inclusion of better educated and older men • The procedures used for assessing conditional risk could be improved • Retrospective design of the interview protocol

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Norris FH et al. (2001)	470 individuals 200 interviewed after Hurricane Paulina (Acapulco), 270 interviewed after Hurricane Andrew (Miami)	Acapulco, Guerrero, Mexico; Miami, Florida, United States	• Mexican culture amplified, whereas African American culture attenuated, differences in the post-traumatic stress of male and female disaster victims • Women, especially Mexican women, were more distressed than their male counterparts following major disasters in their communities • American women scored somewhat higher than American men in measures of intrusion, avoidance, and remorse, whereas the scores of Mexican women were strikingly higher than those of Mexican men • Mexican women were most likely by far to meet all study criteria for severe distress (PTSD)	• Examination of the ways in which culture and gender, alone and in combination, shape the experience of trauma and its aftermath	• Symptoms were assessed by using a relatively short measure • The possibility that some phenomenon other than culture underlies the effects found here cannot be ruled out • Cross-sectional design • The study did not identify the aspects of traditional cultures that make women so vulnerable to posttraumatic stress
Norris FH, Perilla JL & Murphy AD (2001)	470 individuals 200 interviewed after Hurricane Paulina (Acapulco), 270 interviewed after Hurricane Andrew (Miami)	Acapulco, Guerrero, Mexico; Miami, Florida, United States	• Both samples showed very strong and comparable relations between severity of trauma exposure and symptom outcomes • When severity of trauma was controlled for, the Mexican sample showed higher levels of intrusion and avoidance symptoms, and the US sample had higher levels of arousal symptoms		
Norris FH et al. (2001)	24 Mexican survivors of disasters	Guadalajara, Jalisco, Mexico; Homestead, Florida, United Status; Puerto Angel, Oaxaca, Mexico	• Event-related distress, hypervigilance, recurrent recollections, and avoidance of reminders were described more often • In addition to subjects' observed psychological and physical consequences of disasters, they articulated subtle distinctions between acute episodes of distress and lingering, indelible effects • Expressions used that could not be classified specifically as criterion symptoms were cluster analysed, and there clusters composed of *ataques de nervios*, depression, lasting trauma, and somatic complaints	• Comprehensive assessment of well-being following disasters should include *ataques de nervios*, depression and physical health, as well as PTSD	• Small, nonrepresentative sample • Predominance of working class participants • The data were analysed by residents of the United States, thus may be culturally biased
Orth U & Maercker A (2004)	*Study 1:* 137 victims of rape and nonsexual assault Aged 29 to 65 years (mean age of 38.3 years) *Study 2:* 31 victims of rape and nonsexual assault Aged 18 to 62 years (mean age 36.6 years)	German victim assistance association	• Results suggested that tails of perpetrators do not cause retraumatization among the crime victims involved in either the long- or the short-term • Trials variables (outcome evaluation, procedural justice, moral satisfaction with the court decision, relief at the court decision, stress caused by testimony, stress caused by delay before the trial begins, victim blaming by judge, and victim blaming by perpetrator or defender) did not predict post-traumatic stress reactions several years after the trial • Posttraumatic stress reactions did not increase in the first weeks after a trial		• Low response rate restricts the generalizability of the finings • Participants in both studies received support from a victim assistance association, which could have been a moderating factor of negative trial effects on victims • Retrospective assessments • Self-reports • The study was conducted in only one country which may have particularities with its legal system
O'Sullivan E & Carlton A (2001)	16 rape crisis centres 8 independent sexual assault programmes, 8 combined service programmes	North Carolina, United States	• Combined service centres heard form fewer sexual assault victims, did not routinely receive requests for hospital advocates and did not provide systematic community education • Independent centres were the only ones that advanced inclusive definitions of sexual assault, incorporated cultural concerns in assessing their services and outreach, used volunteers as community educators, and targeted community education to young people and males		

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Overholser JC & Beck S (1986)	60 males Aged 18 years or older 12 rapists, 12 child molesters, 12 non-sex-offender inmates, 12 low socio-economic status volunteers, 12 infrequent dater college students	United States	• Heterosocial skill deficits were observed in child molesters and rapists in comparison with the control groups • Rapists displayed higher physiological indices of anxiety during role play scenes that demanded assertive responses • Measures of hostility or impulsivity were not useful in distinguishing child molesters and rapists from the three control groups		
Pennebaker JW, Kiecolt-Glaser JK & Glaser R (1988)	50 healthy under-graduate students 14 men, 36 women	United States	• Writing about traumatic experiences had positive effects on the blastogenic response of T-lymphocytes to two mitogens, on autonomic levels, on health centre use, and on subjective distress		
Pinzone-Glover HA, Gidycz CA & Jacobs C (1998)	152 undergraduate students 39% men, 61% women 85% Caucasian, 12% African American, 3% Asian	Two moderately sized midwestern universities, United States	• Participants in the acquaintance-rape prevention programme became more empathic toward the victim than the control group, postintervention • Within the intervention group, men changed more in their attitudes towards women postintervention than did women – the men in the intervention group became less traditional in their attitudes • Men in the intervention group became more certain of their definitions of rape situations postintervention • Prior to the intervention, women were generally more certain of their definitions than were men, with men in the intervention group approximating women's responses postintervention	• Replication of the current study • Identification of necessary and sufficient components of rape prevention programmes	
Plichta SB & Falik M (2001)	*Nationally representative sample* 1821 women Aged 18 to 64 years	United States	• Among the women who experienced violence, over half experienced sexual abuse – 42% sexual-intimate violence and 10% sexual, non-intimate violence • With respect to sexual violence, women were four times as likely to be violated by an intimate than by a stranger • Over 48% of the physically abused women also reported sexual assault; over 84% of the women who reported sexual assaults also reported physical violence • Consistently across all measures, women who experienced sexual, intimate violence, compared with women who experience physical, non-sexual violence, were far more likely to report poor or compromised health status • Women who experienced intimate sexual violence were 4–5 five times more likely to suffer from depression anxiety than women who did not experience violence • The vast majority of women who had been abused, assaulted or raped had not discussed their experiences with a doctor • While women who experienced violence were as likely as other women to have a regular source of care or regular doctor, they were far more likely to experience or perceive barriers to obtaining care • Women who experienced violence were more likely than other women to acknowledge difficulties in communicating their concerns to their doctors		• The survey results and estimates can be viewed as conservative • The data do not provide complete information on the frequency or number of assaults or gender of the perpetrators

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Radomsky NA (1992)*	120 women scheduled for comprehensive physical examinations	Parsons Clinic, Red Deer, Alberta, Canada	• Parental alcoholism and parental rigidity were associated with increased prevalence of chronic illness and physical or sexual abuse among women patients		
Regehr C, Regehr G & Bradford J (1998)*	71 victims of rape or attempted rape in adulthood	Canada	• Women with generalized beliefs that they could not control events in their lives were more likely to attribute responsibility for their rape to permanent intrapsychic factors and were more likely to be depressed • Women who perceived that they had higher levels of internal control tended to have higher levels of education, were more likely to be employed, and were less likely to be depressed more than 1 year after having been raped		
Reilly MR et al. (1992)	920 undergraduate students 386 men (mean age 20.7 years), 534 women (mean age 19.9 years) Over 90% white Americans	University of Rhode Island, Kingston, Rhode Island, United States	• Men were more tolerant of sexual harassment, more likely to believe that heterosexual relationships were adversarial, more likely to subscribe to rape myths, and more likely to admit that they might sexually assault someone under some circumstances • Significant positive correlations were found among men's self-reported tolerance for sexual harassment, adversarial sexual beliefs, acceptance of rape myths, likelihood to rape, and experience as a sexual victimizer • Among women, belief and attitude measures were positively correlated but experience of sexual victimization was not reliably related to any other measure		
Resick PA et al. (1981)	252 individuals *Victim group:* 93 rape victims recruited from a rape crisis centre Aged 15 to 71 years *Control group:* 87 women recruited from social service agencies (mean age 28.6 years) *Single-testing victim groups:* 72 victims recruited from a rape crisis centre	United States	• Victims experienced programmes in social adjustment postrape • The day-to-day functioning of victims was impaired up to 8 months following the assault • Many of the victims reported taking time off their jobs or being fired because of the overall disruption resulting from the rape • Many victims quit their jobs because they were unable to continue working in vulnerable settings • Victim's involvement with the criminal justice system created more disruptions affecting work and financial adjustment • Social and leisure activities were disrupted for 2 months following the rape • The two areas showing the least disruption were those concerning the victim's immediate family and other relatives		
Resick PA & Schnicke MK (1992)	39 rape victims (mean age 30.6 years) 19 completed cognitive processing therapy, 20 comparison sample	United States	• Survivors who received cognitive processing therapy improved significantly from pre- to posttreatment on both PTSD and depression measures and maintained their improvement for 6 months • Many of the women in the treatment group reported substantial improvement in the quality of their lives	• Assessment of the relative importance of cognitive processing techniques compared with pure exposure • An evaluation of the relative effectiveness of a longer exposure component in determining an optimal treatment • Comparison of the effectiveness of writing and reading and imaginal exposure techniques • Investigation to determine if there are differences in outcome between group and individual cognitive processing therapy	• Subjects were not randomly assigned, creating a quasi-experimental design • As the treatment was not compared with other treatments its superiority cannot be assessed

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Resick PA et al. (2002)	121 female victims of rape (mean age 32 years) 71% white, 25% African American, 4% other	United States	• Both cognitive processing therapy and prolonged exposure were highly successful in treating PTSD as well as depressive symptoms in this sample of chronically distressed rape victims • Cognitive processing therapy was superior to prolonged exposure in remediating guilt cognitions	• Examination of the full range of variables that might have affected treatment completion	
Resnick HS et al. (2000)	3006 female rape victims who received postrape medical care Aged 18 years or older	United States	• The majority of rapes were perpetrated by someone known to the victim • Of the 56 subjects who had a medical examination following the incident, a slight majority informed the health care provider of the sexual assault • African American, Hispanic and Native American subjects were more likely to receive medical care follwing the rape than were white or other subjects • Fear of death or injury during the assault increased the likelihood that subjects would receive medical care following the rape • Use of drugs or alcohol decreased the likelihood that subjects would receive medical care following the rape • Postrape concerns such as fear of sexually transmitted diseases, HIV/AIDS, or public identification was positively associated with medical care following the rape • Subjects were 9 times more likely to receive timely medical care if the rape was reported to the police • One in five victims reported an adult rape to police or other authorities		• Correlational nature of the study • Sample size attrition • Potential recall bias • Because this was a residential telephone survey, homeless women and those who do not have a residential telephone could not be included
Resnick HS et al. (1993)	4008 adult women (mean age 44.9 years) 85.2% white	United States	• Lifetime exposure to crimes that included sexual or aggravated assault or homicide of a close relative or friend was 36% • Overall sample prevalence of PTSD was 12.3% lifetime, and 4.6% within the past 6 months • The rate of PTSD was significantly higher among crime than noncrime victims (25.8% vs. 9.4%) • History of incidents that included direct threat to life or receipt of injury was a risk factor for PTSD	• Epidemiological studies of PTSD to include a more comprehensive assessment of sexual assault as a risk factor	
Resnick HS et al. (2005)	205 female victims of forced vaginal, oral or anal penetration within the previous 72 hours Aged 15 years or older (mean age 26.1 years) 48% African American, 50% white	United States	• Early levels of distress predicted psychopathology at the 6-week point • Women who saw the videotape intervention prior to the forensic examination were significantly less likely to report anxiety or distress most of the time or all of the time while watching the video than women in the standard treatment condition who reported anxiety or distress most or all of the time while waiting for the examination • At 6 weeks post-rape, marijuana use was significantly lower in women receiving the video intervention • No significant differences were noted in abuse of alcohol or hard drugs at 6 weeks postrape between the two groups	• Evaluation of which components of early treatment following exposure to traumatic events, such as imaginal or in vivo exposure, psychoeducation or cognitive restructuring, are most effective • Assessment of the optimal timing and duration of specific intervention strategies post-trauma • Control for history of prior traumatic events or other patient history characteristics when evaluating effects of treatment	

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Resnick HS et al. (1999)	48 adult victims of forced vaginal, oral or anal penetration within the previous 72 hours (mean age 30.63 years) 51.9% African American, 48.1% Caucasian	United States	• Psychological distress at the time of the forensic exam was strongly related to PTSD symptomatology 6 weeks postrape • The acute postrape hospital-based video intervention successfully reduced distress during forensic examinations		
Richardson D & Campbell JL (1982)	187 undergraduate students 90 male, 97 female	United States	• The male offender was attributed less and the situation was attributed more responsibility when the offender was drunk than when he was sober • Subjects derogated the female victim's character and assigned her greater responsibility when she was drunk than when she was sober • Victim's intoxication had no effect on participants' attributions of relative blame		
Rosenthal EH, Heesacker M & Neimeyer GJ (1995)	245 undergraduate students 122 male, 123 female Aged 18 to 22 years	Large southern university, United States	• Intervention recipients adhered less to rape myths and expressed less rape-supportive attitudes than did controls • There was no significant difference in intervention effects for gender or traditionality		• The intervention and several of the dependent variables were geared towards only one form of sexual aggression, date rape, which limits the generalizability of the results • All participants were college students, limiting generalizability of the results • Low reliabilities, which may obscure statistically significant effects
Roth S, Wayland K & Woolsey M (1990)*	540 females 345 female undergraduate students, 195 female college employees	United States	• Victims of sexual assault were almost twice as likely as non-victims to meet given criteria for a psychiatric case • Date rape victims were as distressed as victims of chronic childhood assault • Repeated victimization was related to denial, a symptom of post-traumatic stress		
Rothbaum BO et al. (1992)*	95 female victims of rape Aged 17 to 65 years	United States	• PTSD and related psychopathology decreased sharply between soon after the assault and 4 weeks after the assault for all subjects • Victims whose PTSD persisted throughout the 3-momth study did not show improvement after the 4-week assessment • Subjects who did not meet criteria for PTSD 3-months after the assault showed steady improvement over time		
Ruch LO et al. (1991)*	184 females admitted to a sexual assault treatment centre Aged 14 years or older	United States	• Relationship to the assailant was the only assault variable with a significant effect on trauma		

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Ruch LO & Chandler SM (1983)	326 victims of sexual assault admitted to a treatment centre Aged 14 to 72 years	Urban hospital, United States	• Trauma level was affected by variables relating to the attack, the victim's demographic characteristics, social support systems and prior stress • Mental illness, substance abuse problems, and significant recent life-changes drastically reduced a victim's coping ability in the aftermath of a rape • Victims with prior experiences of sexual assault were significantly less traumatized		
Sanday PR (1981)	156 tribal societies	United States	• Rape in tribal societies is part of a cultural configuration that includes interpersonal violence, male dominance and sexual separation • In tribal societies women are often equated with fertility and growth, men with aggression and destruction • Rape is interpreted as the sexual expression of these forces in societies where the harmony between men and their environment has been severely disrupted		
Sandberg DA, Matorin AI & Lynn SJ (1999)	323 female undergraduate students	United States	• Post-traumatic symptomatology, but not dissociation, moderated the link between previous and subsequent sexual victimization • Neither post-traumatic symptomatology nor dissociation mediated revictimization	• Replication of current study among noncollege, community and clinical populations	• Other forms of maltreatment or trauma that might account for repeat sexual victimization were not included • Possible response bias
Santello MD & Leitenberg H (1993)*	401 female undergraduate students who had been victims of sexual aggression by an acquaintance since age 16 years	United States	• Two years on average after the assault, victims reported more psychological problems on the Brief Symptom Inventory than a comparison group who had not been assaulted since age 16 • Disengagement methods of coping with sexual aggression per se accounted for unique variance in general psychological distress as measured by the Global Severity Index of the Brief Symptom Inventory and in post-traumatic stress disorder (PTSD) symptoms as measured by a DSM-III-R derived checklist		
Santiago JM et al. (1985)*	35 rape victims Aged 20 to 60 years 110 nonabused matched control subjects aged 18 to 66 years	United States	• Rape victims were found to be significantly more depressed, generally anxious and fearful than control subjects • Only 1 rape situation variable, the survivor having been a prior victim of sexual assault, was found to be related to a higher degree of depression and anxiety		
Saunders BE et al. (1992)	391 women Aged 18 years or older 72.9% white, 27.1% black or other	Charleston County, South Carolina, United States	• Childhood rape victims were more likely than nonvictims to have ever met DSM-III diagnostic criteria for a major depressive episode, agoraphobia, obsessive–compulsive disorder, social phobia and sexual disorders • Child rape and molestation victims were more likely than victims of noncontact assault to have had crime-related PTSD	• Exploration of the factors related to victims and incidents of childhood sexual abuse that are related to specific types of psychological problems and mental disorders • Studies are needed to explicate the bio-psycho-social mechanisms that tie experiences of childhood sexual assault to increased risk for mental disorders • Retrospective and longitudinal studies designed to track the development of mental health problems among victims	• The limits of retrospective, associational, risk factor research must be acknowledged • The representativeness of the sample is questionable • Only selected major mental disorders were assessed • The issue of retrospective screening for victimization is complicated by adaptive responses used by some victims of childhood sexual assault

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Schwartz MD & Leggett MS (1999)	65 rape victims	Ohio, United States	• There was no evidence that women raped due to intoxication were less affected emotionally than women who were raped by force • There was no evidence that women raped due to intoxication blame themselves more than women who were raped by force • Most victims did not classify their experiences as rape		
Sharkansky EJ et al. (1999)	86 inpatients in a substance-abuse treatment programme (mean age 40.64 years) 97.7% male, 2.3% female 80.3% white, 16.9% African American, 2.8% Hispanic	Boston, Massachusetts, United States	• PTSD diagnosis was related to substance use in situations involving unpleasant emotions, physical discomfort, and interpersonal conflict, but not to substance use in other situations		• Retrospective data • The study did not assess for the presence of additional psychiatric diagnoses
Short LM, Hadley SM & Bates B (2002)*	327 health care providers	United States	• Providers at WomanKind hospitals (a non-profit health care based programme for victims of domestic/intimate-partner violence) demonstrated significantly higher knowledge, attitudes, beliefs and behaviours than those at comparison hospitals		
Smith ME & Kelly LM (2001)	7 women rape victims Aged 22 to 60 years 100% Caucasian	United States	• The thematic structure of a woman's recovery from rape comprises three main themes: reaching out, reframing the rape and redefining the self		
Sorenson SB & Golding JM (1990)*	2700 adults 1415 Hispanic, 1285 non-Hispanic white	United States	• Men and women reported roughly equal rates of criminal victimization • Hispanics reported fewer victimizations than non-Hispanic whites • Bring a crime victim was associated with increased suicidality and depression • Increased risk of suicidality following criminal victimization occurred irrespective of race, gender, education and current mental disorder • Those who were mugged, sexually assaulted or experienced multiple victimization were at greatest risk for depression		
Sorenson SB et al. (1991)*	3131 adults	United States	• Of the 433 sexually assaulted respondents, two thirds reported more than 1 incident – the average number of incidents per person was 3.2 • Victims of a single of sexual assault did not differ from those who had suffered multiple incidents on a wide range of variables including demographics, mental disorders, and general functioning • Once an initial victimization had occurred, personal characteristics of the victim were not related to risk for subsequent sexual assault		
Sorenson SB & Telles CA (1991)*	2392 individuals 1243 Mexican Americans, 1149 non-Hispanic whites	United States	• Subjects who met criteria in the DSM-III for lifetime mental disorder were more likely to be physically aggressive towards a spouse and were more likely to have been sexually victimized by an intimate		

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Stephens RS & Roffman RA (2000)	291 adult marijuana users seeking treatment (mean age of 34 years)	United States	• Marijuana use, dependence symptoms and negative consequences were reduced significantly in relation to pretreatment levels at follow-ups for both the extended group intervention and the brief individual intervention	• Examination of the possibility of matching clients to appropriate treatment on the basis of individual characteristics	• Generalization of the findings may be limited to treatment-seeking marijuana users with similar sociodemographic characteristics
Stewart BD et al. (1987)*	118 victims of sexual assault	United States	• Compared to victims who sought treatment within 1 month of their assault, more of those who delayed treatment seeking were raped by someone they knew, and fewer used physical means to defend themselves against the assailant • Those who delayed treatment-seeking reported considerable rape-related distress and were more anxious and significantly more fearful than were victims of recent rape		
Stewart SH et al. (2000)*	294 adult women substance abusers	Canada	• PTSD symptoms were significantly positively correlated with frequency of heavy drinking in negative situations, but unrelated to frequency of heavy drinking in positive and temptation situations		
Stormo KJ, Lang AR & Stritzke WGK (1997)*	742 undergraduate students	United States	• Subjects rated the victim as more, but the perpetrator as less, responsible and blameworthy after consuming alcohol • When the victim was more intoxicated and impaired than her assailant, intoxication of the perpetrator did not serve to excuse his behaviour, but incriminated him more • Women generally assigned more blame to the victim		
Sudderth LK (1998)	30 rape survivors	United States	• Participants who had been raped by men they knew often delayed telling anyone about the rape and experienced more negative reactions than those attacked by strangers • Reactions from support sources ranged from support and inconsistent support to silence/avoidance and hostility • The unpredictable pattern of reactions made all the survivors more hesitant about discussing their experiences with others		• A significant portion of the participants were or had been rape crisis volunteers, thus there may be an over-representation of participants with feminist leanings • Retrospective accounts
Sullivan CM & Bybee DI (1999)	278 battered women	United States	• Women who worked with advocates experienced less violence over time • Women who worked with advocates reported higher quality of life and social support, and had less difficulty obtaining community resources	• Evaluation of similar programmes with a more diverse sample of participants as well as more diverse types of advocate	• The diversity of the study population was limited • The diversity of the advocates used was also limited
Tarrier N et al. (1999)*	54 patients with chronic PTSD	England	• There were no significant differences between the efficacies of imaginal exposure and cognitive therapy • There was significant clinical improvement at 12-months compared with pretreatment • 39% of those followed up still met criteria for PTSD • Victims of crime displayed higher levels of symptoms at follow-up than victims of accidents		

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Taylor S et al. (1998)	103 victims of motor vehicle accidents who were referred to psychiatrists (mean age 39.4 years), 419 United Nations peacekeepers deployed in Bosnia from Canada (mean age 27.5 years)	Canada	• The findings suggests that DSM-III-R and DSM-IV PTSD symptoms are composed of two factors (intrusions or avoidance and hyperarousal or numbing), and that these factors load on a single higher order factor • Intrusions give rise to avoidance, and hyperarousal gives rise to numbing		• Investigation into whether the factor structure reported in the present study is stable across types of trauma, such as sexual assault and natural disasters • Examination of the mechanisms of PTSD
Testa M et al. (1992)*	475 women Aged 18 to 45 years	United States	• Among women receiving treatment for either alcoholism, being battered or mental health problems, subjects who had been sexually abused exhibited more psychological symptoms and lower self-esteem than subjects who had not been abused • Among women who were not currently receiving treatment, subjects who experienced supportive reactions following disclosure of sexual abuse had fewer psychological symptoms and somewhat higher self-esteem than those who did not receive support • Social support had no apparent effect on the long-term adjustment of subjects in the treatment group		
Tieger T (1981)*	392 third-year undergraduate students	United States	• A manipulation of the attractiveness of the victim produced several findings indicating that views of rape as a sexually motivated crime mediating attributions of blame to the rape victim • Gender differences in attitudes towards rape were also prevalent throughout the factor structure of beliefs that was found		
Tjaden P & Thoennes N (2000)	16 000 individuals 8000 men, 8000 women	United States	• Married/cohabiting women reported significantly more intimate-perpetrated rape, physical assault, and stalking than did married/cohabiting men • Women reported more frequent and longer lasting victimization, fear of bodily injury, time lost from work, injuries, and use of medical, mental health and justice system services		
Trowell J et al. (2002)	71 sexually abused girls Aged 6 to 14 years (mean age 10 years) 63% white, 11% black Caribbean, 10% mixed parentage, 7% Chinese, 4% Mediterranean origin 3% unknown	England	• Both treatment groups (focused individual psychotherapy and psychoeducational group therapy) showed a substantial reduction in psychopathological symptoms and an improvement in global functioning, but with no evident difference between individual and group therapy • Individual therapy led to a greater improvement in manifestations of PTSD		• Small sample size • Lack of a control group • Attrition level was higher than hoped • The therapies were so different that masking the subjects was impossible • The sample was a cohort with high level of psychological disturbance and family dysfunction

* abstract only

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SUllman SE (2000)	323 adult sexual assault victims	United States	• This study provides empirical support for the reliability and validity of a new self-report measure of social reactions to rape victims, the Social Reactions Questionnaire	• Examination of whether the length of time since the assault occurred affects social reactions reported and their relationships with adjustment	• Convenience sample • Retrospective study design • The lack of independent assessment of social reactions reported by victims • Few victims of sexual coercion and unwanted sexual contact were included • Low number of mental health agency victims included
Ullman SE (1997)	155 women Aged 18 years or older 81% non-Hispanic white, 4% African American, 5% Hispanic, 5% Asian, 5% other	Los Angeles County, California, United States	• Attributions of blame were related to assumptions about self and world, but were unrelated to self-rated recovery • Women sexually victimized in both childhood and adulthood had lower self-worth and were more likely to make external attributions of blame • Increased self-blame was related to poorer recovery for women assaulted in childhood and adulthood	• Investigate whether therapeutic attempts to modify attributions enhance recovery • Identification of potential social network responses that may be associated with attributions made by survivors of sexual assault	• Convenience sample
Ullman SE (1996)*	155 female victims of sexual assault Aged 18 years or older	Los Angeles County, California, United States	• Tangible aid/information support was more commonly received from formal support providers (e.g. rape crisis centres, police, physicians) • Emotional support/validation was more commonly reported by subjects telling rape crisis centres than subjects telling informal support providers (e.g. friend/relative) • Being blamed, treated differently, distracted and discouraged from talking about the assault were common responses experienced by subjects telling physicians or police • Emotional support from friends was related to better recovery than emotional support form others • The impact of victim blame on adjustment did not vary according to type of support provider		
Ullman SE (1996)	155 female victims of sexual assault Aged 18 years or older	Los Angeles County, California, United States	• All negative social reactions were strongly associated with increased psychological symptoms, whereas most positive social reactions were unrelated to adjustment • The only social reactions related to better adjustment were being believed and being listened to by others • Emotional support and tangible aid were unrelated to recovery • Negative social reactions of being treated differently, having someone take control, and distraction were all related to poorer self-rated recovery and to more psychological symptoms • Avoidance coping mediated the association of negative social reactions with adjustment	• Study on a larger representative sample of sexual assault victims in order to examine the prevalence of social reactions and how social reactions to victims vary according to their age at assault and the type of assault they experienced • Examination of the effects of social reactions on recovery for recently assaulted victims	• Cross-sectional design • Standardized measures of adjustment were not used in this study • Convenience sample • The sample were disproportionately well-educated, had higher income and were Caucasian

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Ullman SE & Brecklin LR (2003)	*National representative sample* 627 women with histories of sexual victimization (mean age 34 years)	United States	• PTSD and stressful life events were associated with greater odds of chronic medical conditions among women sexually assaulted in childhood only • Additional traumatic events were associated with greater odds of chronic medical conditions among victims of adult sexual assault • Older age and being married were associated with greater odds of lifetime health care professional contact for mental health/substance abuse issues among certain victim subgroups • Stressful life events were related to greater help-seeking for child victims, and traumatic events were related to greater help-seeking in adult victims • Alcohol dependence symptoms and PTSD were each associated with greater odds of lifetime health care professional contact among women victimized in both childhood and adulthood, whereas depression was related to greater odds of help-seeking for women victimized in one life phase only	• Studies of representatively sampled victims to examine the role of postassault psychological sequelae in both the health-related outcomes and service seeking patterns of sexual assault victims • Analysis of psychosocial factors in both prospective and retrospective life history studies to examine the role of varying event histories in sexual assault victims' adjustment • Longitudinal studies of woman with varying histories of sexual assault to identify risk factors for health problems and service seeking in both immediate postassault and longer term follow-up periods	• Retrospective design • Non-representative sample of sexual assaults • Small sample size of victims of sexual assault in both life phases • The health care-seeking measure was assessed as general lifetime help-seeking, not victimization-related service seeking specifically
Ullman SE & Brecklin LR (2002)	619 women sexually assaulted in childhood and/or adulthood Aged 15 to 54 years (mean age 34.04 years) 74.5% Caucasian	United States	• Victims of sexual assault in both child and adult life phases reported more traumatic life events, alcohol dependence symptoms, greater likelihood of PTSD, and mental health service seeking than victims of sexual assault in one life phase only • Women from ethnic minorities with less formal education, more traumatic and stressful life events, and longer duration of sexual abuse had greater odds of PTSD within certain sexual assault history subgroups • More education and being Caucasian were related to greater mental health service seeking • More traumatic life events predicted greater service seeking for victims of adult sexual assault • Among adult victims, stressful life events were associated with seeking help • For adult victims, current social conflict with social network members was related to increased odds of service seeking • For adult victims, having medical insurance was related to greater likelihood of service seeking	• Examination of the correlates of recovery and help seeking in women with varying histories of sexual victimization	• Retrospective design • Single-item screening questions were used to assess childhood sexual abuse and adult sexual assault • Possible recall bias • Small sample size of victims of sexual assault in both life phases • Mental health service seeking was assessed as general lifetime help-seeking, not victimization-related service seeking specifically
Ullman SE & Filipas HH (2001)	323 victims of sexual assault (mean age 30 years) 52.2% Caucasian, 26.1% African American, 6% Hispanic, 5.7% Asian, 10.1% other	United States	• Victims of stranger rapes with more injury were more likely to seek support from formal service providers • Victims seeking formal assistance reported receiving more negative social reactions when disclosing their assault than victims soliciting support from informal social network members only • Frequency of receipt of positive social reactions did not differ as a function of disclosing to formal support providers or informal sources only, with the exception of tangible aid, which was more commonly provided by formal support sources	• Replication of current study with a larger, more representative sample of victims of sexual assault • Longitudinal studies to examine formal and informal support-seeking processes • Collection of detailed data regarding women's reasons for disclosure and non-disclosure of sexual assault	

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Ullman SE & Filipas HH (2001)	323 victims of sexual assault (mean age 30 years) 52.2% Caucasian, 26.1% African American, 6% Hispanic, 5.7% Asian, 10.1% other	United States	• Less education, greater perceived life threat, and receipt of more negative social reactions upon disclosing assault were each related to greater severity of PTSD symptoms • Victims from ethnic minorities reported more negative social reactions from others • Victims of more severe sexual victimization reported fewer positive, but more negative reactions from others • Greater extent of disclosure of the assault was related to more positive and fewer negative social reactions • Telling more persons about the assault was related to more negative and positive reactions	• Current study with a more representative sample	• Retrospective design • Possible recall bias • It is not known whether results are generalizable to the larger victim population • The lack of a clinical interview assessment of PTSD
Ullman SE & Siegel JM (1994)	2364 adults (mean age 42 years) 46% male, 54% female 57% non-Hispanic white, 43% Hispanic	United States	• Exposure to traumatic events was associated with younger age, less education, recent life events and a history of psychiatric disorders • Risk of increased post-traumatic stress symptoms following a traumatic event was associated with other life events, sexual assault and household strain • Level of post-traumatic stress symptoms varied according to the type of traumatic event reported after adjusting for demographic factors • Women and younger adults reported more post-traumatic stress than other subjects	• Longitudinal studies to assess whether chronic strains and social support influence psychological symptoms of adults with and without histories of traumatic events	• Only "distressing" traumatic life events were included because of the wording of the question employed • The open-ended assessment of trauma history is likely to have resulted in underreporting of traumatic events • Retrospective design • 25% of respondents reported some "other" distressing traumatic experiences, which could not be explored in further detail
Ullman SE & Siegel JM (1993)*	240 women who were sexually assaulted in adulthood	United States	• Sexual distress was more common for women attacked by intimates • Fear/anxiety was more common for women assaulted by strangers • Depression did not vary according to the victim–offender relationship		
Vaa G, Egner R & Sexton H (2002)	38 women who had participated in time-limited multimodal group treatment for the psychological sequelae of sexual abuse	Norway	• The women had been highly symptomatic at the onset and generally improved following treatment and at follow-up • Previous therapy and pre-therapy level of symptoms predicted a higher level of post-treatment symptoms, while better post-treatment status and younger age predicted fewer symptoms at the time of follow-up • On the whole, clients perceived their interpersonal functioning as better at follow-up than it had been after treatment		• The initial and post-treatment status were not recorded using standardized tests • This is not a control study
Valentiner DP et al. (1996)	215 female victims of assault (mean age 30.4 years) 103 rape victims, 112 victims of non-sexual assault 68% African American, 29% Caucasian, 3% other	United States	• Victims showed a substantial decline in psychological disturbance during the 3 months following the assault • Three months post-assault, rape victims showed higher levels of wishful thinking and PTSD than victims of nonsexual assault • Wishful thinking showed a positive association and positive distancing a negative association with severity of PTSD, controlling for assault type, initial levels of severity of PTSD, and other coping strategies	• Investigation of the direct and indirect associations of positive distancing with severity of post-trauma symptoms • Examination of models that integrate personal, contextual and coping variables on the early course of PTSD	• The generalizability of the results is limited as many assault victims do not seek assistance from police or counselling services, and not all victims who do seek services agree to participate in research • Victims who were assaulted by family members or in the context of an ongoing relationship were not included in the study

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Van Wie VE & Gross AM (1995)	101 female undergraduate students (mean age 19.57 years) 100% white	Southeastern university, United States	• Women who indicated that they had been forced to have intercourse because their partner used some degree of physical force, waited longer to signal when the male on the audiotape should have stopped making sexual advances than a group of women with no such experience • No relationship was found between the couple's previous sexual history and the amount of time needed by participants to determine that the woman did not desire further sexual activity • No relationship was found between adherence to rape myth and response latency scores		
Watts C et al. (1998)	966 women Aged 18 years or older	Zimbabwe	• Forced sex and withdrawing sex were both used by men as a means of punishing or controlling their partners • It is commonly believed that men have a right to have sex with their wives whenever they want – except at specific times when sex is taboo • Men and women's perceptions as to whether forced sex is acceptable or not depend upon the context in which it has occurred, and the degree of physical force used • Men who threatened or who were physically violent towards their partners were more likely to force sex and/or withdraw sex than those who were not violent • Forced sex was more likely to occur in contexts where the woman may have felt she had the right to refuse sex		
Wolfe J et al. (1994)	109 female non-treatment seeking veterans of the Viet Nam War (mean age 49 years) 95.4% white	United States	• Both war-zone exposure and PTSD independently predicted health complaints in female Viet Nam War veterans • The effects associated with exposure decreased when PTSD was controlled for, whereas the effects associated with PTSD remained when exposure was controlled for	• Examination of how duration of exposure or distress may relate to subsequent health perceptions or the onset of actual structural or biological changes • Assessment of stressor chronicity to determine whether length of exposure enhances the variance seemingly contributed by PTSD • Investigation of specific mechanisms that underlie discrete symptomatology	• PTSD symptom scores are not necessarily interchangeable with a PTSD diagnosis • Self-reports of health status were used • Retrospective design • Nonrandom sampling
Workman JE & Freeburg EW (1999)	632 undergraduate students 315 men, 317 women Aged 17 to 63 years (mean age 23.6 years)	Midwestern university, United States	• Attribution of responsibility to a victim was significantly influenced by perceiver gender and victim's dress • Men attributed more responsibility to the victim than women • Perceivers' attributions of the victim's responsibility for date rape were greater when the victim was wearing a short skirt than when wearing a moderate-length or long skirt • As women's personal relevance increased, attribution of responsibility to the victim decreased • Men attributed less responsibility to the male perpetrator than women • As men's situational relevance increased, attribution of responsibility to the perpetrator decreased	• Investigation of other attributed causes of date rape • Examination of the role of situational and personal relevance in attributions of responsibility to a perpetrator • Examination of the role of situational and personal relevance in jurors' decisions about an incident of date rape • Investigation of dress as a variable in attribution of responsibility for date rape • Determination of the point on a continuum where attribution of cause leads to attribution of responsibility and responsibility to blame	

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Wyatt GE (1992)	55 African American and white women Aged 18 to 36 years	Los Angeles County, California, United States	• African American subjects were less likely to disclose incidents involving sexual assault • Many subjects experienced lasting psychological effects, including mistrust of men or people in general, continued emotional distress in connection with the abuse, specific fears and chronic depression	• Examination of the effects of both gender and ethnicity on the aftermath of rape • Investigation of the reasons for non-disclosure of rape incidents	
Wyer RS, Bodenhauden GV & Gorman TF (1985)	70 undergraduate students 50% male, 50% female	United States	• There was no evidence that subjects' personal reactions to rape are mediated by the concept that aggression is normal and socially sanctioned behaviour • Exposure to aversive consequences of aggression did not affect perceptions of the seriousness of rape and beliefs that the defendant should be punished • Activating concepts about close personal relationships between men and women generally increased both subjects' beliefs that a rape victim was harmed and their beliefs that her testimony was true; however, although it decreased beliefs that the victim was responsible when she did not resist, it increased judgements of her responsibility when she resisted • Activating intimacy-related concepts decreased beliefs that the victim was responsible among female subjects but increased such beliefs among male subjects • Portrayals of women as sex objects decreased male subjects' perceptions of the victim's credibility and increased their beliefs that she was responsible for the incident; these portrayals had the opposite effect on female subjects' belief		
Yescavage K (1999)	46 male undergraduate students Aged 17 to 24 years Approximately 90% White	Southeastern university, United States	• When a woman engaged in some sexual activity and, as a consequence, a later refusal, perceptions of her accountability for the rape increased drastically. Simultaneously, accountability ratings decreased dramatically for the perpetrator • A victim was perceived as more accountable and a perpetrator less accountable for the rape when the couple had been together longer and was sexually active • Compared to sexually aggressive men, sexually nonaggressive men made fewer negative remarks towards the victims across all scenario types		
Zoellner LA, Goodwin ML & Foa EB (2000)	76 treatment-seeking female sexual assault victims with chronic PTSD Aged 18 to 57 years (mean age of 29.61 years) 52% African American, 40% Caucasian, 4% Hispanic, 1.3% Asian, 2.7% Other	United States	• Negative life events, anger, depression and severity of PTSD were all related to self-reported physical symptoms • Severity of PTSD predicted self-reported physical symptoms beyond other variables • The reexperiencing cluster of PTSD, and not the hyperarousal cluster, was related to self-reported physical symptoms	• Inclusion of participants with acute symptoms of PTSD as well as traumatized nonanxious controls • Utilization of multiple measure of physical complaints to minimize reporting style biases as well as examine different components of physical health	• The study examined severity of PTSD and not PTSD itself • Reliance on self-reported measures of physical symptoms

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