

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

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

The prevalence of sexual violence

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

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

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

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

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

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

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

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

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

Barriers at the level of the justice system include:

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

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

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

Adverse outcomes of sexual assault experienced by victim/survivors

Immediate effects of sexual violence for the victim/survivor

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