

### *Rape Crisis Online*

The NSW Rape Crisis Centre established a new service, Rape Crisis Online, in December 2005. The service provides a person-to-person, on-line, real-time information and support service for anyone who has been sexually assaulted and is the first of its kind. Targeted at young people, the service responds to the finding that many survivors of sexual assault report that the most difficult thing after the assault, is telling what has happened for the first time. Advantages of this approach as a first contact with services include survivors being able to access help from a quiet, private location, being able to type words rather than say them and being able to access instant support and information backed up by a website (NSW Rape Crisis Centre, 2005).

Information on the first seven months of operation provided by Jacqueline Burke, Counselling Coordinator at the NSW Rape Crisis Centre, indicates that a total of 149 online contacts were made by 93 individual people to Rape Crisis Online up to July 31, 2006. Around a third had never spoken to anyone before about the violence. The majority (64%) were aged between 16 and 34 years, with approximately 30% from rural NSW. Callers were encouraged to make contact with the NSW Rape Crisis Centre and over a third made subsequent telephone contact. For those who did not want to make contact, counsellors suggested other options.

In line with Lievore's (2005) finding, 30% of callers did not talk directly about being assaulted but asked questions such as "if someone did ... to me, is that sexual assault?". The language and content of most of these calls indicated that the authors were young and wanting help but were unsure of the outcome of 'telling'. Of the callers who spoke directly of sexual violence, 30% had been assaulted in the past seven days and 50% had been assaulted six months or more ago. Overall, 40% had been sexually assaulted as adults, 30% had been assaulted when they were children and a few had been gang raped. On line contacts followed the same pattern as telephone contacts with 68% of calls being received between 3 pm and 11 pm.

### **General health service providers working with victim/survivors of sexual assault: Some recommendations**

The vast majority of women who experience violence including sexual violence do not access formal support agencies such as sexual assault centres. In the most recent analysis of a large scale Australian study of violence against women, Mouzos and Makkai (2004) found only 16% of women who experienced intimate partner violence and only 9% of those who experienced non-partner violence subsequently contacted an agency. Furthermore, while the limited evidence on formal sexual assault services indicates that users regard them highly, no research has yet been conducted in Australia to determine how survivors of sexual violence regard the quality of care and support they receive from primary health care providers.

Given that the majority of survivors access primary health care services rather than specialist sexual assault services, it is imperative that primary health care providers are equipped to enquire about and respond appropriately to disclosures of sexual violence, to detect negative health outcomes including adverse psychological outcomes and to conduct consultations and examinations so as to minimise secondary trauma.

All health care professionals who see female clients need to keep in mind that up to a third of them are likely to have experienced some form of sexual violence over their lifetime.

### The need to work differently

Primary health care providers have been trained to develop expertise in the diagnosis and treatment of ill health and to act as authority figures in relation to their clients. As such, they become accustomed to devising treatment plans, giving advice and expecting clients to adhere to those plans and advice.

Increasing patient compliance may be desirable in other spheres of health care but it should not be a goal when working with victimised girls or women. Indeed it is likely to be highly counterproductive because it mimics the controlling behaviour of the perpetrator and reinforces the woman's sense of powerlessness and lack of agency. Health care workers must strive to be as unlike the perpetrator as possible in all their interactions with victimised women. A non-directive, woman-centred therapeutic approach is indicated.

Unlike sexual assault counselling and advocacy services where no physical examinations are carried out, primary care providers routinely engage in a range of physical examinations that have the potential to cause secondary traumatisation.

#### *Intimate or intrusive physical examinations*

Secondary traumatisation is most likely to occur in situations that share some or many of the same features as previous episodes of violence. Intimate gynecological examinations are a case in point.

Any clinical examination or procedure that places women in a helpless, powerless or humiliating position where it is impossible for them to exercise control or express preferences or participate in decisions which impact on their emotional wellbeing and/or physical integrity and dignity, will serve as strong reminders of the violence endured outside the consulting room.

A history of trauma and violent victimisation can transform what health care providers might consider 'ordinary' or 'everyday' procedures into formidable challenges to victimised women's abilities to cope physically and psychologically.

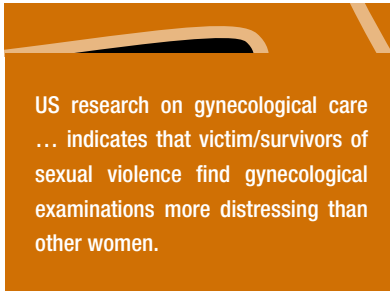
Primary health care providers need to reconsider the traumatic potential of a range of procedures from a client centred perspective and ask the following questions:

- Is there any way this procedure or the manner in which I am carrying it out might be humiliating or traumatic to victims of sexual violence?
- How can I engage women in shared decision making around this kind of clinical care to maximise them feeling safe, informed and in control of what happens?

Some procedures such as Pap testing and other intimate gynecological examinations that occur routinely in pregnancy and labour or in testing for sexually transmitted infections are likely to trigger reminders of past violence and to provoke the same physical and psychological responses as the original violence. Apart from a small pilot study on the Pap testing experiences of survivors carried out at CASA House

(Carlson, 2002), no Australian research to date has been funded to investigate this critical aspect of service provision for victim/survivors.

US research on gynecological care, however, indicates that victim/survivors of sexual violence find gynecological examinations more distressing than other women. Survivors are more likely than non-abused controls to rate their gynecological care experiences negatively and during a gynecological examination report more trauma like responses including overwhelming emotions, intrusive or unwanted thoughts, memories, body memories and feelings of detachment from their bodies as well as more shame, fear and anxiety than other women. Most women (82%) had *never* been asked about a history of sexual violence by a gynecological care provider (Robohm & Bутtenheim, 1996). Similarly, Smith and Smith (1999) reported that survivors of childhood sexual abuse reported higher levels of anxiety during a gynecological examination than non-abused women. The traumatic stress following sexual violence is thus evidenced in the trauma like responses of victimised women to gynecological examinations and may explain why some find Pap tests unbearable (Farley, Golding, & Minkoff, 2002). A traumatic experience of the Pap smear procedure could significantly delay the length of time to subsequent screening or prevent it from occurring altogether. This needs to be investigated further.



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### Primary health care that is responsive to the needs of survivors

Primary health care that is responsive to the needs of survivors has an important role in supporting the empowerment of survivors as opposed to reinforcing their disempowerment. It is only in the presence of a trustworthy ally that a survivor is likely to feel comfortable in telling her story or as Herman (1992) puts it, being able to “speak of the unspeakable”.

The establishment of trust is therefore critical. A strategy to achieve this includes ensuring that all discussions about sexual violence occur in a safe and private place. A number of WHO documents on violence against women stress the importance of prioritising women’s safety in any encounter they might have with researchers or clinicians (WHO, 1999; WHO, 2004). This might be summarised as: “Ask alone and ask safely”.

If there is any likelihood of interruption during the discussion that could violate confidentiality, warn of this possibility in advance and agree on a change in the topic of conversation (WHO, 1999).

To provide psychological support, both the words and actions of the health care provider must demonstrate to the victimised girl or woman (who has taken the risk of trusting that provider with her disclosure of violence) that the provider:

- believes what she says about her experience of violence;
- acknowledges her feelings and validates that her emotional reactions to the sexual assault/abuse are normal;
- will work with her and support her to make her own decisions on what is best for her;
- will provide her with information and contacts to other services that could help her;
- says that ‘no one deserves violence’ and no one can deal with the trauma it causes alone;

- informs her that sexual assault is a crime and a violation of her human rights;
- takes a careful history of sexual victimisation including the type or types of violence experienced, when the violence started and how long it continued and an assessment of its severity;
- undertakes an evaluation of each woman's current psychological needs, symptoms and concerns and whether and in what way these have changed over time (signs of depression, anxiety and traumatic stress including sleeping difficulties are particularly important indicators of gender based violence); and
- keeps up-to-date information in a convenient form to provide survivors information and referral to sexual assault, legal and other human services within the community.

The notion of stages in healing from sexual violence may be 'a convenient fiction' (Herman, 1992) but it is this convenience that most recommends it. When listening to women talk about their concerns and preoccupations about sexual violence and its effects, primary health care workers are likely to be able to respond more meaningfully if they understand the different stages and their associated concerns and psychological tasks.

## Conclusion

Sexual violence is a multidimensional problem. In attempting to work sensitively and effectively with survivors in a way that contributes to them regaining control over their lives following the devastation of sexual assault, it is salutary to keep in mind that no single factor explains such violence and equally, no single person can overcome it. Just as sexual violence results from the complex interplay of individual, relationship, social and cultural and environmental factors, so, too, its solution must also involve all those who have the opportunity to reduce such violence and eliminate its preventable harms by working together, where possible, to build synergistic relationships.

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