

BRIEFING PAPER

Mental Health Responses for Victims of Sexual Violence and Rape in Resource-Poor Settings

INTRODUCTION

“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”. Sexual violence as defined by the World Report on Violence and Health (Jewkes, Sen & Garcia-Moreno, 2002)

“Physically forced or otherwise coerced penetration – even if slight – of the vulva or anus, using a penis, other body parts or an object.” Rape as defined by the World Health Organisation (Jewkes, Sen & Garcia-Moreno, 2002)

Sexual violence is a pervasive yet, until recently, largely ignored violation of women's human rights in most countries (WHO, 2005; Kohsin Wang & Rowley, 2007). It occurs across socio-economic and demographic spectrums, and is frequently unreported by victims (Rennison, 2002; Tjaden & Theonnes, 2006). Sexual violence is associated with negative physical, sexual

and reproductive health effects and, as importantly, it is linked to profound long-term mental health consequences (Astbury & Jewkes, in press; Jewkes, Sen & Garcia-Moreno, 2002).

The needs of rape survivors* are often overlooked by public sector health services in resource poor settings. Where services for rape survivors do exist, generally they are limited to the provision of medico-legal services (Sundstrom, 2001), with little attention given to addressing the psychological impacts of rape (Astbury & Jewkes, in press).

Rape, given its specific definition within the broader context of sexual violence, has been the subject of the majority of the relevant literature. As a result, this briefing paper will focus predominantly on rape. To date, most of the evaluation of interventions targeting the mental health consequences of rape has taken place in the developed world. The extent to which these findings remain valid in other settings remains unknown.

* The terms survivor and victim of sexual violence will be used interchangeably throughout this briefing paper.

* This briefing paper was written by Thomas Callender and Liz Dartnall.

This briefing paper provides: an overview of existing literature on the mental health effects of sexual violence and rape; a summary of effective interventions; and outlines a brief research agenda for mental health responses to sexual violence. It is based on work commissioned by the SVRI on mental health and sexual violence and is informed by the knowledge and experiences in this area of the SVRI Coordinating Group.

The Mental Health Aftermath of Sexual Violence

A global meta-analysis of child abuse prevalence figures found self-reported CSA prevalence ranged from 164/1000 to 197/1000 for girls and 66/1000 to 88/1000 for boys (Stoltenborgh et al, 2011). Amongst adults, estimated prevalence of sexual violence at the hands of their intimate partners is greater, falling between 10-50% of women (WHO, 2005). Up to 30% of respondents in a multi-county study reported that their first sexual experience was forced (WHO, 2005).

Rape is a particularly traumatic violation of an individual (Kessler et al., 1995; Resnick et al, 1993; Koss et al, 2003). Women are more commonly victims, although men are also sexually abused and appear to suffer the same mental health impacts as women (Stevens, 2007; Tolin & Foa, 2006; Breslau et al, 1997; Ullman & Filipas, 2005).

Immediately post-assault, most victims will experience shock, intense fear, numbness, confusion, feelings of helplessness, and / or disbelief, in addition to self blame, hyper-arousal and high levels of anxiety (Campbell, Dworkin & Cabral, 2009; Jewkes & Dartnall, 2008; Chen et al., 2010; Vickerman & Margolin, 2009). One third of rape survivors will go on to develop PTSD* (WHO, 2009; Yuan, Koss & Stone, 2006).

Symptoms typically increase in severity over the first three weeks before a progressive decline over the next three months

(Campbell, 2001; Rothbaum et al, 1992). For many victims these feelings will resolve themselves within this period, however for others, symptoms continue far longer (Dunmore, Clark & Ehlers, 2001; McNally, Bryant & Ehlers, 2003). Rothbaum et al (1992) found that, of those who developed PTSD post-rape, at three months half were still suffering with the condition. Similarly, even with counselling, half of victims still suffer from stress after three months (Tarrier et al, 1999; Kilpatrick et al, 1992). High levels of fear and anxiety as well as patients still meeting PTSD diagnostic criteria have been found up to 16 years after the event (Kilpatrick et al, 1992; Ellis, Atkinson & Calhoun, 1981).

Factors that Influence the Psychological Impact of Sexual Violence:

- A victim's socio-biological characteristics.
- A victim's perception of their rights and their status.
- A victim's belief about what constitutes sexual violence.
- Prior history of trauma, be that sexual or other.
- Prior mental health issues.
- The relationship of the offender to the victim.
- A victim's appraisal of the circumstances of the violence (e.g. threat to life, self-blame).
- A victim's coping mechanisms.
- Positive family and social support.
- Cultural background.
- Perceived and actual response of society, including any formal services approached, to disclosure of sexual violence.
- For childhood sexual abuse the duration, frequency and severity of the abuse, in addition to the relationship of the offender to the victim.

Campbell, Dworkin & Cabral, 2009; Hillberg et al, 2011; Jewkes, Penn-Kekana & Rose-Junius, 2005; Briere & Jordan, 2004; Yuan, Koss & Stone, 2006.

* PTSD can be diagnosed using either the WHO's (1992) ICD-10 criteria or the American Psychiatric Association's (1994) DSM-IV criteria. In contrast to ICD-10, under DSM-IV guidelines, a victim cannot be diagnosed with PTSD in the first month after a trauma. Instead, during the first month, their symptoms are referred to as Acute Stress Disorder. The WHO's definition has been employed in this paper.

Coping with Sexual Violence

Survivors must negotiate and interpret not only the assault itself but the responses of their society to their disclosure of the assault (Campbell, 2001; Campbell, Dworkin & Cabral, 2009). Throughout the world, sexual violence remains highly stigmatised, with 53 countries yet to legally define marital rape as a crime (Women Face Bias, 2008). In many cases, blame is cast on the victims rather than the perpetrators, with the victim suffering dishonour and shame sometimes thought to extend to the whole family (Kohsin Wang & Rowley, 2007; Jewkes et al., 2002; Jewkes, Penn-Kekana & Rose-Junius, 2005). Disbelief of the victim and the commonly reported perception that the victim provoked the rape lead to secondary victimisation of the survivor at the hands of family and friends as well as the health care, police and judicial services (Ahrens, 2006; Filipas & Ullman, 2001; Kohsin Wang & Rowley, 2007; Campbell, 2001; Campbell, Dworkin & Cabral, 2009; Patterson, Greeson & Campbell, 2009).

Lack of disclosure is associated with more severe psychological consequences, particularly in children, and it is therefore of great importance that societal perceptions of rape are changed so that victims may feel safer in revealing assault (Stevens, 2007; Ruggiero et al., 2004).

Rape fundamentally challenges a survivor's "world of meaning" as well as concepts of safety and trust in one's environment (Conte, 1988 cited in Koss, Figueredo & Prince, 2002; Campbell, 2001). In the aftermath of rape, strong social support protects survivors from prolonged and even more severe psychological consequences of rape (Campbell et al., 2001). However, at the same time, the reactions of survivors (e.g., irritability, depression, mood swings) can alienate the informal support

structures on which they may rely (Ahrens & Campbell, 2000). Additionally, disclosed sexual assault can cause traumatisation of the close family or friends of survivors, potentially complicating the recovery process (Veronen et al., 1989 cited in Campbell, 2001; Campbell & Wasco, 2005). Importantly, any negative responses or attitudes by close social support structures, or the feeling that one lacks social support, have a disproportionate effect on the mental health aftermath of rape, underlining the need for more general interventions to change societal attitudes towards sexual violence as well as efforts designed to educate those to whom the survivors may disclose (McNally, Bryant & Ehlers, 2003; Campbell, Dworkin & Cabral, 2009).

In the aftermath of rape, no survivor should feel unsupported or unable to disclose assault. Survivors of sexual violence bear the brunt of the psychological burden but all society must come to grips with its consequences.

Child Sexual Abuse

Child sexual abuse (CSA) is associated with significant rates of mental health disorders that can extend well into adult life, particularly if the sexual abuse involved actual intercourse (Jonas et al., 2010; Cheasty, Clare & Collins, 1998; Briggs & Joyce, 1997). As with adults, child victims have an increased risk of a range of psychopathologies in the aftermath of sexual violence, including PTSD, depression, anxiety, and dissociation (Maniglio, 2009; Seng et al., 2005). Compounding this, both children and adults suffering from PTSD are highly susceptible to physical co-morbidities such as circulatory problems, respiratory or bowel disorders, and infection, leading to impaired ordinary functioning (Seng et al., 2005).

CSA is associated with learning difficulties and regression of / or slower development, as well as negative behavioural patterns in later life (Maniglio, 2009). Child victims are more likely to engage in unsafe sexual practices and be re-victimised, whilst some male victims may go on to sexually abuse others (Maniglio, 2009; Whitaker et al, 2008).

Children seen in the first few weeks post-rape should be treated with particular care, but in the same way as is suggested for adults later in this document (Keesbury & Askew, 2010). Crucially, for any treatment plan involving child survivors to be successful, mechanisms must exist for the protection of children from re-victimisation, especially those abused by close family members and for the protection of children abused by adults in positions of authority (Maniglio, 2009). Discussion of the tailoring of psychotherapeutic treatments to each child in the intermediate and long term is particularly complex and beyond the scope of this briefing paper.

Rape of boys and men

The sexual abuse, including rape of males, is a particularly under-researched topic. Its prevalence is generally lower than amongst females, but nevertheless of concern throughout the world. Men and boys suffer from similar mental health disorder symptoms as women and girls in the aftermath of rape and have to negotiate the same, or potentially greater, negative societal reactions (Jewkes et al, 2002).

Male victims are thought to be even less likely to disclose the assault and so are highly likely to have to cope on their own with the psychological impact. Studies suggest that this can lead to higher levels of delinquency and crime (Jewkes et al, 2002), and is also associated with perpetration of sexual abuse.

Mental Health Responses for Rape Survivors

Many of the harmful and lasting psychological impacts of sexual violence may be prevented or minimized with structured interventions and the provision of psychological support post rape (Astbury & Jewkes, *in press*). Whilst many people will recover spontaneously from the psychological aftermath of rape, the identification and treatment of psychopathology can be of great benefit to survivors (US National Center for PTSD, 2007).

Survivors attach great importance to having their story believed, as well as being treated with respect, kindness, empathy and understanding (Battaglia et al., 2003; Astbury & Jewkes, *in press*). This, as well as a non-judgemental attitude, should be the basis of any treatment and the ethos of any service. Astbury and Jewkes, *in press*, note, "In countries and settings where there have been concerted efforts to improve post-rape care, essential features of successful efforts have included: 1) carefully selecting people who choose this area of work, 2) deepening their understanding of the social context of rape, and 3) exploring their values more generally in an effort to provide an empathetic and non-judgmental service."

Most survivors who do seek formal support will present at one of the following front-line services: a police station, hospital, rape crisis centre or hotline (Keesbury & Askew, 2010). At this stage, many survivors may be more interested in immediate practical support than psychological intervention, for example medical support in the case of physical injury (McNally, Bryant & Ehlers, 2003; Decker & Naugle, 2009). Staff at all these facilities should, at a minimum, be aware of the referral options available. Ideally, to prevent the possibility of re-

traumatisation or victim-blaming, hospital and police staff should be educated in concepts of gender equality, sexual violence, relevant laws and how to treat victims in a sensitive and non judgemental way.

In resource poor settings, most efforts to strengthen responses to survivors of sexual violence have so far focused on the training of specialised staff based in hospitals or crisis centres who administer limited services – immediate care and, a forensic exam – before referring patients on to mental health practitioners or social workers for mental health interventions, if the latter are available. In many cases there is no capacity to provide psychological interventions.

Early Responses

Early interventions helping individuals through their initial reactions to assault can reduce or even prevent more severe psychological distress (Foa et al., 1999; Resnick, Acierno & Waldrop, 2007). As a first step, the safety of the patient must be established.

In the developed world, use has been made of psychological debriefing and / or other adaptations of cognitive behavioural therapies in the immediate aftermath of any serious trauma, however considerable controversy surrounds the practice (Litz, Gray & Adler, 2002; McNally, Bryant & Ehler, 2003). Current evidence indicates that debriefing should not be encouraged in the first month after assault (Litz, Gray & Adler, 2002; McNally, Bryant & Ehler, 2003). Rather than assuming that the form of emotional processing employed by psychological debriefing – immediate expression of emotions – is suitable for all, staff should be supportive and allow the survivor to determine what they wish to share and whether they would like further psychological help (Rachman, 2001; Litz, Gray & Adler, 2002; Foa, 2001 cited in

McNally, Bryant & Ehler, 2003). Instead, the literature supports the use of Psychological First Aid as a first response to a survivor post rape (see Box 2).

A survivor's response in the first 4 weeks post-assault is considered a good indicator of their likely long-term mental health prognosis (Resnick et al, 1999; McNally, Bryant & Ehlers, 2003; Shalev, 1992; Brewin et al, 2002). Some, but not all survivors, may find it difficult to cope on their own and may develop chronic symptoms (Dunmore, Clark & Ehlers, 2001). Scarce resources should be targeted to these individuals so that they receive psychological interventions in the medium to long term. Though a screening tool was developed by Brewin et al (2002) to identify those likely to develop PTSD after a traumatic event, has not been tested on rape victims.

In the first few weeks post-rape, particular indicators have been noted in a variety of studies [Box 1] that can be used to identify victims who are likely to develop chronic PTSD and need further formal assistance (McNally, Bryant & Ehler, 2003; Dunmore, Clark & Ehlers, 2000; Halligan et al, 2003; Brewin et al, 2002). All survivors should be given the option of longer-term psychological intervention, however, those identified by screening are likely to develop psychological/mental consequences and should be particularly encouraged and helped to seek formal mental health support services.

Though there have been no specific evaluations undertaken of such a combination of interventions, the guidelines in Box 2 are consistent with

Box 1: Indicators of likely development of chronic PTSD

- *Persistent Dissociation*: This encompasses a range of components, including depersonalisation, a lack of awareness of one's environment and emotional numbing.
- *Rumination*: Constantly retelling and re-examining the event in one's mind.

Negative appraisal of the trauma in the form of self-blame is important.

- *Disorganised memories of the trauma including non-recollection of important aspects of the trauma.*
- *Maladaptive coping strategies:* E.g. excessive precaution/avoidance, substance abuse.
- *Depression.*
- *Presence of physical reminders:* E.g. scars
- *Severity of symptoms.*

Halligan et al, 2003; McNally, Bryant & Ehlers, 2003; Dunmore, Clark & Ehlers, 2001; Brewin et al, 2002; Ehlers & Clark, 2003; Rachman, 2001.

evidence and based on an amalgamation of the consensus for the prevention of PTSD in acute trauma survivors and best practice in rape crisis centres.

Intermediate and Long Term Responses

In the first months post-assault, the focus of therapy shifts to the management and

Box 2: Immediate mental health interventions for survivors of sexual violence presenting at front line services

- Assess the safety of the survivor.
- Ask about immediate concerns and work out plans to address these.
- Provide psychoeducation/psychological first aid*.
- Help the survivor understand their reactions are normal and explain likely psychological responses and what to expect.
- Aid the survivor in taking control by giving information to assist making informed decisions and offering options.
- Coordinate access to referral resources and safety.
- Assess for and respond to suicidality.
- Provide simple messages to tackle issues of self-blame and guilt.
- Discuss disclosure to family and friends.
- Screen those with delayed presentation for psychological indicators of PTSD.
- Recommend counselling and follow-up

Decker & Naugle, 2009; Foa, et al, 1999; McNally, Bryant & Ehler, 2003; and Resnick et al, 2007. * See Vernberg et al, 2008 or Ruzek et al., 2007 for details on PFA.

prevention of more chronic symptoms. Though each individual will respond uniquely to assault, most studies have focused on the treatments for the three main areas of common psychopathology associated with rape: PTSD, depression and anxiety (Vickerman & Margolin, 2009).

Most therapies and treatments for chronic mental health problems have been implemented in the developed world and may require multiple counselling sessions over the long-term with professional staff (Ehlers & Clark, 2003). Unfortunately, the provision of comprehensive referral services in resource poor settings is difficult with the possible exception of within cities (Keesbury & Askew, 2010). Consequently, this paper only briefly outlines the common therapies and treatments used for PTSD or for all the possible diagnosis (see NICE guidelines for more information: <http://guidance.nice.org.uk/CG26>).

Of the various approaches, evidence consistently points to cognitive behavioural therapies being more effective in reducing symptoms of PTSD than counselling (Ehlers & Clark, 2003; Vickerman & Margolin, 2009; Foa, Zoellner & Feeny, 2006). Combination therapies involving psychotherapy and medications are often used (Foa, et al, 1999). Importantly, rates of substance abuse post-rape are high regardless of previous use (Kilpatrick et al, 1997). The US National Comorbidity Survey indicates that 80% of those suffering from PTSD will have co-morbid psychopathologies ranging commonly from excessive alcohol and/or drug consumption to affective and anxiety disorders (Kessler et al, 1995). Therapies must be tailored to the individual circumstances and needs of each victim.

Traditional modes of healing, be those religious or simply spiritual, have been reported though there has been no evaluation of their effects. In spite of the

Common therapies for the management of victims

- Cognitive behavioural therapies
- Eye movement desensitisation and reprocessing
- Feminist therapy
- Relational therapy
- Management with medication.

above interventions, between 15-50% of survivors will still have diagnosable PTSD or clinical depression at the end of treatment (Vickerman & Margolin, 2009).

Research Priorities

Sexual violence is an under-researched area across the globe but there is a particular lack of research from resource poor countries on the mental health aftermath of sexual violence. To support mental health responses to sexual violence, research is needed regarding:

- Evaluation and documentation of good practice in resource poor countries.
- Adaptation and testing of effective models of care for low- and middle income settings.
- Identification of indicators to measure victims' perspectives of sexual assault services.
- Understanding of rape recovery in different cultures and situations (e.g. conflict/post-conflict).
- Development of appropriate services for children and men.
- Survivors' perceptions of their needs and their views on the benefits of interventions.
- Develop and evaluate interventions to change attitudes towards rape victims and address rape myths.
- Evaluate alternative therapies, such as Dance Movement Therapy, that are used on a small scale to treat trauma victims.

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January 2011