

Endnotes

- 1 A fourth element of responses to sexual assault includes informal networks such as family, friends and peers of victim/survivors. This network is specifically acknowledged in some protocols (see, for example, Queensland Guidelines).
- 2 It is important to note however that the provision of even the most robust forensic evidence will not necessarily achieve a conviction (See Heenan & McKelvie 1996; Taylor 2001; Taylor 2004).
- 3 The range of physical health outcomes of sexual violence enumerated by the WHO include:
 - Homicide
 - Serious injuries, ranging from bruises and fractures to chronic disabilities.
 - Injuries during pregnancy leading to low birth weight, low maternal weight gain, infections and anaemia.
 - Injuries to children. Frequently, children are injured while trying to defend their mothers.
 - Unwanted and early pregnancy either through rape or by affecting a woman's ability to negotiate contraceptive use.
 - In countries where abortion is illegal, expensive or difficult to obtain, women may resort to illegal abortions, at times with fatal consequences.
 - STDs including HIV/AIDS. By affecting a woman's ability to negotiate protection leaving women vulnerable to contracting sexually transmitted diseases (STDs).
 - Women with STDs have a higher risk of complications during pregnancy, including sepsis, spontaneous abortion and premature birth. Some STDs increase a woman's vulnerability to the HIV virus, as well. Violent sexual assault may also increase their risks because resulting tears to delicate vaginal tissue allow the virus easier entry into the bloodstream. With HIV/AIDS, the consequences are usually fatal for the woman, and possibly for her children as well.
 - Vulnerability to disease, (WHO 1997, vol. 8).
- 4 A summary of mental health outcomes includes:
 - depression,
 - anxiety,
 - antisocial behaviour,
 - eating disorders,
 - suicidality, suicide ideation or completion,
 - deliberate self harm,
 - sexual difficulties,
 - Post-traumatic Stress Disorder (PTSD),
 - dissociation,
 - flashbacks and nightmares
 - personal relationship difficulties,
 - compulsive behaviours,
 - panic disorder, and
 - substance dependency, (WHO 1997, vol. 4).
- 5 According to the World Health Organisation's report, *Violence Against Women: A Priority Issue (1997)*: "At least one in five of the world's female population has been physically or sexually abused by a man or men at some time in their life. Many, including pregnant women and young girls, are subject to severe, sustained or repeated attacks." And Astbury (2001) notes that: "To date, research on sexual violence has been preoccupied with reliably establishing prevalence and documenting adverse health outcomes. As a result, there is now a rapidly growing body of evidence attesting to the high prevalence of sexual violence against women . . . in both developed and developing countries and the constantly expanding range of negative health consequences that can occur. Together, this data indicates a public health problem of truly huge proportions."
- 6 The authors suggest the syndrome manifests itself across two distinct phases – an acute phase and the longer term process of reorganisation with a period of outward adjustment in between. The main features of the "syndrome" can be summarised as:

- 1 Acute Phase – occurs immediately following the assault and lasts for several weeks, resulting in the complete disruption of the survivor's life. Reactions may include some of all of the following:
 - a Emotional Reactions – a woman's immediate response to sexual assault is characterized by disbelief, shock, and a wide range of emotions. Although fear of physical injury, mutilation, and/or death is the most common emotion, she may also experience intense feelings of anger, humiliation, degradation, shame, embarrassment, self-blame, and guilt. The woman's feelings of anger, fear, and anxiety can express themselves in crying, sobbing, smiling, shaking, restlessness, and tenseness, or she may hide her feelings and seem to be calm, composed, or subdued. Often this controlled response is misinterpreted as evidence that the assault did not really affect the woman or that it did not even occur. It is important not to interpret a controlled response as evidence that the assault did not really happen or that the events did not really affect the woman.
 - b Physical Reactions – a woman's physical reactions include soreness and bruising specific to areas where she may have been injured (throat, neck, breasts, thighs, arms, legs, or genitals); headaches, fatigue, and sleep disturbances; loss of appetite and nausea; vaginal discharge, infection, and pain associated with gynecological symptoms; and side effects from anti-pregnancy and HIV-related medication such as nausea or temporary disruptions of her menstrual cycle.
 - c Behavioral Reactions – a woman's behavioral reactions may include disturbances in sleeping patterns because of nightmares; in eating patterns because of a decrease or increase in appetite, complaints of food not tasting right, or nausea; and in her ability to concentrate because she can't block out thoughts about the sexual assault.
- 2 Outward Adjustment: a second phase that occurs is apparent outward adjustment as realistic problems and consequences replace the emotional turmoil created by the assault. Characteristics of this phase are that immediate anxiety subsides, the survivor returns to normal pursuits and seems to forget about the assault for a while. There is often a heavy measure of denial, suppression, or rationalization. Anger and depression may be diminished or subdued. The survivor will probably not want to talk to you about the assault during this stage. Some of the practical problems facing the survivor may include: deciding to move to a new location, and having to talk to friends, or co-workers.
- 3 Long-term Response: this is the sexual assault reorganisation phase, where the woman strives to come to terms with the sexual assault and incorporate it into a framework that she can understand. This phase may overlap with the first phase and continue for months or years and encompasses the survivor's process of reorganizing her disrupted life. At this stage, the issues that come up for the survivor will be complex. A woman who has been assaulted may experience some or all of the following:
 - a Changes in lifestyle – this may involve general upheaval in her living patterns such as curtailing normal activities or not going to work or school. She may change her place of residence or employment, or drop out of school in order to avoid being constantly reminded of the assault. She may change her phone number to give herself a feeling of safety. She may reach out in new directions for support.
 - b Nightmares – women report two main types of nightmares:
 - flashback dreams of the actual assault in which the woman wakes up screaming or fighting.
 - mastery dreams in which she gains power over the assailant or obtains revenge
 - c Phobias – a woman may develop fears in reaction to the circumstances of the assault. For instance, she may be afraid of being alone, or leaving the house, or of people who in some way resemble the assailant. If these fears are not acknowledged or validated, they can develop into paranoia, global anxiety, or phobias.
 - d Sexual Dysfunction – a woman may experience a range of reactions such as physical pain, loss of sexual pleasure, disinterest in sex, or dread of sex. Sexual activity may trigger flashbacks and feelings of vulnerability and disgust.

- e Compound Reactions – sometimes a woman’s reactions are compounded by problems with family, money, school or work. Sometimes she might have problems with alcohol or drug abuse.

This description has been adapted from: Sexual Assault – Victim Service Worker Handbook, Victim Assistance Program, Ministry of Attorney General, [Canada] 1993. http://www.uvss.uvic.ca/oursac/rape_trauma.htm. See also Herman 1992; Astbury 2001; and Olle 2004, Case Study Two - Adult Survivors of Childhood Sexual Assault.

- 7 Victims continue to identify this need for themselves. Just over three quarters (74 per cent) of victims who responded to a Victorian phone survey reported that they most needed support “at the time of the assault” while a further 15 per cent said support was critical at the point at which “they first remembered” (D’Arcy 1999: 52-53).
- 8 This finding relates to women between the ages of 15 and 44 years (VicHealth 2004: 25).
- 9 One of the many legacies left by traditional rape laws is the evidentiary burden placed on women to show they physically resisted the offender. The prioritising of forensic medical examinations in cases of recent sexual assault is as much a consequence of this historical emphasis on establishing the credibility of “real rape” victims as it is to ensure victims’ acute health care needs are appropriately met.
- 10 This is also true of protocols being established today. The recent *National Protocol for Sexual Assault Medical Forensic Examinations for Adults and Adolescents*, released by the United States Department of Justice in 2004, gives equal weight to the pursuit of criminal justice responses to the crime of sexual violence and the importance of victims receiving a health care response that is “sensitive, dignified and victim-centred” (2004: iii).
- 11 Carmody notes that while, “the response of individual state governments varied . . . between 1976 and 1981 Western Australia, South Australia, Victoria and New South Wales instigated public enquiries or task forces that later led to legislative reform and the establishment of sexual assault services for victims” (1992: 15).
- 12 These figures are quoted in the document titled “A coordinated approach to better respond to Drug-Facilitated Sexual Assault in Darwin Urban”, Women’s Health Strategy Unit, Department of Health and Community Services, Northern Territory Government, 2004.
- 13 Susan Brownmiller’s naming of rape as “a conscious process of intimidation by which all men keep all women in a state of fear” (1975: 15) epitomised the feminist inspired understandings of rape around this time. Sexual violence is here positioned as an expression of male power under social (and for Brownmiller biological) conditions that systematically perpetuate women’s economic, social and sexual inequality.
- 14 This is a completely inadequate description of the horrors endured by this woman. No re-telling can ever do justice to the pain and horror lived by a victim/survivor – especially not when the “re-telling” is third hand.
- 15 The Government Medical Officer (GMO) is the medical officer charged with carrying out forensic medical examinations in Queensland.
- 16 This response was provided by a worker as part of the small-scale background research undertaken for the ACSSA Briefing Paper, *Responding to sexual assault in rural communities*.
- 17 There are plans to implement SANE programs in Australia based on the model from the United States. However, this is occurring amidst a pool of controversy that some are seeing as more akin to a “turf war” between doctors and nurses. For example, two of the three full-time doctors employed in New South Wales to treat adult victims of sexual assault, Doctors Patricia Brennan and Maria Nittis, suggest that:
 - “A plan to train an initial 30 nurses to examine and take forensic samples from people who have been sexually assaulted would weigh against victims in court, because nurses have less experience in

examining women, and their testimony would be easier for defence barristers to dismiss under cross-examination than doctors.

"In a court case, 'you're going to want to be a doctor - it's not what you know, it's what you represent', said Dr Brennan, the medical director of the sexual assault unit of South Western Sydney Area Health Service.

"But Jean Edwards, the coordinator of sexual assault medical services at Northern Sydney Health, and NSW's only doctor dealing exclusively with sexual assault, said she supported . . . training nurses, 'if you want people who've been sexually assaulted to receive a speedy service close to where they live'. Karen Willis, of the NSW Rape Crisis Centre, also supported the nurse plan. 'Women are being compromised by having to wait' to be examined, she said." (Robotham 2004: 7)

There seem to be both benefits and drawbacks to the implementation of SANEs in Australia. While the literature about SANEs in the United States is resoundingly positive, a short-coming of the research has been that it is entirely generated by speaking with nursing professionals themselves. In other words, there is little research to support the notion that the experiences of victim/survivors in the care of SANEs compare far more favourably than those who have been examined by forensic practitioners.

On the other hand research into SANEs by nurse professionals is extensive and wide-ranging. The development of a professional stream undertaking specialist approaches is at least amenable to being properly scrutinised. This level of scrutiny has never been applied to physicians conducting forensic examinations in sexual assault cases. SANE nursing is relatively recent arrival to the field of professional care of sexual assault victim/survivors and is made even more visible by its contrast with the traditional forensic practitioners. The sheer volume of research into the various programs around the United States and Canada also gives these specialists a high profile.

However, a concern raised by one sexual assault service provider is the potential for nurses who participate to be striving to achieve greater professional recognition at the expense of the kinds of feminist frameworks that services have fought hard to implement and maintain in terms of their approach to service delivery. The implementation of SANE programs certainly warrant close attention given they are increasingly being introduced without any consultation with local services in terms of both how the programs will be implemented and how they might relate to any existing partnerships services might have with doctors who currently perform forensic examinations.

- 18 The conference also declared (in part) that primary health care:
 - 1 *reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;*
 - 2 *addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;*
 - 3 *includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;*
 - 4 *involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;*
 - 5 *requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;*
 - 6 *should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;*

7 *relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community* (emphasis added).

Declaration of Alma-Ata International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf.

- 19 The cohort for Mazza et al's survey was a Melbourne population of 3026 women attending their general practitioner for a consultation. Of these women 28 per cent had experienced some form of domestic violence in the previous year, 30 per cent had experienced "some form of sexual assault since the age of 16", and 40 per cent of these women had experienced some form of sexual assault before they were 16 and 10 per cent had experienced childhood physical abuse.
- 20 This was most apparent in responses to the survey conducted amongst rural and regional Australia for ACSSA's third Briefing Paper (see Neame & Heenan 2004).

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