

“ The ‘hidden’ costs of sexual violence: A multi-dimensional approach to the impact and experience of trauma”

Caroline Kelleher
BA (Hons) Psychology

Supervisor: Dr. Sinéad McGilloway

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NUI MAYNOOTH

DIASCUI NA hÉIREANN Mhúad

**Department of Psychology,
Faculty of Science and Engineering,
National University of Ireland,
Maynooth**

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Abstract

This multi-stage mixed methods study was designed to assess the impact and experience of sexual violence (SV) in a sample of Irish women with a history of rape/sexual assault. A secondary aim was to explore the appropriateness of the trauma response model as a means of contextualising and explaining women's post-rape experiences. *Stage One* involved a series of one-to-one interviews with a selection of stakeholders (n=18) who were providing services to Irish victims of SV. Several important themes were identified from the analysis of these data including: barriers to services, current gaps in service provision; and the perceived impact of SV.

Stage Two comprised a detailed quantitative assessment of a sample of Irish women with an experience of SV (n=65). Participants completed a battery of measures in order to assess a number of key constructs/aspects of their life including: experience of trauma symptoms, recent psychological distress; recent life stress; social support; overall Quality of Life (QoL); and alcohol and drug use. A frequency distribution-matched sample of women (COM group) without a history of SV (n=57) also completed these measures (with the exception of the trauma symptoms measure). The average length of time since the incident of SV was almost 13 years) (M=12 years, 9 months) and approximately one third of the sample had also experienced SV under the age of 16. More than eight women in every ten knew the perpetrator, to a greater or lesser degree. The SV sample was characterised by significantly higher rates of recent psychological distress and negative life events than their comparison group counterparts as well as significantly worse QoL, and lower rates of social support. They also obtained significantly higher scores on all scales of the trauma symptoms measure when compared to the norm group. The relationship of the victim to the perpetrator emerged as a significant factor in relation to current marital status, history of a mental health diagnosis and age at the time of the incident. Women who were older at the time of the sexual assault were found to have significantly lower rates of QoL and were experiencing more psychological distress than younger women. A number of significant and interesting correlations were also found between various subscales of the measures.

Stage Three explored the impact and experience of SV in more detail by means of a series of one-to-one interviews with a reduced sub-sample of women selected from

Stage Two (n=14). These qualitative data supplemented and amplified the findings from the previous two stages of the study. A number of key superordinate themes and sub-themes were identified including: reactions to the experience of SV; impact of the experience of SV; service utilisation; disclosure; recovery and healing; and experiences of participation in the research.

The findings from this study have highlighted a number of important issues in the area of SV in Ireland whilst also adding to the small, but growing pool of literature that is beginning to question the utility of the widely accepted trauma response model as a means of comprehensively and accurately contextualising and explaining women's post-rape experiences. Collectively, the findings demonstrate the often 'hidden' impact of SV and, in particular, the pervasive and long-term effects on both self-esteem and sexual and intimate relationships. Future understanding of the effects of SV would be enhanced by allowing for the possibility for growth and recovery in rape victims as evidenced by the high level of education attainment in the SV sample. The results suggest that current medico-legal responses to SV in Ireland should incorporate appropriate training and awareness-raising initiatives in relation to victims of SV. It is hoped that improvements such as these would result in a measurable increase in, for example, the uptake of formal mental health services by these women. Furthermore, well co-ordinated public education campaigns are urgently required to dismantle the prevailing 'rape supportive' culture. Future research that includes, for example, men, and minority groups is needed while the role of alcohol misuse in the management or exacerbation of PTSD symptoms and factors moderating engagement in sexual risk-taking behaviours post-assault are two additional areas worthy of further investigation.

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Abbreviations and Acronyms

- APA** American Psychiatric Association
- BCS** British Crime Survey
- BESQ** Background, Experiences and Services Questionnaire
- BPS** British Psychological Society
- CDC** Center for Disease Control and Prevention
- CEDAW** Convention for the Elimination of All Forms of Discrimination Against Women
- CES-D** Centre for Epidemiological Study of Depression Scale
- CJS** Criminal Justice System
- COM group** Comparison Group
- CSA** Childhood Sexual Abuse
- CSVC** Cork Sexual Violence Centre
- CVRTC** Crime Victims Research and Treatment Centre
- DJELR** Department of Justice, Equality and Law Reform
- DOHC** Department of Health and Children
- DPP** Director of Public Prosecution
- DRCC** Dublin Rape Crisis Centre
- DSM – IV** Diagnostic Statistical Manual Version IV
- DSM-III** Diagnostic and Statistical Manual of Mental Disorders
- DSM-IV-TR** Diagnostic Statistical Manual Version IV – Text Revised
- DV** Domestic Violence
- EPU** Early Pregnancy Unit
- EUICS** European Union International Crime Survey
- FME** Forensic Medical Examination
- GBV** Gender-based violence
- GFHR** The Global Forum for Health Research
- HSE** Health Service Executive
- IPA** Interpretative Phenomenological Analysis
- IPV** Intimate partner violence
- ISPCC** Irish Society for the Prevention of Cruelty to Children

IRCHSS Irish Research Council for Humanities and Social Sciences
NCS National Comorbidity Study
NCS-R National Comorbidity Study – Replication
NCSS National Cancer Screening Service
NCVS National Crime Victimization Survey
NCWSV National College Women Sexual Victimization
NICS Northern Ireland Crime Survey
NWCI National Women’s Council of Ireland
NNWRSS National Network of Women’s Refuges and Support Services
NVAWS National Violence Against Women Survey
NVC National Victim’s Centre
NWS National Women’s Study
PTG Post-Traumatic Growth
PTSD Posttraumatic stress disorder
QoL Quality of Life
RCC’s Rape Crisis Centres
RCNI The Rape Crisis Network of Ireland
RPCs Regional Planning Committees
SARC Sexual Assault Referral Centre
SATUs Sexual Assault Treatment Units
SAVI Sexual Abuse & Violence in Ireland
SBQ Stakeholder Background Questionnaire
SSVR The State of Services for Victims of Rape
STIs Sexually Transmitted Infections
SV Sexual violence
SVAW Sexual Violence Against Women
UN United Nations
VAW Violence Against Women
WHC Women’s Health Council
WHO World Health Organisation

Chapter One

Orientation Chapter

CHAPTER ONE

Introduction

Sexual violence is a relatively common experience in the lives of women throughout the world (Herman, 2001). While it has been estimated that one in every three women globally, will experience some form of sexual abuse in their lifetime (i.e. coercion, assault) (Tavara, 2006), national figures indicate that one in four women in Ireland, have experienced SV, either in childhood or adulthood (McGee, Garavan, de Barra, Byrne & Conroy, 2002). Sexual violence (SV) incorporates a wide range of experiences including: rape; sexual assault; sexual harassment and intimidation at work, in educational institutions and elsewhere; trafficking in women; and forced prostitution (United Nations, 1993). The negative consequences and harmful effects of SV have been well documented and have been known to persist for many years after the assault (Ellsberg & Heise, 2005; Resick, 2001).

Victims of SV may experience a wide range of physical effects that include, but are not limited to: physical injuries; poor subjective health; injurious health behaviours (e.g. sexual risk-taking, alcohol and drug use); somatic complaints; unwanted pregnancy; sexually transmitted infections (STIs) and HIV; and gynaecological disorders (Heise, Ellsberg & Gottemoeller, 1999). The mental health of these women (and men) is also often negatively affected following their experience and may include: Post-Traumatic Stress Disorder (PTSD); depression; anxiety; phobias/panic disorders; eating disorders; sexual dysfunction; low self esteem; and substance abuse disorders (e.g. Davison, Neale & Kring, 2004; Heise et al., 1999). A series of direct and indirect fatal outcomes, in the form of suicide and AIDS-related deaths may also occur (Heise et al, 1999).

Our contemporary understanding of the impact of SV developed initially from work conducted by Burgess and Holmstrom (1974) in the US who coined the term '*Rape Trauma Syndrome*', based on their detailed observations of rape victims (Herman, 2001). The eventual acceptance of the inherently traumatic nature of rape/sexual assault (due to the acknowledgement of PTSD as a psychiatric diagnosis in 1980) heralded a new era for the research and clinical communities and prompted considerable research into the impact of SV mainly within the context of what became known as the 'trauma-response model' (Morrison, Quadara & Boyd, 2007; Wasco, 2003). The utility of

locating women's commonly reported responses to SV within a post-traumatic framework meant that victims would (theoretically at least) no longer be blamed for their reactions, given that the origin of the stressor was external (Wasco, 2003). Furthermore, it facilitated fruitful connections and collaborations between researchers, resulting in a body of research that has been used, for the most part to develop effective treatments (at last with some populations) aimed at alleviating the symptoms of PTSD (Wasco, 2003).

The rationale underpinning this research is four-fold. Firstly, there is a relatively high prevalence of SV in Ireland and a virtual absence of any research of this kind within an Irish context. Secondly, the study by McGee et al. (2002) was the first to assess the prevalence of SV in Ireland and the authors recommended that future research be undertaken in this area. Thirdly, the incidence of PTSD in rape survivors/victims² has been reported to be higher than for any other trauma population (Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993). Fourthly, the dominant theoretical framework in this area (as mentioned above) – and the one that was used primarily to guide and inform this research - is the trauma response model.

As indicated earlier, this model re-positioned 'blame' for the rape externally, whilst also providing victims with a legitimate psychiatric diagnosis worthy of treatment and intervention. Its acceptance as an adequate explanation of women's typical post-assault responses (Burgess and Holmstrom, 1974) provided further validation for the feminist movement which had already '*offered a new language for understanding the impact of sexual assault*' (Herman, 2001:31). Under this trauma response model, a rape victim would typically exhibit: symptoms of avoidance and emotional numbing; hyperarousal symptoms such as an exaggerated startle response; and a re-experiencing of the rape in the form of flashbacks, nightmares or intrusive thoughts (Davison, Neale & Kring, 2004).

However, critics have questioned the comprehensiveness of the PTSD model as an adequate and accurate account of the impact of SV on women (e.g. Campbell, Dworkin & Cabral, 2009; Wasco, 2003; Burstow, 2005). The individual effects on physical and

²The terms 'survivor' and 'victim' will be used interchangeably throughout this thesis to indicate someone who has had an experience of SV.

mental health described earlier are not the only empirically supported consequences of this crime; familial and societal consequences are increasingly being included in contemporary explanations of SV (Bennett & Manderson, 2000; Morrison et al., 2007). For example, the World Health Organisation (WHO) proposes an ecological model of violence against women (VAW¹) that takes account of the complex interaction of risk factors operating at the individual, family, community and societal levels (Heise et al., 1999). Furthermore, solutions to this social and public health problem will only be successful if information and evidence from all of these levels are used to inform efforts, both to prevent SV occurring in the first place, and to respond appropriately and sensitively to its victims (Centers for Disease and Control and Prevention (CDC), 2004; Harvey, Garcia-Moreno & Butchart, 2007).

Wasco's (2003) review raised several interesting questions around certain aspects of this model that would benefit from further investigation; these also provide a solid rationale for this current study. Overall, the available evidence indicates that there is a gap in our current understanding about SV, which in turn, further supports the rationale for the current research, as well as a reliable and empirically based theoretical framework from within which to begin our investigations. The specific research questions driving the study were:

- What is the typical profile of women who have experienced SV in Ireland (e.g. in terms of their sociodemographic characteristics, background and history)?
- How does SV impact on the lives of Irish women?
- What specific areas of their lives are most affected by their experience (as assessed by objective measures of QoL, general health, social support, trauma symptoms etc.)?
- How do these women compare to others who have *not* had such an experience?
- What are the subjective views and experiences of women who have been exposed to SV?

¹ VAW encompasses all aspects of the physical, psychological and sexual harm of a woman.

- What are the views and experiences of SV service providers with respect to the perceived impact of SV on their clients and the kinds of barriers to, and gaps in, support service utilisation?
- To what extent does the trauma response model adequately capture women's post-assault responses?

The present study was funded by a postgraduate scholarship from the Irish Research Council for Humanities and Social Sciences (IRCHSS). The overarching aim of the study was to address a significant gap in our knowledge by conducting a comprehensive and multi-dimensional assessment of the 'hidden' impact of SV in the lives of Irish women. A secondary aim was to explore the appropriateness of the trauma response model (ref) as a means of contextualising and explaining women's post-rape experience. The specific objectives of the study were to:

1. Investigate the experiences of stakeholders providing services in the SV sector in Ireland and specifically, to ascertain barriers to services and gaps in current service provision, as well as the perceived impact of SV on clients. Service provider advice on the most effective and sensitive way of identifying and recruiting women for participation in the research was also sought.
2. Conduct a detailed quantitative assessment of a sample of rape victims/survivors using a range of measures designed to illuminate the impact of SV in multiple aspects of their lives and to compare these with a matched comparison group.
3. To explore in detail, participants' experiences of SV and their subjective views on its impact on their physical and mental health, relationships, quality of life and overall well-being. Their views and experiences of post-assault services were also explored.

The study comprised three discrete, but inter-related stages, each of which was conducted to address (respectively) the above three objectives and the specific research questions indicated earlier. These three stages provide a useful framework for the study, a number of elements of which require detailed consideration within an empirical,

theoretical and policy/practice context. Each stage of the study was undertaken to address (chronologically) one of the three objectives outlined earlier and each 'fed into' and informed the next stage. For this reason, the three stages of the research are presented separately here in the form of a Method section followed by Results section, after which the findings from all three stages of the research are then integrated and discussed in the final chapter of the thesis. This treatment of the three stages of the research also allowed for greater clarity and conciseness. The final chapter then, comprises a detailed Discussion, which is intended to present an integrated, coherent and critical synthesis and evaluation of the findings emanating from all three stages of this research. The remainder of this chapter provides a brief introduction to the study (which will be considered in more detail in the next chapter), as well as a brief outline of the content of the remainder of the thesis.

Chapter Two provides a review of the extant literature in the field. It begins by outlining the range of definitions used in the area of SV, as well as the legal definitions of these offences within an Irish context. This is followed by a comprehensive overview of the prevalence of SV both in the U.S. (where the majority and generally most up-to-date research has been conducted) and elsewhere. The multi-level impact of SV is then considered and a detailed account of the empirical research is reported. Rape and sexual assault in the context of PTSD is explored next, with descriptive and epidemiological data presented by way of context. Important risk factors for PTSD with particular relevance for this at-risk population are then examined, followed by a critical analysis of the utility of the trauma response model in understanding SV against women. The evolution of this field is briefly outlined and contemporary limitations, as reported in the literature, highlighted.

Chapter Three provides information relevant to the Irish context, including a critical review of the research related to SV in Ireland, as well as policy and practice-related issues within an Irish context (and in some cases, also the UK). The prevalence of SV in Ireland is reported using data from the limited research in this area (i.e. The SAVI Report, McGee et al., 2002) as well as national crime statistics, and annual statistics from the main support service providers in this country (i.e. Rape Crisis Centres). Research on Irish (and UK) attitudes to SV is also explored, together with an examination of the role of rape myths in maintaining them. Ireland's attempts to

respond to the problem of SV have been multi-level with developments in legislation, and the provision of medical and legal services. Fundamentally however, it is the Rape Crisis Centres (RCCs) that have responded to victims of SV in terms of providing support and advice in dealing with the harmful and often painful effects of their experience. A brief history of the development of these services within an Irish context and current service provision is also provided. This chapter concludes with a brief overview of some research that has examined the experiences of rape victims within the Irish Criminal Justice System (CJS).

Chapter Four is the first of three individual Method chapters in the thesis, each of which pertains to a different stage of the study. This chapter is divided into two sections. Section A provides a brief introduction to the study design and outlines how key methodological issues were addressed across all stages of the study. The research was conducted within the two complementary frameworks/paradigms of pragmatism and critical realism and a mixed methods approach was used to address the study aims and research questions. Information on ethical issues is also provided at the end of this section. Section B of this chapter provides the methodological details for Stage One of the study. This stage involved a series of one-to-one interviews with service providers who were working with women with an experience of SV; this part of the project was designed, in part, to inform the remaining stages of the research. All design, data collection, and analysis details for this first stage of the research, are presented in this section.

Chapter Five presents the findings from Stage One of this study and is the first of three Results chapters (each of which pertains to a separate stage of the study). A total of 18 stakeholders responding to women with an experience of SV, took part in face-to-face interviews with the researcher. The topics covered in the interviews included participants' opinions on: barriers to services; current gaps in current service provision; and the impact of SV on women based on their experiences. In addition, participants were probed on effective recruitment strategies for the remaining stages of the study. This information, in conjunction with the data from the interviews, was used (in part) to inform Stages Two and Three.

Chapter Six is the second of the three Method chapters and describes the Methodology used in Stage Two of this study. This stage involved a cross-sectional, comparative survey of participants with an experience of SV, aimed at assessing the widespread impact of SV in a range of areas. A frequency-matched comparison sample of women without an experience of SV was also included. This chapter provides details on the various recruitment and data collection materials designed specifically for this stage of the research. Finally, detailed psychometric information on the battery of measures is presented, along with appropriate procedural and data analysis approaches.

Chapter Seven presents the results from Stage Two of the research. This chapter is also in two sections. In Section A, extensive background information on the SV sample (n=65) is presented first including: details of their experience of SV; their experience of disclosure and counselling services (if any); and subjective ratings of the impact that SV has had in their lives. This is followed by similar information for a matched comparison group of women (COM group) (n=57) (i.e. women without an experience of SV). The selection of measures completed by both groups covered a range of aspects of their lives including: quality of life; recent psychological distress; life events; social support; and alcohol and drug use. The SV sample also completed an extensive trauma symptom measure. The differences between these groups were then examined and a series of between-group, within-group and subgroup analyses were subsequently reported. The second section of this chapter (Section B) presents two illustrative case studies of a 'high' and 'low' trauma symptom scorers. This section offers the reader a comparative profile of two women with an experience of SV and demonstrates the typical widespread and varied impact of SV in these women's lives.

Chapter Eight is the third and final Method chapter and presents the methodological details pertaining to the third stage of the study. This stage was employed to supplement and amplify the findings from Stage Two and involved in-depth interviews with a sub-sample of women with an experience of SV. Sampling, data collection, and analysis techniques are all presented in this chapter whilst issues particular to this type of qualitative research and the analysis technique used (e.g. reflexivity) are also discussed.

Chapter Nine is the final Results chapter and presents the findings from Stage Three of this study. Participants were asked a range of questions relating to: their experience of

SV; the impact of their experience; their experience of disclosure and services; and research feedback. Again, this chapter is in two sections. Section A presents the background information on the sub-sample (n=14) of women who participated in the one-to-one interviews. Section B presents the results of the qualitative analysis. A wide range of issues was raised here by participants including: the types of coping strategies they employed post-assault; the impact of their experience on their physical and mental health as well as on their sexual and intimate relationships; their positive and negative experiences with medico-legal and support services; issues related to disclosure (i.e. barriers to, and encouraging it); and finally, resources which they identified as critical to their recovery and healing.

Chapter Ten is the concluding chapter in this thesis and provides an integrated synthesis and critique of the key findings from all three stages of the study. These are located within a broad empirical and policy-based context and their implications for current and future service provision is also discussed. Some of the key issues addressed in this chapter include: the profile of participants; the hidden impact of SV; mental health status and the use of medical services; dysfunctional sexual behaviour and its impact on health and well-being; developing legal and medical responses to SV; improving societal responses to SV by dismantling our rape supportive culture; preventing SV through awareness raising and public education campaigns; and expanding the PTSD framework. This chapter concludes with a discussion of the strengths and limitations of the study as well as directions for future research and new research questions. New theoretical insights into SVAW and changes to our conceptualisation and responses to it are also suggested.

Chapter Two

Literature review

CHAPTER TWO

Review of the Literature

This chapter begins by considering the evidence, from a variety of perspectives, on the scale of the problem of SV worldwide and, in so doing, provide at least in part, a context and rationale for the current study. However, first of all, in the interests of clarity, the varying definitions that are used in this field are examined. The widespread impact of SV is then explored, followed by an overview of the literature on PTSD, a particularly common disorder in rape victims. Pertinent risk factors are delineated next, after which there follows an assessment of, the utility of PTSD and the trauma response model as a comprehensive conceptual framework for understanding women's responses to rape and sexual assault.

2.1 Definitions of violence against women (VAW)

There are a number of key terms used to describe the violence experienced by women as a direct result of their gender. These include: 'Violence against women' (VAW); 'gender-based violence' (GBV); 'intimate partner violence' (IPV); 'domestic violence' (DV); and 'sexual violence against women' (SVAW). Article 1 of the United Nations Declaration on the Elimination of Violence Against Women (1993), defines VAW as: *"Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life."* Thus, VAW may take a range of forms such as physical, sexual, psychological or emotional violence (including coercive acts) and/or the threat of physical or sexual violence. Article 2 of the same declaration goes on to describe more specific acts of violence encompassed by this definition such as: sexual harassment; rape including marital rape; spousal battering; sexual abuse of female children; female genital mutilation; and rape in war (Bennett, Manderson & Astbury, 2000).

Krug, Dahlberg, Mercy, Zwi and Lazano (2002:149) define 'sexual violence' (SV) 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.” ‘Intimate Partner Violence’ (IPV) – also referred to as ‘domestic violence’ (DV) (see below) - is considered to be the most prevalent form of abuse experienced by women, followed closely by SV (WHO, 2005; United Nations, 2006). IPV has been defined as: “...any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship.” (Heise & Garcia-Moreno, 2002:89).

Perhaps the most useful way of conceptualising VAW is to place it on a continuum ranging from sexual harassment to murder, with IPV and SV falling somewhere in between (Herman, 2001). IPV/domestic violence (DV) has historically been linked with married or co-habiting partners and perhaps, in the public’s mind, has been largely confined to physical abuse. However, it should be noted that in many cases, SV is also an intrinsic part of the experiences of women in these situations; in fact, Martin, Taft and Resick (2006) posit that between 10%–14 % of all married women and 40%–50 % of battered women have experienced marital rape.

2.1.1 Irish legal definitions of rape and sexual assault

Given the context of the current study, it is also important to consider the legal definitions of rape and sexual assault in Ireland. An individual can be prosecuted for a number of sexual offences under current Irish legislation. The four main categories relating to adult sexual offences, as opposed to the sexual abuse of a child, include: rape; rape under section 4; sexual assault; and aggravated sexual assault. Section 2 (1) of the Criminal (Rape) Law Act 1981 defines rape as follows: “*A man commits rape if: (a) he has unlawful sexual intercourse with a woman who at the time of the intercourse does not consent to it, and (b) at that time he knows that she does not consent to the intercourse or he is reckless as to whether she does or does not consent to it.*”

Rape under section 4, as provided by the Criminal Law (Rape) (Amendment) Act, 1990, allows the prosecution of either a man or a woman and defines this offence as: “*In this Act “rape under section 4” means a sexual assault that includes: (a) penetration (however slight) of the anus or mouth by the penis, or (b) penetration (however slight) of the vagina by any object held or manipulated by another person*”. Sexual assault and aggravated sexual assault, under Irish legislation, are covered by Section 2(1) and 3(1) of the same Criminal Law (Rape) (Amendment) Act, 1990. Sexual assault involves an

intentional indecent action that causes unwanted contact whereas "aggravated sexual assault" means: "*a sexual assault that involves serious violence or the threat of serious violence or is such as to cause injury, humiliation or degradation of a grave nature to the person assaulted.*"

All of these definitions have been provided in order to contextualise the data that are presented below on the prevalence of SV throughout the world. The studies identified as relevant to this review have focused, where possible, on SV, although it should be noted that there is a substantial degree of overlap in, and variation between, concepts/terminology (i.e. DV includes SV). Thus, where statistics from DV/IPV studies are cited, material concerned specifically with experiences of SV has been extracted (where possible) for discussion. In addition, due to the fact that definitions of SV can vary from one jurisdiction to the next, the selection of the prevalence data was guided, in part, by an understanding of rape and sexual assault as defined legally, above. Therefore, 'rape' and 'sexual assault', in the context of this thesis are deemed to refer to experiences as an adult, and these terms are used interchangeably throughout the text. In addition, the literature uses the terms 'victim' and 'survivor' to refer to an individual who has been raped and/or sexual assaulted. Therefore, these terms will also be used alternatively throughout, to refer to an adult female who has had an experience of rape and/or sexual assault.

2.2 Global prevalence of sexual violence

Current research suggests that one in every three women worldwide has been assaulted, coerced, or been a victim of some form of sexual abuse during their lifetime (Heise et al., 1999; WHO, 2002). Unfortunately, due to the culturally sensitive and personal nature of this crime, data have not been collected in a regular or consistent way in many countries. Furthermore, methodological differences and the variation in cultural interpretations of SV, makes cross-comparisons difficult and potentially unreliable, both from one study to the next and across countries. In addition, a recurring concern when reporting prevalence and incidence data relating to rape, is the systematic under-reporting of this crime; in other words, the recorded figures and official crime statistics are likely to significantly underestimate the true scale of the problem (Koss, Heise, & Russo, 1994). Nonetheless, in an attempt to indicate the magnitude of the problem, a sample of some of the most commonly reported U.S. and European epidemiological

studies on rape (or that incorporate a SV element), will be examined. Comparisons will also be made, where possible, with available crime statistics (i.e. actual reported incidences of rape and sexual assault) for the country in which the study was conducted.

2.2.1 The US context

The first national prevalence data on rape that became available in the U.S., were based on the collective findings from two nationwide studies - *The National Women's Study* (NWS) and *The State of Services for Victims of Rape* (SSVR), both of which were conducted, or funded, by the National Victim's Centre (NVC) and the Crime Victims Research and Treatment Centre (CVRTC) at the Medical University, South Carolina. The report entitled: '*Rape in America: A report to the nation*', was the first of its kind to provide national empirically based statistics on the number of women who were forcibly raped in the U.S. (Kilpatrick, Edmunds & Seymour, 1992). Information was provided, not only on the extent of rape, but also on the number of rapes that were actually reported to the police, as well as key factors influencing the rate of reporting (Kilpatrick et al., 1992).

The NWS was a three-year longitudinal study of a national probability sample of adult American women aged 18 and older (N=4008) (Kilpatrick et al., 1992). The study was based on data, not only on the women's lifetime experiences of forcible³ rape, but also on major mental health problems (e.g. PTSD, depression, suicide attempts, substance misuse) and alcohol and drug consumption (Kilpatrick et al., 1992). The second study (SSVR), on which the above report was based, was conducted by the National Victim Center and involved a sample of agencies that provided counselling services to victims of rape (N = 370). Information was sought on their views on a range of topics, including how to increase police reporting, the impact of high profile rape cases on victim reporting, as well as the number of service users previously seen (during 1990–1991) (Kilpatrick et al., 1992).

³ The authors used a conservative definition of rape that specifically defined 'forcible rape' as: "an event that occurred without the women's consent, involved the use of force or threat of force and involved sexual penetration of the victims' vagina, mouth or rectum." (Kilpatrick et al., 1992:i)

In the NWS, participants were asked to indicate if they had been subjected to rape in their lifetime, whether or not the attacker was known to them and if they had reported the rape to the police (Kilpatrick et al., 1992). When compared with U.S. Census estimates for that period (1990-1991), it was estimated that at least 12.1 million adult American women, or one in every eight, had been a victim of forcible rape at some point in their lifetime (Kilpatrick et al., 1992). Further findings indicated that 683,000 (0.7 %) adult women reported being raped in the 12 months prior to taking part in the study (Kilpatrick et al., 1992). While this figure does not include rape experienced by women under the age of 18 years, it was still 5.3 times larger than the 130,000 indicated in the *National Crime Survey* (NCS)⁴ conducted during approximately the same period (Kilpatrick et al., 1992).

Several years after the above report was published, a national telephone survey - *National Violence Against Women Survey* (NVAWS) - based on a large gender-balanced sample (N=16,000) - was conducted in order to compile participants' experiences of rape, physical assault and stalking (Tjaden & Thoennes, 1998). The results showed that approximately one in six U.S. women (17.6 %) reported an attempted, or completed rape, in their lifetime (i.e. as a child and/or as an adult), 0.3% of which had taken place during the previous 12 months (Tjaden & Thoennes, 1998). According to these figures (i.e. based on U.S. Census figures (1995) for adults aged 18 and over), an estimated 302,100 women are forcibly raped in America annually, whilst almost 18 million women are raped at some point in their lifetime (Tjaden & Thoennes, 1998). If the *number of times* a woman was raped is taken into consideration, the figure for incidences of rape in the 12 months prior to the study rises sharply to 876,064 annually (Tjaden & Thoennes, 1998). Furthermore, women were significantly more likely than men, to experience being raped or physically assaulted by their current or former spouse, co-habiting partner or their date (25% versus 8% respectively) (Tjaden & Thoennes, 1998). According to the two previous studies (the NWS & the NVAWS), prevalence rates for forcible rape in the early to mid-nineties in the U.S. ranged from 7.6%-13%; based on the lower figure in that range, that amounts to 1.3 American women being raped every minute, 78 every hour and 1871 every day (Kilpatrick et al.,

⁴The NCVS is an annual report produced by the Bureau of Justice Statistics in the U.S. that provides a detailed picture of crime incidents and trends. In 1993 a complete methodological re-design was completed and this report is now known as the National Crime Victimization Survey (NCVS).

1992). The most recent *National Crime Victimization Survey* (NCVS) (2009) reported 203,830 incidences of rape/sexual assault in the U.S. in 2008, a decrease of 18.5% on the previous year (US Department of Justice, 2009).

Several other studies have investigated prevalence rates for rape amongst adult American women on college and university campuses. For example, Koss, Gidycz & Wisniewski, (1987) found completed or attempted rape rates of 27.5% (N = 3187) in a national sample of men and women enrolled in 32 educational institutions across the U.S. Other researchers in Canada later reported a similar rate of 23.3% amongst a national probability sample of women (N=1853) drawn from 95 universities and colleges (N= 853) (DeKeseredy & Kelly, 1993). A later study by Brener, McMahon, Warren and Douglas (1999) revealed almost identical rates (20%) in another sample of American college students (N = 4838) who had been raped at some stage in their lives.

In one of the largest and most recent studies conducted with college women – the *National College Women Sexual Victimization* (NCWSV) study – almost three per cent of the sample (N = 4446) had experienced an attempted, or completed rape (Fisher, Cullen & Turner 2000). While this rate, at first glance, does not appear to be exceptionally high (i.e. approximately 1 in 36 college women experiencing a completed or attempted rape in an academic year), the period of reference for the questions in this survey was approximately seven months (6.91 months); therefore, when projected over the course of an average college career (approximately five years), rape victimisation in women attending higher education institutions might be estimated to be in the region of 20%-25 % (Fisher, et al., 2000).

2.2.2 The non-US context

With regard to prevalence data elsewhere in the world, the World Health Organisation (WHO) has collated a wide range of statistics on VAW. One such report produced in 2002 – the *World Report on Violence and Health* - presented data from several nationally representative population surveys that asked women about their experiences of SV, as well as their experience in a physically abusive intimate relationship (Krug, et al., 2002). Further data were presented on a wide range of other types of SV including: forced sexual initiation; gang rape; sexual trafficking; sexual coercion and harassment in schools, health care settings, armed conflict and refugee settings; and child marriage

(Krug et al., 2002). However, the focus here, as elsewhere in the chapter, is restricted to SV, as defined by rape (forced sex) or sexual assault as an adult woman (i.e. aged 16 years or more). The two main sources of data on which the WHO report is based, included victims of crime surveys and a small number of national surveys involving representative samples of women (Krug et al., 2002). For illustrative purposes, Tables 2.1 and 2.2 present a selection of the statistics from less developed countries in Asia, Latin America, Africa and Eastern Europe.

The first table (Table 2.1) shows statistics from two international crime surveys carried out by the United Nations Interregional Crime and Justice Research Institute (UNICJRI 1998a and UNICJRI 1998b) in countries in the developing world, or in transition (Krug et al., 2002). Figures range from 0.8% of women in the Philippines who experienced sexual assault during the preceding five years, to 8% of women in Albania. Interestingly, Latin American countries seem to report the highest prevalence rates, overall, for sexual assault (Krug et al., 2002). Importantly, the authors noted that none of the studies made a distinction between stranger rape and rape by an intimate partner, a point that some have argued, may lead to a sizable underestimation of the prevalence of SV (Krug et al., 2002). By contrast, Table 2.2 presents a sample of population-based surveys with women who reported sexual victimization by an intimate partner. This shows considerable variation in overall rates ranging from 2.5% in Finland to 42% in Durango, Mexico, but the extent to which this reflects a true variation in prevalence rates across regions, or the influence of different cultural factors, is unclear (e.g. what is considered to acceptable sexual behaviour in one country may not be in another).

One of the most comprehensive studies on women's health and domestic violence was co-ordinated and conducted by the WHO, in an attempt to address some of the methodological shortcomings that tend to characterise research in this field. This transnational study, conducted during 1998-2004, reported findings of physical and sexual abuse amongst women (n=24,000) aged 15-49 years, across nine urban and six rural sites in ten different countries (Ellsberg & Heise, 2005).

Table 2.1. Percentage of women aged 16 years and over, who reported having been sexually assaulted in the previous five years - selected cities, 1996-1997.⁵

<i>Country</i>	<i>Study population</i>	<i>Year</i>	<i>Sample size</i>	<i>Percentage of women (16 years+) sexually assaulted in the last 5 years (%)</i>
Africa				
Botswana	Gabrone	1997	644	0.8
Uganda	Kampala	1996	1197	4.5
Latin America				
Bolivia	La Paz	1996	999	1.4
Brazil	Rio de Janeiro	1996	1000	8.0
Asia				
Philippines	Manila	1996	1500	0.3
Indonesia	Jakarta & Surabaya	1996	1400	2.7
Eastern Europe				
Hungary	Budapest	1996	756	2.0
Albania	Tirana	1996	1200	6.0

Data were collected using standardized questionnaires and procedures (and interviewer training) designed to elicit women's experience of physical abuse, sexual abuse and both physical and sexual abuse, by their partner (WHO, 2005). Only the figures for women's experiences of sexual abuse (or SV) are reported here due to the focus of this current research. Overall, most of the sites included in the study reported a prevalence of partner-related SV of 10%–50% (WHO, 2005). The top three countries, in this respect, included: Bangladesh (City – 37 %; Province – 50 %), Ethiopia (59 %), and Peru (City – 23 %; Province – 59 %) (WHO, 2005). Serbia, and Japan were the lowest (both at six per cent) followed closely by Brazil City at ten per cent (WHO, 2005).

⁵ Adapted from E.G. Krug, L.L. Dahlberg, J.A. Mercy, A.B. Zwi & R. Lozano (eds.), 2002. *World Report on Violence and Health*. Geneva: WHO.

Table 2.2: Percentage of adult women reporting sexual victimization by an intimate partner - selected population-based surveys, 1989-2000.⁶

<i>Country</i>	<i>Study population</i>	<i>Year</i>	<i>Sample size</i>	<i>Percentage assaulted in past 12 months</i>		
				<i>Attempted or completed forced sex (%)</i>	<i>Attempted or completed forced sex (%)</i>	<i>Completed forced sex (%)</i>
Chile	Santiago	1997	310	9.1		
Finland	National	1997-98	7051	2.5	5.9	
Mexico	Durango	1996	384	42.0		
	Guadalajara	1996	650	15.0	23.0	
Puerto Rico	National	1993-96	7079			5.7
Sweden	Teg, Umeå	1991	251		7.5	
Switzerland	National	1994-95	1500		11.6	
West Bank & Gaza	Palestinians	1995	2410	27.0		

Closer to home, Hagemann-White (2001) conducted a review of VAW in Europe that examined 11 prevalence surveys carried out in nine European countries between 1986 and 1997. However, only six of the studies included a measure of SV, typically within an intimate relationship (Hagemann-White, 2001). Four of the other studies measured physical violence only whilst the fifth reported prevalence data from an Irish study, which will be covered in more detail in the following chapter. As indicated in Table 2.3, the prevalence rates in Europe, for sexual assault and rape, range from 0.6 % to 25 % and from 5.5% to 7.4 % respectively (Hagemann-White, 2001). As with the previous studies the accurate interpretation and comparison of these figures is hindered by variations in methodology and terminology as well as under-reporting (Hagemann-White, 2001). What is noteworthy, however, is that when this review was published,

⁶ Adapted from E.G. Krug, L.L. Dahlberg, J.A. Mercy, A.B. Zwi & R. Lozano (eds.), 2002. *World Report on Violence and Health*. Geneva: WHO.

just eight years ago, there were inadequate data for accurate cross-national comparisons, both with the U.S. and amongst countries within Europe (Hagemann-White, 2001). The review by Hagemann-White identified just 11 European studies on VAW in adulthood - from 1986 to 1997 - that used a random or representative sample of the population in an entire country, or large region within a country.

Table 2.3: Sexual violence in intimate relationships: Data from a number of European surveys (1986-1997).⁷

<i>Country</i>	<i>Year</i>	<i>Sample</i>	<i>Prevalence figures for</i>	
			<i>Rape (R)</i> (%)	<i>Sexual Assault (SA)</i> (%)
Netherlands	1986	1016 women aged 20-60 years	7.4	21
Germany	1992	11,116 men & women 16+ years	5.7	NA
Switzerland	1994	1519 women aged 20-60 years	NA	11.6 ^a
Portugal	1995	1000 women aged 18 & over	NA	0.6*
Finland	1997	4995 women aged 18-74 years	NA	25 ^{***}
Germany (regional)	1997	304 women & 256 men aged 17-20 years	5.5 ^{***}	22 ^{***}

a. These are combined figures including R; no separate figures for R were given.

* This is a combined figure of SA by a husband or lover in the last year (0.5%) and in previous years (0.6%)

** Combined figure for SA by current cohabiting partner ever (6%) and past cohabiting partner (19%)

*** Combined figures for R (force only - 1.6%; either force or drugs - 3.9%) and SA (force only - 8.2%; either force or drugs - 13.8%)

The findings presented here, comprise a relatively comprehensive selection of the main international prevalence studies, which have hitherto been conducted on SV. Despite the difficulties in making valid and meaningful cross-comparisons, the range of figures support the premise that an experience of SV is likely to occur in a substantial proportion of the female population throughout the world. Some of the consequences of this significant social problem at both a societal and familial level will now be briefly

⁷ Table adapted from C. Hagemann-White (2001). European research on the prevalence of violence against women. *Violence Against Women*, 7(7), 732-759.

profiled whilst the empirical evidence on the far-reaching impact of SV on individual women's lives.

2.3 The impact of sexual violence

The study of the impact of SV may be reasonably located within a number of theoretical frameworks, some of which are outlined here. For example, the effects on overall health and well-being may be usefully examined within a Quality of Life (QoL) framework and indeed; QoL has been examined in a range of trauma populations including rape victims (e.g. Holbrook, Hoyt, Stein et al., 2002; Rapaport, Endicott & Clary, 2002). QoL encompasses several dimensions of health and well being including: physical and occupational functioning; psychological well being; experience of social support and interaction; and the presence of somatic symptoms (McGee, in Kaptein & Weinman, 2004). The evidence described here, considers, the effects of SV on physical and mental health as well as its far-reaching social consequences.

2.3.1 Physical health consequences of sexual violence

While the great majority of women who are sexually assaulted do not sustain direct physical injuries (e.g. Tjaden & Thoennes, 2000), the physical consequences of such an experience may persist for many years after the assault. For example, according to Ellsberg and Heise (2005), VAW has direct consequences, not only for a woman's physical health, but also in terms of increasing a woman's risk of ill health in the longer term. Table 2.4 highlights some of the major health consequences of VAW.

2.3.1.1 Physical injuries and medical services utilisation

In the U.S.-based NVAWS study, 36.2% of rape victims (158/439) sustained a physical injury as a result of being raped by an intimate partner, and of those, less than a third (31%, 49/158) received medical care (Tjaden & Thoennes, 2000). While the largest proportion of the sample reported minor injuries such as bruises, welts and scratches, others sustained more serious types of injuries such as chipped or broken teeth, broken bones, lacerations, dislocated joints and internal injuries (Tjaden & Thoennes, 2000). According to the results of a logistic regression analysis, the women in the study who were raped by a spouse or co-habiting partner (i.e. rather than a date) were more likely to be injured during the assault (Tjaden & Thoennes, 2000).

Table 2.4: Typical health outcomes of violence against women. ⁸

Partner abuse, sexual assault, child sexual abuse

<i>Fatal outcomes</i>	Homicide Suicide Maternal mortality AIDS-related
<i>Nonfatal outcomes</i>	
Physical health	Injury Functional impairment Physical symptoms Poor subjective health Permanent disability Severe obesity
Chronic conditions	Chronic pain syndromes Irritable bowel syndrome Gastrointestinal disorders Somatic complaints Fibromyalgia
Mental health	Post-traumatic stress Depression Anxiety Phobias/Panic disorder Eating disorders Sexual dysfunction Low self-esteem Substance abuse
Negative health behaviours	Smoking Alcohol and drug abuse Sexual risk-taking Physical inactivity Overeating
Reproductive health	Unwanted pregnancy STIs/HIV Gynaecological disorders Unsafe abortion Pregnancy complications Miscarriage/Low birth weight Pelvic inflammatory disease

⁸ Adapted from L. Heise, M. Ellsberg, & M. Gottmoeller, (2002). A global overview of gender-based violence. *International Journal of Gynaecology and Obstetrics*, 78, Suppl. 1, S5-S14.

Despite the fact that most women do *not* have injuries after being raped (e.g. Kilpatrick, Edwards & Seymour, 1992; Krug et al., 2002), they have been found to have much higher levels of service utilisation in the years following the assault than women without a history of sexual victimisation. For example, several studies have found that women survivors of sexual assault perceive their health to be poorer than matched comparison samples (e.g. Koss, Woodruff, & Koss, 1990; Waigandt, Wallace, Phelps & Millner, 1990; Masho et al., 2005). A recent study by Rivara et al. (2007) compared women with and without a history of IPV (N = 3333) with respect to their level of health care utilisation and medical care costs; IPV, in the context of this study, included physical, sexual and psychological violence by present or past intimate partners (Rivara, et al., 2007). The authors found that women with a history of IPV (N = 1546), even five years after the abuse had ended, had used health care services 20% more often than those women without such a history (Rivara et al., 2007).

The types of service provision in the above study included visits to: primary and specialist care providers; emergency and urgent care visits; acute care hospitalisation; behavioural health services; laboratory and radiological services; and the use of prescription drugs (Rivara et al., 2007). The female participants with a history of abuse had 27% more prescriptions filled, 14% more specialist visits and 17% more visits to their GP. These findings corroborate those from a number of earlier studies (e.g.; Kimerling & Calhoun, 1994; Wenzel, Anderson, Spelliscy & Gelberg, 2001; Coker, Reeder, Fadden & Smith, 2004).

2.3.1.2 Sexual and reproductive health

The effect of SV on the reproductive and sexual health of a woman is multi-faceted. Not only are there direct risks, such as internal injuries, exposure to STIs and HIV and unwanted pregnancy, but victimised women are more likely to engage in risky sexual behaviours (e.g. multiple sexual partners, less contraceptive use) (Handwerker, 1991; Lang et al., 2003; Messman-Moore, Coates, Gaffey, & Johnson, 2008) which can further compromise their sexual and reproductive health and well-being.

Thus, the experience of rape can expose women to a host of STIs with subsequent implications for their reproductive health and even their fertility. Most studies report STI rates of between five and fifteen per cent (Lacey, 1990; Murphy, 1990; Beebe,

1991). However, there is considerable variation across studies, depending on the range of diseases for which women are screened and the types of tests used. For instance, in one study conducted in Thailand, 10% of the women in their sample had contracted an STI from rape (Archavanitkui & Pramualratana, 1990). By contrast, Jenny et al. (1990) found STI infections in 43% of their sample of female rape victims while the *NVAWS* found that only 3.1% of the female rape victims in their sample had contracted some type of STI as a result of the assault (Tjaden & Thoennes, 2006).

Given that a significant proportion of women do not report the rape and/or seek medical care, untreated STIs can lead to more serious chronic conditions, such as chronic pelvic pain or pelvic inflammatory disease (PID), which, in turn, can cause infertility (Koss, et al., 1994). In fact, female victims of sexual assault attended doctors for gynaecological and sexual dysfunction symptoms more often than they did for dermatological or eye complaints (Koss et al., 1991; Phelps, Waigandt, Wallace, & Miller, 1989). While the risk of contracting HIV during a rape is relatively low, it is nonetheless a credible and recognised consequence of SV (WHO, 2002), in spite of the lack of accurate transmission rates during an assault (Koss et al., 1994; Tavara, 2006). More importantly, if the perpetrator is aggressive and causes genital or anal injury (which is often the case in forced sex), then the woman's exposure and risk of infection is of a much more serious nature (WHO, 2003a).

Pregnancy as a result of sexual violence is undoubtedly a considerable risk and carries with it an elevated predisposition to a range of issues such as miscarriage, pre-term labour and low birth weight and foetal distress (Heise, Ellsberg & Gottmoeller, 2002). In a recent study by McFarlane et al. (2005), 20% of the women in their sample (N = 148) experienced a rape-related pregnancy. In another, three-year longitudinal study (the NWS), a national sample of American women (N = 4008) was assessed on a range of rape-related physical and mental health outcomes (Holmes, Resnick, Kilpatrick & Best, 1996). They found a national rape-related pregnancy rate of five per cent that translated, according to their estimates, into over 32,000 pregnancies annually (Holmes et al., 1996). More locally, an epidemiological study of sexual assault victims presenting to a Dublin-based Sexual Assault Treatment Unit (SATU), found that of the 14% of women thought to be at risk of pregnancy due to the assault (N = 38), three had resulted in a confirmed pregnancy (MacGuinness, 1997).

The relationship between women's history of violence and negative pregnancy outcomes is unclear, although some have suggested that high levels of stress (as in a domestic violent situation) and the increased likelihood of harmful maternal health behaviours (e.g. smoking and alcohol/drug use) by victimised women, can lead to low birth weight babies (e.g. Petersen et al., 1997). Additionally, many rape-related pregnancies end in abortion, owing to the fact that the baby is unwanted in the first place (Tavara, 2006). For example, half of the women in the NWS had an abortion whilst another 11.8% had a spontaneous abortion. However, access to abortion varies and, in some countries where it is permitted (e.g. following a rape), medical and administrative barriers (e.g. insufficient services to meet demand, costs) still exist (WHO, 2003b).

2.3.1.3 Stress related illnesses

The psychological distress caused by rape can often find expression in a range of somatic complaints. For example, while half of all cases of chronic pelvic pain (CPP) (as mentioned earlier) can be explained by the presence of adhesions, or infections, the remaining half do not have any identifiable pathology (Heise et al., 2002). Several studies with women suffering from CPP have found that they regularly have either a history of sexual assault (Chapman, 1989; Ehlert, Heim & Helhammer, 1999), or physical and sexual abuse by their intimate partners (Schei & Bakketeig, 1989; Schei, 1990). Other stress related illnesses frequently reported by women who have been sexually victimised include: migraine headaches; irritable bowel syndrome; fibromyalgia; asthma; diabetes; hypertension; heart disease; and arthritis (Bonomi et al., 2006; Campbell, 2002a; Crowell & Burgess, 1996; Plichta, 2004). According to Kimerling and Calhoun, the symptoms more frequently reported by women in the aftermath of a sexual assault, relate less to injuries sustained as a direct result of the trauma and more to what they have called '*somatic and psychophysiological reactions to severe stress*' (1994: 333).

2.3.2 Mental health consequences of sexual violence

One of the most widely accepted and empirically supported mental health consequences of rape and sexual assault is Post-Traumatic Stress Disorder (PTSD) (Davison, Neale & Kring, 2004; McGee et al., 2002; Ullman, Filipas, Townsend & Starzynski, 2007). According to Muran and DiGuiseppe (2000), the acknowledgement of rape by the

*DSM-IV-TR*⁹ (APA, 2000), as a possible precursor of PTSD, means that the existence of posttraumatic stress (PTS) symptoms in rape survivors can be automatically assumed (Joseph et al., 1997; Briere & Jordan, 2004). In a national U.S.-based study, Kilpatrick et al. (1992) found that almost one third of all rape victims (31%) had developed PTSD at some point after the event and that 11% still had it currently (Resick, 2001). In population terms, these figures account for 3.8 million women who have had rape-related PTSD plus another 1.3 million who are currently experiencing these symptoms (Kilpatrick et al., 1992). Resick (2001) suggests that because some of these rapes may have occurred decades earlier, the severity of the impact and symptoms at the time, may have been forgotten, thereby grossly underestimating this figure.

While the PTSD model of understanding responses to SV has been largely accepted by researchers and mental health professionals alike, there are some limitations to this model. Women's post-assault reactions are inherently complex and highly individualised, as reflected in the wide range of psychological problems and co-morbid psychiatric disorders, which they may develop over many years. For example, the initial reactions to the intense distress of a sexual trauma include shock, fear, anxiety and social withdrawal (Herman, 1992). The hallmark symptoms of a PTSD diagnosis (avoidance, hyper-arousal, and re-experiencing) manifest themselves in: emotional detachment; sleep disturbance; hyper-vigilance; nightmares; and visual and auditory flashbacks (Davison et al., 2004). However, this is by no means the only presenting profile of a woman with a history of SV and co-morbidity with other psychiatric problems is not uncommon.

2.3.2.1 Co-morbidity with other psychiatric disorders

The literature has shown that two of the most prominent psychological responses to rape, are depression and anxiety (Petraik & Hedge, 2002). Anxiety post-assault is both common and seems to be largely fear related (i.e. fear of rape-related situations) (Kilpatrick, Resick & Veronen, 1981; Steketee & Foa, 1987; WHO, 2005) in one, albeit dated study, this was shown to persist for up to 16 years after the incident (Calhoun, Atkeson & Resick, 1982). In other more recent research, Boudreaux and colleagues (1998) collected data from 391 adult women from the community, on crime

⁹ Diagnostic Statistical Manual Version IV- Text Revised.

victimisation and prevalence of psychopathology. Almost one quarter (23%) of their sample reported experiencing a completed rape and those who were more likely to report a history of rape, had received a diagnosis of PTSD plus one of the following – major depressive episode (MDE), agoraphobia, obsessive-compulsive disorder and social phobia (Bordreaux et al., 1998).

In one of the largest epidemiological studies ever undertaken in this area (N = 5877) high levels of co-morbidity between PTSD and several other disorders, were also reported in women exposed to a traumatic stressor. These included: major depressive disorder (49%); dysthymia (23%); social phobia (28%); alcohol abuse (28%); and drug abuse (27%) (Kessler et al., 1995; O'Shea, 2001). The NWS has also produced compelling evidence on the significant mental health consequences of rape. For instance, rape victims with PTSD were 13.4 times more likely than non-victimised women to have two or more major alcohol problems (20.1% versus 1.5%) and were 26 times more likely to have two or more serious drug abuse problems (7.8% versus 0.3%) (Kilpatrick et al., 1992). While some have suggested that the development of these disorders may be a result of the maladaptive coping methods employed in attempting to deal with PTSD (e.g. drinking to reduce symptoms and then becoming addicted), others have argued that this could only be determined on a case-by-case basis (Resick, 2001).

Lastly, suicidal ideation and behaviours are closely related to depression (Weaver et al., 2007) and are also relatively common in victims of sexual trauma (Krug et al., 2002; Sarkar & Sarkar, 2005; Stepakoff, 1998). Reliable estimates suggest that anything from 2.9% to 50% of assault victims have contemplated suicide within one month of the assault and may do so up to 16 years later (Frank, Turner & Duffy, 1979; Ellis, Atkeson & Calhoun, 1981). Kilpatrick et al. (1985) observed that almost one in five (19.2%) of the rape victims in their sample (N = 2004) had attempted suicide compared to only 2.2% of non-victims, whilst a further 44% reported suicidal ideation. Clearly, suicide and suicidal ideation are very real and serious issues for women who have been sexually violated (Foa & Rothbaum, 1998; Krug et al., 2002; Masho, Odor & Adera, 2005). The combined effects of this interpersonal violation coupled with a the wide range of physical, psychological and somatic responses described here, place women in this situation under inordinate amounts of stress which, amongst other things, may result in severely diminished QoL.

2.3.3 Social consequences of sexual violence

The experience of SV may also have serious social consequences for survivors/victims, to the extent that their negative emotional reactions may permeate their social and personal interactions. This may, in turn, lead to indirect effects such as, unemployment (which in turn reduces income) and the loss of social support - a factor critical to successful recovery from this type of victimisation (Littleton & Breitkopf, 2006; Schumm, Briggs-Phillips & Hobfoll, 2006). These social consequences are explored in more detail below.

2.3.3.1 Employment and economic consequences

Most of the data relevant to the economic consequences of SV is derived from research on the effects of IPV on women, in securing and maintaining employment. Whilst a situation of continued domestic abuse (e.g. where a woman living in a DV situation may be physically prevented from getting a job) may differ to some extent from a single incident of SV, there is also considerable overlap between the two. Therefore, most of the findings from these studies may be relevant, to a greater or lesser degree, to women who have had an experience of SV.

Several studies have identified a range of short-term employment-related effects amongst victims of IPV including absenteeism, reduced productivity and loss of employment (Leone et al., 2004; Riger, Raja & Camacho 2002; Tolman & Rosen, 2001). A woman who finds herself in an employment pattern such as this, coupled with the numerous mental and physical health consequences already described, may also incur more serious and longer term repercussions, such as under-employment, an inconsistent work history, and reduced actual and potential earnings (Brush, 2003; Tolman & Rosen, 2001). Greenfield, et al. (1998) estimated that victims of IPV lose approximately \$18 million annually in wages due to missing work, loss of jobs and an inability to maintain regular and uninterrupted employment; over a lifetime, this amounts to nearly \$1 billion in lost earnings (NCIPC, 2003).

Byrne and colleagues (1999) examined the socio-economic impact of interpersonal violence amongst a large sample of women in the US (N=2863). Based on data from the NWS, participants provided responses, at three different time points, on their experiences of victimisation, as well as information on a range of sociodemographic

variables, such as, income, marital status, education and employment (Byrne et al., 1999). These last four variables were used as proxy measures of social adjustment and were subsequently evaluated as risk factors for, and outcomes of, victimisation (Byrne et al., 1999). While some of these were identified as significant risk factors for sexual and physical assault (e.g. living under the poverty line, being newly divorced), only employment status was found to be a significant outcome of victimisation. In other words, women who experienced a new assault since the beginning of data collection were more than twice as likely to be unemployed at follow-up, than women who had not this experience. Furthermore, the experience of a new (or subsequent) assault, for women who were employed at the outset and with a prior history of assault, increased their risk five fold for subsequent unemployment (Byrne et al., 1999).

2.3.3.2 Loss of interpersonal support and resources

One of the classic reactions to an experience of rape is social withdrawal and isolation. For instance, in an early study, Nadelson, Notman, Zackson and Gornick (1982) found that more than half of the rape victims in their, albeit small, sample (N=41) had considerably restricted their social life and were still only socialising with friends up to 15–30 months post-assault. In addition, social withdrawal in rape victims has been found to be associated with greater PTS symptomatology (Gutner, Rizvi, Monson, & Resick, 2006). This relationship between social withdrawal and PTSD has also been found in other trauma populations (e.g. Boscarino, 1995). The difficulties experienced by those around a rape survivor (discussed in more detail in the next section) can serve to reduce even further, her access to suitable social support at a time when she is most likely to need it. According to Ahrens and Campbell (2000), friends of the victim, who do not have a prior history of assault, are as equally unprepared for the repercussions of such an event as the victim themselves. This withdrawal and subsequent reduction in social support may be compounded further by the negative reactions of family and friends to victims' disclosures, in the form of blaming the victim and/or not believing her (Filipas & Ullman, 2001; Starzynski, Ullman, Filipas & Townsend, 2005).

One analysis of the loss of interpersonal resources in the aftermath of a traumatic event, such as rape or sexual assault, has been proposed by Hobfoll (1991). He suggests that a trauma, both during and after, can cause the loss of a number of important and highly valuable resources including: a sense of safety; self-esteem; trust in people or the

environment; and perception of control (Resick, 2001). The findings of studies that have investigated and tested this model, have been generally supportive of this view, in that those with the greatest resource loss were also found to have experienced the most distress and post-traumatic symptoms (Resick, 2001). For example, in one sample of women recruited from a drug and alcohol treatment centre (N = 105), increased PTSD symptoms were found to be associated with higher levels of interpersonal resource loss (Schumm, Hobfoll & Keogh, 2004). The authors recommended that interventions with women with both a history of substance abuse and interpersonal victimisation, should include strategies to preserve and strengthen interpersonal resources (Schumm et al., 2004).

2.3.3.3 Familial costs of sexual violence

The Global Forum for Health Research (GFHR) has identified a number of priority areas for research that are related to the impact of sexual violence on the family unit. These include: the effects on children of experiencing and witnessing violence; the inter-generational transmission of violence within the family; the short and long-term impact of SVAW on family cohesion and stability; and the reduction in the earning capacity of the family (Bennett & Manderson, 2000). For example, children who witness VAW in the family home are at a significantly increased risk of being abused themselves and/or perpetrating the abuse themselves as adults (WHO, 2002). This predisposition perpetuates the cycle of violence and can go on to negatively impact an entire new generation (WHC, 2007). Children who have been exposed to domestic violence have also been reported to suffer from significantly more health problems, difficulties in school and elevated levels of aggressive and antisocial behaviours (Christopheropoulos et al., 1987; Heise et al., 1999).

As the great majority of rape victims are female, researchers have also focused on the secondary impact of SV on male intimate heterosexual partners, and especially since they are often the most significant source of social support immediately following the assault and in the longer-term (Cwik, 1996). Research by Remer and Ferguson (1995) has shown that partners also undergo a period of adjustment in the immediate period after the assault and that relationship problems typically arise when there are discrepancies between the adjustment of both partners. Early research by Crenshaw (1978) revealed that 50%-80% of relationships break up after the woman has been

raped. Relationships with intimates can also be affected sexually and much of the research with couples in this area has focused on the deterioration of sexual functioning post-assault (Connop & Petrak, 2004).

Family members, parents, intimate partners and friends of women who have had an experience of SV, may also experience a form of secondary traumatization and their experiences of negative psychological consequences have been found to be consistent, irrespective of the victim's level of distress (Davis, Taylor & Bench, 1995). A fear of violent crime was also found to be significantly higher in female rather than male friends of rape victims (Davis et al., 1995). In one study, quantitative and qualitative data were collected from 60 friends of adult female rape victims (Ahrens & Campbell, 2000). They reported a range of intense emotional and psychological reactions to the disclosure including: anger at the assailant (96.6%); shock (71.7%); nightmares about the assault (10%); desires to seek revenge (68.3%); and feelings of isolation in dealing with it (6.7%) (Ahrens & Campbell, 2000).

2.3.4 Societal costs of sexual violence

In recent times VAW, including rape and SV, has increasingly being seen as a major social problem rather than as an individual or personal one (Crowell & Burgess, 1996). Consequently, an ecological framework accounting for the pervasive effects of VAW at all levels of society (i.e. the individual, relationship, community and societal levels) has been increasing in popularity (Waters et al., 2004). The GFHR has identified a range of societal costs, which are directly caused by the existence of SV in our communities including: the cost and burden of increased utilisation of community services, hospitals and private health care; the cost of the legal responses to SV; the social impact of increased HIV/STI transmission and unwanted pregnancies; and the cost of training and resourcing the agencies that respond to victims of SV, such as the police, SATUs and health workers (Bennett & Manderson, 2000). Whilst it is difficult to estimate the economic costs of SV due to the multiple factors involved and the considerable under-reporting of the crime, the information below provides some indication of the costs to society, both in monetary terms and lost productivity, as well as an increased fear of victimisation amongst women in general.

2.3.4.1 Economic costs and lost productivity

A report produced by the Center for Disease Control and Prevention (CDC), in 2003, estimated that the cost of intimate partner rape, physical assault and stalking, exceeded \$5.8 billion in the US annually (NCIPC, 2003). They estimated the economic costs of IPV to society by combining figures for direct costs (e.g. health care-related visits such as ambulance transport, emergency department visit, outpatient clinic visits) with indirect costs (e.g. the value of lost productivity for paid work and household chores for injured victims and present value of lifetime earnings for victims of fatal IPV) (NCIPC, 2003). Furthermore, it has been estimated - based on statistics from the NVAWS - that 322,230 rapes by an intimate partner, occur annually in the US, 31% of which result in physical injuries that require medical attention (NCIPC, 2003). The average medical care cost per IPV rape was \$516 (NCIPC, 2003). For mental health care, which normally involves multiple visits, the cost was estimated to be \$978 per rape for those who receive treatment (NCIPC, 2003). With regard to lost productivity and the ability to perform normal everyday household chores, an estimated 1.1 million days of activity are lost every year due to IPV rape; this is equivalent to 3872 person years (NCIPC, 2003). Figures from the UK rate sexual offences as one of the most costly offences to society with an average cost of £31,438 per offence (Duborg, Hamed, & Thorns 2005).

Post, Mezey, Maxwell and Wibert (2002) also attempted to assess both the direct and indirect costs of SV. They estimated the prevalence of rape and sexual assault and the incidence of sex offence homicide in Michigan, in North America. According to their figures, 61,581 women were raped and/or sexually assaulted in the state during 1996 (Post et al., 2002). After adjusting for inflation and the high cost of living, they estimated that the total cost for one rape or sexual assault amounted to \$108,447; that is, \$10,000 higher than the national average. Estimates of the cost of SV have also been provided for Australia and the UK. In Australia, the financial cost of IPV (which included sexual assault), was estimated to be \$8.1 billion for 2002-2003 (Access Economics, 2004), while sexual offences in the UK incurred costs of £8.46 billion, second only to those for homicide (Dubourg et al., 2005).

2.3.4.2 Increased fear in the community

Another social consequence of crime and, in particular, interpersonal victimisation – and one that permeates far beyond the direct victims into the neighbourhoods and wider

community - is fear and specifically fear of crime (Crowell & Burgess, 1996). The occurrence of SV in communities often creates an atmosphere of foreboding fear, both for women (victimised and non-victimised) living in the neighbourhoods and for the service providers who respond to them (e.g. RCC staff, hospital staff, police). The fear of rape, even amongst women who have never been subjected to this crime, is greater than that for any other crime and as a result, women typically take greater precautions to avoid being raped than for any other crime (Holgate, 1989). Much of the research in this area has examined women's feelings of fear and vulnerability in public spaces and in their local communities (e.g. Ferraro, 1996; Stanko, 1990; Koskela & Pain, 2000). In an earlier study by Skogan and Maxfield (1981), six out every ten women in their sample who were living in 26 of the largest cities in the US, felt 'very unsafe' or somewhat unsafe' if they were out alone in their neighbourhoods at night (in Gordon & Riger, 1991). In another early study, Gordon and Riger (1978) found that about one third of their female participants reported feelings of concern about being raped at least once a month, while many more said at least once a day.

Fear in people who respond to rape victims, such as volunteer rape advocates¹⁰ has also been briefly examined, mostly in the U.S. An increased fear of rape or sexual assault is widely considered to be a typical (and universal) emotional reaction to the direct experience of rape, although it is interesting to note that this increased fear has also been found amongst service providers (Matthews, 1994). Alexander, de Chesnay, Marshall, Campbell, et al. (1989) also reported a similar reaction in a group of nurses involved in researching the archive records of an RCC. More recently, Wasco and Campbell (2002) examined the relationship between rape, anger and fear in a group of rape victim advocates, using qualitative methods. They identified a multi-dimensional fear response in their participants which included: fear as a result of a direct threat (e.g. from an alleged perpetrator); fear triggered by identifying with a particular aspect or characteristic of the women whom they were helping; and a fear for the safety of an individual close to them (usually a family member such as a child) (Wasco & Campbell, 2002).

¹⁰ These are the US equivalent of RCC volunteers in Ireland who offer support (and advocacy where appropriate) to victims of SV (e.g. SATU or court accompaniment).

Historically, research in the SV field has tended to focus on the fear of rape and its effect on women. Arguably, however, this analysis lacks an in-depth assessment of the impact of rape and sexual assault on the wider community with regard to, for example, its health, well-being and ideals (Morrison et al., 2007). In addition, the social costs to the community of rape and sexual assault specifically, as opposed to the broader issue of VAW, merits further attention (Morrison et al., 2007). A number of factors have been identified as reliable indicators of community strength and well-being including: freedom from violence and discrimination; economic security and participation; and social inclusion (VicHealth, 1999). Aspiring to create societies with these attributes has been the focus of numerous United Nation Acts (e.g. CEDAW, discussed in the next chapter) and further research in this area is needed to guide and inform this process.

2.4 Rape and sexual assault and the prevalence of PTSD

As mentioned earlier, one of the most common mental health consequences of rape is PTSD. The trauma response model has had widespread acceptance and applicability as a framework for understanding responses to rape/sexual assault. However, in order to assess the validity of this model, a closer examination of the literature is warranted. This section begins with a definition of PTSD followed by some brief background information, its prevalence in the general and ‘at-risk’ populations, and risk factors associated with developing it after a traumatic event. Finally the utility of this framework as an adequate account of women’s post-rape experiences is explored.

The cluster of symptoms necessary to confirm a diagnosis of PTSD was formally introduced in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) in 1980 (PTSD: American Psychiatric Association (APA), 1980) (Davison, et al., 2004). The key criterion for PTSD in later issues of the manual (the *DSM-IV-TR*: APA, 2000) (classed as an anxiety disorder) is ‘*exposure to a traumatic event causing extreme fear*’ (Davison et al., 2004:164). Clients must also report experiencing at least one or more of the following (from each of three major categories of symptoms) that have impaired work, personal or social functioning, for more than one month:

1. Re-experiencing of the traumatic event through, for example, intrusive thoughts, repetitive distressing dreams and/or auditory/visual flashbacks

2. Avoidance of trauma-related stimuli or numbing of responsiveness. For example, the client may avoid feelings/thoughts or people/places that recall the event and/or experience feelings of detachment or isolation from other people or feelings of shortened life expectancy.
3. Symptoms of increased arousal, such as difficulties in concentrating, insomnia, increased anger/irritability and exaggerated startle response or hypervigilance (Morrison et al., 2007).

2.4.1 Background to PTSD

PTSD has its origins in World War 1 combatants who were often executed for cowardice as a direct result of the prevailing thinking of the time, which held that soldiers who exhibited 'shell-shock' when removed from the combat fields, were essentially weak in character (Joseph et al., 1997). However, by the Second World War, clinical descriptions of post-traumatic reactions to combat (e.g. 'combat fatigue') were relatively prevalent, although scattered in the literature (Joseph et al., 1997). Nonetheless, the consolidation of these symptoms as a stand-alone 'disorder' was not empirically researched until the time of the Vietnam War in the 1960s and early 1970s (Joseph et al., 1997).

The number of potential traumatic events that have been suggested to precipitate the onset of PTSD, has now been expanded by the *DSM-IV-TR* (APA, 2000) to include: motor vehicle accidents (Norris, 1992); natural disasters, such as floods (Green et al., 1990); concentration camp survival (Kinzie, Sack, Angell et al., 1986); rape/sexual assault (Steketee & Foa, 1987); and even the death of a loved one (Davison et al, 2004) (Joseph et al., 1997). Thus, the experience of one of more of these 'traumatic events' is viewed as a significant causal factor for the disorder; by contrast, previous thinking had implicitly suggested that the origins of the disorder lay within the individual (i.e. '*that the person would be alright were he or she made of sterner stuff*') (Davison et al., 2004:164).

2.4.2 Descriptive and aetiological epidemiology

According to Helzer, Robins and McEvoy (1987) the lifetime prevalence rate of PTSD in the US general population is between one and three per cent, a figure representing over two million people. This overall rate increases to nine per cent in an at-risk

population who have experienced a traumatic event (Breslau, 1998). The first *National Comorbidity Study* (Kessler, Sonnega, Bromet, Hughes et al., 1995) carried out in the U.S. by Kessler and colleagues, asked participants (N=5877) about their most traumatic experiences either in childhood (e.g. child abuse, molestation, neglect) or adulthood (e.g. rape, physical assault, threat with a weapon) (Resick, 2001). The authors reported an estimated lifetime prevalence of PTSD of 8% overall (i.e. 5% of males and 10% of females overall) (Kessler et al., 1995). The more recently conducted *National Comorbidity Study – Replication* (NCS-R) yielded a rate of 6.8% in the general population, and as above, this rate was higher in women than in men (9.7% versus 3.6%) (Kessler et al., 2005). Interestingly, the prevalence of PTSD has been found to be traditionally lower in European countries (e.g. Alonso et al., 2004; Frans, Rimmo, Aberg, & Fredrikson, 2005). For example, Darves-Bornoz et al., (2008) examined the association between the experience of posttraumatic events and the presence of PTSD in a large sample of adults in six European countries (N=21,425) (i.e. Spain, Italy, Germany, Italy, Belgium and France). The prevalence of PTSD in the 12 months prior to the study was 1.1% with the highest rate being found in Italy (2.63%) (Darves-Bornoz et al., 2008). A second study by Bronner, Peek, de Vries, Bronner, et al., (2009) found a slightly higher rate of current PTSD (3.8%) in a representative community sample in the Netherlands (N=2238).

A closer examination of prevalence rates in specific ‘at-risk’ populations has helped to develop our understanding of the prevalence of PTSD and its risk factors. For example, in 1983, the United States Congress conducted the largest study of combat veterans in the *National Vietnam Veterans Readjustment Study* (NVVRS) (N = 3016) (Kulka et al., 1990). They investigated the prevalence of PTSD - in conjunction with the presence of other psychological problems - in veterans who had served in the combat zones in the Vietnam War, in the U.S. and other areas abroad (Resick, 2001). Despite the fact that most of the veterans had achieved a successful re-introduction to civilian life, 30.9 % of male, and 26 % of female veterans were diagnosed with full PTSD at some point in their lives (Kulka et al., 1990).

Victims of terrorist attacks, crime, natural disasters and motor vehicle accidents also tend to have typically high levels of PTSD. In the last decade, the incidence of large and

catastrophic terrorist attacks on both U.S and European cities has dramatically increased the global incidence of PTSD. For instance, research conducted in the wake of the '9/11' attacks with disaster relief workers (N=109) at Ground Zero (i.e. the site of the World Trade Centre in New York city) who had experienced either direct or indirect trauma exposure, reported PTSD rates of 6.4%, and 4.6% respectively (Zimering et al., 2006). A similar, but much larger study, conducted with over 11,000 Manhattan residents living near the World Trade Centre at the time of the attack, reported a prevalence rate of 'probable PTSD' of 12.6 % (DiGrande et al., 2008). Likewise, 2.3 % of a random sample of Madrid residents (N = 1589) - when assessed one to three months after the Madrid Train bombings in March 2004 - were found to have symptoms consistent with PTSD (Miguel-Tobal et al., 2006). These, and other studies, indicate that PTSD, overall, is a common disorder, which, in the general population, may be considered to be '*as common as schizophrenia and almost as common as depression*' (Yule, 1999:12).

Rothbaum et al. (1992) found that 94% of the women in their study who had been raped (N = 95), fulfilled the criteria for a diagnosis of PTSD at the time of their first assessment (i.e. 13 days, on average, following the assault – and approximately half of that number still had full PTSD 12 weeks later (Resick, 2001). In an earlier study on a range of different offences, Kilpatrick et al. (1987) reported a lifetime PTSD prevalence rate of 57.1 % associated specifically with rape (Joseph et al., 1997). In the NCS study mentioned earlier (Kessler et al., 1995), rape was the event most likely to be reported to be the most upsetting, and the most likely to lead to PTSD (Resick, 2001). Foa and Riggs (1993) argue that reactions to sexual assault tend to be more severe and enduring than reactions to other types of assault (Petrak & Hedge, 2002). In another study conducted around the same time, the criteria for a PTSD diagnosis were met by nine per cent of women who had experienced a traumatic event (i.e. a disaster or accident) (Resnick et al., 1993). However, the prevalence rates of PTSD after rape, sexual assault and physical assault were dramatically higher at 32%, 31% and 39% respectively (Resnick et al., 1993).

2.4.3 Risk factors for PTSD

It is clear from the epidemiological data presented above that not everyone who experiences a traumatic event, goes on to develop PTSD. Ozer et al., (2003) report that while, on average, 50 – 60% of the US population experience a traumatic event in their lifetime; only approximately five to ten per cent of them go on to develop PTSD. Some interesting research has been undertaken to identify the range of demographic, peri-traumatic and psychosocial risk factors for PTSD, although the results have been mixed. These factors include: age; race; gender; education; family environment; degree of social support; prior childhood trauma or victimization; prior psychological functioning; type of trauma; level of exposure; level of violence; acquaintanceship status; and peri-traumatic dissociation (Resick, 2001). Those that are most relevant to the present study and which have the strongest empirical support are reviewed below. Conveniently, a relatively recent meta-analysis of predictors of PTSD and its symptoms, identified seven possible risk factors which included: psychological adjustment; prior trauma; family history of psychopathology; perceived life threat during the trauma; peritraumatic emotional responses; post trauma social support; and peri-traumatic dissociation (Ozer et al., 2003).

2.4.3.1 Demographic variables

2.4.3.1.1 Gender and age

Statistics have shown fairly reliably that women have a higher lifetime prevalence of PTSD than men (e.g. Breslau, et al., 1991; Kessler et al., 1995, 2005). For instance, Breslau et al. (1997a) reported higher PTSD prevalence rates in women than men (N = 1007) whilst Bell and colleagues (2003) reported similar findings with a sample of adults in Northern Ireland seeking psychiatric help (N = 643). Kessler et al (1995) suggest that the higher rates of PTSD in women (reported earlier) from their study might be explained, at least in part, by the differences in the types of trauma experienced. Thus, whilst men were more likely to have experienced at least one trauma, women were more likely to indicate that they had experienced the type of trauma most closely associated with, and most likely to cause, PTSD, such as rape (Resick, 2001). Similarly, Olf and colleagues (2007) reported that women are 2.30 to 2.49 times more likely to develop lifetime PTSD than men following exposure to similar traumatic events. More recently, Tolin and Foa (2008) published a meta-analysis of almost 300 articles (N=290) examining the gender differences in PTSD rates. They

reported that females were more likely than their male counterparts to be diagnosed with PTSD across a range of different types of traumatic incidents (e.g. adult sexual assault, child sexual abuse, accidents, combat, disaster or fire, witnessing death or injury) (Tolin & Foa, 2008). They concluded that women and girls are more likely than men and boys, to meet the diagnostic criteria for PTSD, regardless of the type of study, population or any other methodological variables (Tolin & Foa, 2008).

The age at the time a trauma is experienced, has also been shown to be a significant factor in the likelihood of developing PTSD. For example, a study by Norris (1992) examined the frequency and impact of 10 potentially traumatic events in a gender-, age- and race-balanced sample of adults (N=1000) recruited from four cities in the US. The younger age group (18-39 years) showed the highest rates of PTSD (Norris, 1992). Kessler et al's (2005) epidemiological study on the lifetime prevalence of DSM-IV disorders also identified the lowest prevalence in the oldest age cohort whilst Davidson, Hughes, Blazer and George (1991) reported that 77% of their participants (N=2985) with a confirmed diagnosis of PTSD were under the age of 45 (Resick, 2001). Frueh and colleagues (2007) also examined age differences in the prevalence of PTSD and other psychiatric disorders amongst a sample of veterans attending primary care clinics in the U.S (N = 745). The results showed that elderly veterans (≥ 65 years; N = 318), in spite of reporting higher rates of combat exposure, only had a 6.3% prevalence rate for PTSD when compared to the 18.6% rate found in the middle-aged group (45-64 years; N = 358) (Frueh et al., 2007). In fact, those in the oldest age group had lower levels of psychiatric disorders when compared to the younger (18-44 years; N = 69) and middle-aged groups (Frueh et al., 2007). These findings allude to a possible resiliency in the older age groups that is potentially operating as a protective factor their management and/or experiences of PTS symptoms.

2.4.3.1.2 Socio-economic status and education

The data on the extent to which socio-economic status (SES) and education-related factors impact upon the development and severity of PTSD, is more variable. An early study of female rape victims (N=72) in the late 1980s found significant correlations between lower SES and poor outcomes on a range of symptom measures (Cohen & Roth, 1987 in Resick, 2001). However, at around the same time, Kilpatrick, Saunders, Amick-McMullan and Best (1989) found no relationship between the psychopathology

of rape victims and SES. Keane et al. (1998), in a more recent study of Vietnam veterans (N= 1461), found that those with current PTSD were more likely to report having less education on arrival in Vietnam, than those without PTSD. However, Breslau et al. (1997b) failed to find any association between education level and current PTSD.

More recent research in the UK compared Armed Forces personnel who had been deployed to the Iraq War in 2003, with personnel who had not been deployed to the initial stage of fighting (Iversen et al., 2008). The authors found that post-traumatic symptoms amongst those who had been deployed were associated with, amongst other things, low educational attainment (Adjusted odds ratio = 2.07) and marital status (being single) (adjusted odds ratio = 1.36) (Iversen et al., 2008). While the research findings here are inconclusive, they nonetheless raise some interesting findings. For example, Resick (2001) posits that the effects of socio-economic and educational differences may be indirect in that, those with less education and income may experience more traumatic stressors. This hypothesis finds some corroboration in findings by Byrne et al. (1999) who suggest that women are more likely to experience multiple stressors such as unemployment, divorce and poverty, if they have been physically or sexually assaulted.

2.4.3.2 Peritraumatic variables

The experiences and reactions of individuals during the trauma, as well as the type of trauma they experience, may also influence the severity of their symptoms as well as their likelihood of developing full-blown PTSD. Some of the more relevant peritraumatic-related ¹¹ variables that have found support are briefly described below.

2.4.3.2.1 Type of trauma

As previously indicated, some incidents are more likely to result in a diagnosis of PTSD than others. Kessler et al's (1995) national epidemiological study on the prevalence of psychiatric disorders in the general population found that rates for PTSD were much higher in participants who had experienced interpersonal victimization as opposed to those who had been involved in accidents or natural disasters. In fact, according to

¹¹ Peri-traumatic is defined as the experience of something (e.g. peri-traumatic dissociation) *during* a traumatic event.

Resick, 65% of men and 46% of women who were assessed for 'rape trauma' were found to have a diagnosis of PTSD' (Resick, 2001:105). Research with both war veterans (e.g. Fontana & Rosenheck, 1994) and disaster victims (e.g. Gabriel et al, 2007) also suggests that the longer the exposure to a traumatic stressor and the greater the level of violence associated with it, the more likely the subsequent development of PTSD.

Breslau et al. (1999) - in line with research on gender differences - posit that in spite of women having a lower overall exposure rate to traumatic stressors, they may be especially vulnerable to PTSD as a result of elevated exposure to specific trauma events, which are more likely to lead to PTSD. Olf et al. (2007) comment that these are very often interpersonal victimisations such as rape or sexual abuse. Given that more than one third of women in the U.S. typically report experiencing intimate partner violence during the previous 12 months, it is perhaps not surprising that women have higher rates of exposure to events such as these (Plichta & Falik, 2001). The length of exposure to a trauma may also play a part, as it can vary considerably from traumatic stressor to traumatic stressor. For example, in a combat situation, there may be sporadic exposure to a traumatic stressor, whereas the level of exposure in the case of rape is particularly high (Resick, 2001). This may, in part, account for some of the elevated rates of PTSD in women who have been raped.

2.4.3.2.2 Peritraumatic dissociation

Dissociative symptoms at the time of the trauma such as depersonalisation, amnesia, and out-of-body experiences, have also been shown to be associated with increased levels of PTSD thereafter (Davison et al., 2004). Substantial work in this field has focused on Vietnam combat veterans and provided support for this finding, while more recent studies have been inconclusive. For example, Bremner, et al., (1992) compared a group of Vietnam War veterans with and without PTSD (53 and 32 respectively). The former reported dissociating more, at the time of the combat trauma, than those without PTSD (Bremner et al., 1992). More recent work with survivors of an industrial disaster in a petrochemical factory in France (N = 129) found that peri-traumatic dissociation was related to the development and endurance of PTSD symptoms 15 months after the accident (Birmes, Daubisse, & Brunet, 2008). Another study by Shalev, Peri, Canetti and Schreiber (1996) - which employed a sample of college patients (both civilian and

military) (N = 51) - examined the predictive ability of a range of variables (e.g. age, gender, education, event severity and peritraumatic dissociation) with respect to PTSD status six months after the initial assessment. Only peritraumatic dissociation significantly predicted PTSD at the six-month follow-up (Shalev et al., 1996).

Furthermore, a meta-analysis conducted in this area found peri-traumatic dissociation to be the strongest predictor of PTSD symptomatology, with an effect size of 0.35 (Ozer et al, 2003). However, another more recent review of 17 prospective studies (investigating the independent predictive value of peri-traumatic dissociation in the development of PTSD symptoms after a single trauma) found that there were no, or only very weak indications of the predictive value of peritraumatic dissociation (van der Velden & Wittman, 2008). Thus, the findings for the predictive value of peri-traumatic dissociation tend to be mixed, but are nonetheless important in view of their central role in the development of PTSD.

2.4.3.3 Psychosocial factors

A number of other important psychosocial factors have also been identified as placing someone at increased risk of experiencing more enduring symptoms of PTSD; these include early family environment (e.g. early parental separation or family psychiatric illness) and a history of prior victimization and experiences of trauma as a child (especially in the case of child sexual abuse) (Resick, 2001). In addition, the presence of psychological difficulties prior to the traumatic experience and the level of social support received thereafter, have been identified in some studies. As summarised earlier, SV may impact upon a victim's experience of, and access to, social support and so any research on the role of social support in the development and maintenance of PTSD, is relevant. Similarly, any impairment in psychological functioning pre-trauma should be taken into consideration.

2.4.3.3.1 Prior psychological functioning

The psychological well being of an individual prior to their traumatic experience has been identified in the literature as playing a role in the development and persistence of PTSD. For example, Kühn et al. (2006) examined the onset, course and remission of psychiatric disorders in a sample of hospital patients attending an emergency department (N = 58). Prior to their attendance, 35% of the sample had a psychiatric

history whilst at the six- month follow-up, 10% still met the criteria for full or sub-syndromal¹² PTSD (Kühn et al., 2006). In an earlier study with Vietnam veterans (N = 3016), Kulka et al (1990) also found that a psychiatric history was likely to predict current PTSD whilst Breslau et al. (1997b) discovered that a history of major depression, in a sample of mothers (N=801), increased their vulnerability to PTSD after a traumatic incident. With regard to prior psychological adjustment, Ozer et al. (2003), in their review of 23 articles (N = 6797), found effect sizes ranging from - .13 to .47 for the key risk factors they identified. A more detailed examination of these studies found that the relationship between PTSD and previous psychological adjustment was stronger when the traumatic incident involved non-combat interpersonal violence as opposed to exposure to direct combat situations (Ozer et al., 2003).

2.4.3.3.2 Social support

Social support refers to the degree to which a person experiences support from family, spouses/partners and friends and tends to include both quantitative and qualitative elements; that is, the number of people with whom someone has regular contact and the frequency of that contact and the extent to which someone perceives that they actually, or could, receive support from those around them (Resick, 2001). Its role in mental health and well being following stressful or traumatic events lies in its proposed ability to act as a buffer for the individual against psychological distress (Cohen & Wills, 1985). Boscarino (1995) investigated the effect of social support in a sample of war veterans (N=2490) in a study that also looked at PTSD, depression, substance abuse/dependence and anxiety disorders. He found that veterans with low social support were almost at a 180% greater risk of developing PTSD than those with high social support (Boscarino, 1995). Furthermore, having controlled for level of combat exposure, those who had experienced lower quality social support, were significantly more likely to be currently diagnosed with anxiety, depression, alcohol abuse or PTSD (Resick, 2001).

Likewise, a recent meta-analysis of 14 risk factors for PTSD identified social support to have the largest effect size ($\eta = 0.4$) in (Brewin, Andrews, & Valentine, 2000). A few years later, Ozer et al. (2003) conducted a review of the literature on predictors of PTSD

¹² Sub-syndromal PTSD means that the client/participant is exhibiting post-traumatic symptoms but not sufficient for a diagnosis of PTSD.

and its symptoms (which incorporated 21 further studies not included by Brewin and colleagues). They found social support to be the second strongest predictor of PTSD with an effect size of 0.29 (Ozer et al., 2003). It is worth noting that while research has shown that there is a clear relationship between post-trauma psychological symptoms and social support, the nature and direction of this relationship requires further empirical clarification (Resick, 2001). Questions still remain as to whether or not poor social support impacts on how an individual copes after a traumatic event, or the extent to which the inherent nature of PTSD as manifested in avoidant and withdrawal behaviours, isolates the victim from any surrounding supportive resources (Resick, 2001).

In summary, PTSD is a relatively common disorder in the general population with an even higher prevalence in vulnerable populations, such as war veterans and disaster survivors. What is notable however is that victims of sexual violence (SV) are more likely than other populations that have been exposed to a traumatic stressor, to develop PTSD, or some form of post-traumatic symptoms. In addition, many of the PTSD risk factors appear particularly salient to women's post-rape experiences. However, how accurate and complete is the PTSD model as an independent framework for understanding and responding to these women? Some of the research from this area that has examined this question is explored below.

2.5 Utility of the PTSD model in understanding the effects of SV

The formal acceptance of the diagnostic category of PTSD in the DSM-III heralded the first official re-framing of women's reactions and experiences post-assault as a legitimate response to what may be considered a deeply traumatic stressor. As already indicated in a number of studies, almost three-quarters of women reported some degree of PTSD symptoms during the first 12 months after an experience of SV (Resnick et al., 1989). While the three cluster symptoms of PTSD – re-experiencing, numbing/avoidance, and arousal – have garnered considerable clinical support, the empirical basis for them is still mixed (Foa & Rothbaum, 1998; Asmundson, Stapleton, Taylor, 2004; Gottesman, 2007). For example, in one study by Foa and colleagues (1995), a factor analysis of the 17 PTSD symptoms, as delineated by the DSM-IV diagnostic criteria, found that there was *not* a large degree of overlap between the cluster symptoms identified therein and those in the three clusters of the DSM-IV

diagnosis (Foa & Rothbaum, 1998). One of the more interesting study findings was that the presence of numbing symptoms (as opposed to any of the other clusters of symptoms) was more effective in facilitating a differential diagnosis of people with and without PTSD; that is, only a small number of individuals without PTSD endorsed the numbing symptoms (Foa & Rothbaum, 1998). Surprisingly however, according to the diagnostic criteria of the DSM-IV, it is possible to receive a diagnosis of PTSD in the absence of any numbing symptoms (Foa & Rothbaum, 1998).

The controversy surrounding the PTSD diagnostic criteria has meant that, in recent years, some researchers and clinicians have been calling for a revision or introduction of new diagnoses, in the forthcoming DSM-V (Press release APA, 1st May 2008) that will accurately capture the experience of PTSD. Others have openly critiqued PTSD as an accurate diagnosable syndrome (e.g. Burstow, 2005; McHugh & Treisman, 2007). Additionally, traditional understandings of trauma, particularly in relation to women's experiences following rape, have been subjected to increasing criticism by leaders in this field (e.g. Berg, 2002; Wasco, 2003). The following section examines briefly how our understanding of rape and sexual assault has developed within the context of the PTSD framework.

2.5.1 Rape Trauma Syndrome (Burgess & Holmstrom, 1974)

A new language around, and understanding of, SV developed largely as a result of the feminist movement of the 1970s (Herman, 2001). This movement not only raised the public awareness of rape, but according to Herman, it also led to a '*new social response to victims*' and re-defined rape as a crime of violence rather than a sexual act (Herman, 2001:31). At around the same time and before the genesis of PTSD as a psychiatric diagnosis, an interesting study was being conducted by two researchers (a psychiatric nurse and sociologist) in North America (Burgess & Holmstrom, 1974). They were recording and categorising the post-assault experiences of women (n=109) and children (n=37) who reported being raped and who had been admitted to the emergency department of a local Boston hospital. The authors identified a distinctive and common stress response pattern, similar to reactions seen in war veterans at the time (e.g. flashbacks, nightmares) and involving a range of emotional, physical and behavioural responses (Ray, 2008). The core of this acute traumatic reaction was the experience of intense subjective terror, during which they feared being killed (Burgess, 1983).

Burgess and Holmstrom (1974) argued persuasively, despite the rather small sample size, that there was sufficient universality of responses among victims to suggest that they constituted a 'clinical entity' (Burgess, 1983:100).

The authors described two phases to this response pattern: (i) an acute or disruptive phase, and (ii) a (long-term) re-organization phase (Burgess, 1983). The former which may last from a few days to a couple of weeks post-assault, is characterised by a complete disruption of the woman's life, accompanied by a range of feelings, such as shock, fear, shame, guilt, embarrassment, anger and self-blame. The researchers noted that while the expression of these emotions/reactions can vary from one person to the next, they generally fell into one of two broad response styles:

1. *Expressed style* – whereby the woman openly expresses her emotions and may cry, laugh, be silent or appear restless or agitated
2. *Controlled style* – whereby the woman contains her emotions and may downplay her fear, anger or anxiety and may sit calmly and respond to any questions in a detached and logical way.

The second re-organisation phase is characterised by a range of rape-related symptoms, which may last from months to years after an assault (Burgess, 1983). During this phase, the woman attempts to recover from her experience and re-introduce a sense of order and control back into her world (Burgess, 1983). This work was significant in its contribution to the decision to include PTSD as a diagnosis in the 1980 version of the DSM (DSM-III; APA, 1980) and in the expansion of the list of possible 'traumatic events causing extreme fear' in a subsequent edition of the manual (DSM-IV-TR, 2000). The suggestion that the event (i.e. rape), rather than the person/individual, was a significant causal factor in the genesis and development of PTSD had, and continues to have, important implications for its treatment as well as for, professional and public opinion on the apportionment of blame in rape cases and how rape is treated within the legal reform and judicial systems (Burgess, 1983; Frazier & Borgida, 1992; McGowan & Myers, 2004).

2.5.2 PTSD, rape and women: Criticisms and controversies

Since the early 1990s, the nature and extent of empirical support for the conceptual origins of PTSD has been the subject of critical scrutiny and considerable scepticism (e.g. Yehuda & McFarlane, 1995; Herman, 2001). Hence, Rosen and Taylor (2007) commented that, in almost 25 years of clinical experience and research investigation, few if any of the assumptions and theoretical underpinnings of PTSD have gone unchallenged. Similarly, Spitzer, First and Wakefield (2007) observed that, not since the introduction of Dissociative Identity Disorder (in 1994), has a diagnostic category created such controversy in relation to its central assumptions, diagnostic criteria, and clinical utility.

In a relatively recent paper, Burstow (2005) presents an extensive critique of PTSD and the DSM. She argues that the original construction and subsequent inclusion of this diagnosis, unlike most other DSM diagnoses, partially arose due to the efforts of individuals external to the psychiatric profession (Burstow, 2005). She reports that the American Psychological Association (APA) was lobbied first by American veterans and later by feminist therapists, to create a new diagnosis that would '*recognize the long-term psychological damage incurred by soldiers in combat*', thereby facilitating access to therapeutic services for them (Burstow, 2005:430). From the perspective of feminist therapists, an official recognition of the violence (i.e. in the form of a psychiatric diagnosis) and the routine traumatisation of women in an inherently patriarchal society, legitimised their experiences and on a more practical note, extended health insurance coverage, thereby allowing them to seek professional treatment and conferring their right to seek compensation (Burstow, 2005).

Burstow posits that the current PTSD diagnosis is not only problematic, but also undesirable and only serves to over-medicalise thoughts and behaviours '*in the absence of proof that anything medical is occurring*' (Burstow, 2005:438). Berg (2002) has also queried the benefits of the PTSD diagnosis for women. Written from a feminist standpoint, she posits that while the debate around PTSD has been critical in challenging some historical assumptions (e.g. the contention that female psychopathology is of a purely internal origin), it omits the damaging influence of society and its institutions on women's lives. In sum, while PTSD as a diagnostic category is not without its problems and limitations, it has demonstrated some utility as

a model in understanding women's experiences in the aftermath of a sexual assault; this is discussed in more detail below.

2.5.3 Understanding the effects of female sexual assault: Applications of the post-traumatic stress model

Wasco (2003) published an interesting and thought-provoking review paper that examined the limitations and applications of trauma response models, such as PTSD, in describing the experiences of women who have been raped or sexually assaulted. In line with previous researchers (e.g. Brown, 1991; Harvey, 1996; Gilfus, 1999), she argues that these traditional models and understanding of responses to trauma '*are likely too narrow to accurately capture the true complexities of women's experiences of sexual violence in a gendered society*' (Wasco, 2003:309). Nonetheless, she also highlights some potentially useful aspects of the post-traumatic (or PTSD) framework such as: creating a scientifically and clinically-based explanation for the typical reactions of women after rape; its role in generating research into the predictors and outcomes of sexual assault and facilitating useful comparisons through uniform concepts and reliable instruments; connecting researchers in the field of rape/sexual assault with a much wider research community thereby facilitating the development of effective and reliable treatments; and, given the structure of the American health care system, ensuring that PTSD as a diagnosis gives women who have been raped, access to support services via their health insurer (Wasco, 2003).

According to Wasco, the model is limited by a lack of supplemental contextual information for both clinicians and researchers, which would facilitate the understanding of normative actions and reactions by women after an experience of SV (Wasco, 2003). By drawing on the empirical evidence, Wasco carefully illustrates some of the limitations in the current understanding of rape-related post-traumatic symptoms as explained by the PTSD framework. These are important in the context of the present study and are covered in more detail below.

2.5.3.1 Limitations of the traumatic event as the cause or source of harm

Within the traumatic response model, the *traumatic event* is positioned at the centre of the harm experienced by a woman who has been raped. Inherent in this concept (and diagnosis) is that the event (i.e. the sexual assault) was extreme, more than likely violent

and that it evoked feelings of intense fear, horror or even fear of death (Wasco, 2003). However, according to Wasco, this implicit understanding fails to account for the *'specific cultural, social, and relational context in which sexual violence usually occurs'* (Wasco, 2003:311). For example, while some rape and sexual assaults are most certainly violent and involve some degree of injury or risk of death, not all do so. As mentioned earlier, up to 69% of women, who are raped, do not incur any physical injury (Tjaden & Thoennes, 2000). Wasco goes on to suggest that, rather than thinking about rape as a single event or incident, it would be more accurate to envisage it as a process that starts as a wider social problem (i.e. violence against women) well in advance of the rape and continues long after it, in the form of pervasive societal reactions that often blame women (Wasco, 2003).

Secondly, Wasco criticises some of the key beliefs of the 'shattered assumptions' theories of trauma which hold, that the experience of a trauma shatters the assumptions of the average non-traumatized individual that the world is a predictable, safe and just place (Wasco, 2003). Gilfus (1999) purports that this paradigm largely reflects the world-view of middle-class, non-victimized, White, America which, when combined with a history of racism and oppression (e.g. enslavement of African-Americans), may not capture the experience of the world as felt by a substantial proportion of the female population (Wasco, 2003). According to Wasco (2003), racial and ethnic minorities, victims of child sexual abuse, poor and working class people, are just some of the types of women who may not have their assumptions of a safe, just world shattered by an experience of rape. In fact, she suggests that this experience may serve to confirm beliefs that women are not in control of their bodies sexually and that violence is a 'normal' part of life. Thus, imbued within this is the potential for *'a pattern of harm and recovery that is more intricate than what has been accounted for in most published literature on trauma'* (Wasco, 2003:313).

2.5.3.2 Limitations of the symptom clusters

Wasco (2003) also expresses concerns over the limiting nature of the three clusters of symptoms, as delineated by a formal diagnosis of PTSD, in their ability to capture the 'true' experiences of women who have been raped. While she concedes that some studies have shown that most women (73%-94%) fulfil the criteria for a diagnosis of PTSD after an experience of rape (Kramer & Green, 1991; Rothbaum et al., 1992),

these are not the only symptoms experienced by victims. As illustrated earlier, survivors of rape frequently experience depression, damaged self-worth, lowered self-esteem, self-blame and stress-related physical symptoms, none of which are fundamental symptoms of PTSD, nor are they adequately explained by this original theoretical framework (Wasco, 2003). As indicated earlier, rape and sexual assault may also give rise to a range of physical consequences that may exact a heavy toll on the physical and sexual health of a victim (e.g. sexually transmitted diseases, unwanted pregnancies, sexual dysfunction, sexual risk-taking behaviours etc.) (Wasco, 2003).

Another potential problem relates to the ethnocentric nature of some of the clusters of PTSD symptoms and in particular, avoidance/numbing or hyperarousal (Wasco, 2003). Cross-cultural researchers have found that, while many cultural groups experience one of the classic PTSD symptoms (i.e. intrusive thoughts and memories), the experience of others (e.g. hyperarousal) often depends on the '*ethnocultural affiliation*' of an individual (Marsella, Friedman & Spain, 1999 cited by Wasco, 2003:314). For example, work by Jenkins (1999) with Latina refugee women in El Salvador; found that, while participants commonly reported experiencing nightmares (i.e. a re-experiencing symptom) and increased irritability and difficulty concentrating (i.e. a hyperarousal symptom), very few typically experienced numbness or avoidance (Wasco, 2003). If numbing/avoidance, as reported by Foa and Rothbaum (1998) earlier, is one of the distinguishing cluster symptoms of PTSD, then the cultural applicability of the diagnosis, as it stands, may warrant revision. Finally, Wasco (2003) suggests that women, who belong to ethnic minorities and other marginalized groups in a society, may hold a worldview that is different, to a large extent from that of the most of the population. This means that rape, as experienced by these women, may be viewed, experienced and coped with, in different ways that are not consistent with the pre-ordained symptom clusters of the PTSD diagnosis (Wasco, 2003). This lack of understanding of the cultural nuances of trauma responses could mean that the harm experienced and reported by these women is not detected by clinicians and researchers alike, leaving them perhaps even more vulnerable than originally anticipated (Wasco, 2003).

2.5.4 *The current state of the trauma field: A summary*

Most commentators would agree, in light of the above criticisms that the contemporary study of trauma is characterised by some uncertainties and is in a state of flux. McHugh and Treisman (2007), in a recent paper, proposed that since its inception, PTSD has become a household word and has therefore been chronically over-used; consequently, it exists in many forms today including: 'acute'; 'chronic'; 'delayed'; 'complex'; and 'subsyndromal PTSD'. The authors argue that the proliferation of this diagnosis, both in the public and mental health arenas, has impacted negatively on the field of trauma and impeded, rather than improved, our understanding of typical psychological reactions to traumatic stressors (McHugh & Treisman, 2007). Others, such as Rosen (2007) and Spitzer et al., (2007), have also called for a revised definition of PTSD, with the addition of more stringent criteria in order that *'the construct at least captures more closely what it was intended to capture'* (Spitzer et al., 2007:240). Furthermore, Ray (2008) concisely states what should be the ultimate aim of future research in this area; that is, to broaden the historical over-reliance on PTSD and its symptoms as being the only anticipated outcome of a traumatic disturbance.

2.6 Conclusion

From the findings presented here, it is clear that rape/sexual assault is a significant and pervasive social problem across all countries, both in the developed and developing worlds. This is not only a problem of the less educated, and poorer countries, but also of the more industrialised and 'civilised' societies in the West. If we assume that at least one in three women will experience some form of SV in their lifetime, it is reasonable to expect that the effects of this crime will be felt far beyond the individual level, as encapsulated within the ecological model. Research conducted mainly within the framework of the trauma response model, has provided a useful psychological 'profile' of a typical individual with PTSD within the rape and sexual assault survivor population. In sum, a woman in the aftermath of a rape or sexual assault would typically present with a diagnosis of PTSD as well as increased physiological arousal, often in the form of insomnia; an exaggerated startle response, hyper-vigilance, irritability and poor concentration (Petrak & Hedge, 2002). In addition, they may exhibit spontaneous avoidance that involves avoiding memories or shutting down affect (responsiveness numbing). Thus the reality of living with this disorder (PTSD) in the aftermath of a

rape, can wreak havoc on an individual's normal and adaptive functioning (Resick, 2001).

Re-experiencing of the assault may include flashbacks, nightmares or intrusive thoughts in the form of images, perceptions or recollections of the event, whilst the increased arousal often alternates with dissociative experiences, subjective emotional numbing, derealization, depersonalization and dissociative amnesia (Petraak & Hedge, 2002). Depression, suicidal ideation, and a sense of hopelessness are also common along with diminished interest in normal activities, including relationships and sexual activity (Petraak & Hedge, 2002). Self-blame, shame and guilt for what happened are frequent feelings expressed by rape victims (Resick, 2001). However, as the research reviewed here has shown, this represents only part of the reality. Some of the other intrinsically 'hidden' costs of this crime include: individual effects on physical health as well as mental health consequences other than PTSD and the economic and social costs borne by a society attempting to adequately respond to, and prevent, SV (as well as responding to the needs of traumatised children and distressed partners, family and friends).

However, a question still remains around the appropriateness of the trauma response model with respect to women's post-assault experiences and reactions and as the research has shown, the impact of rape does not fit as neatly into the three-symptom clusters/PTSD framework as previously thought. Wasco's (2003) review raised several interesting questions around certain aspects of this model that would benefit from further investigation. These are re-examined later in the final chapter of this thesis.

Chapter Three

**The Irish context:
Research, policy, and
practice**

CHAPTER THREE

The Irish context: Research, policy and practice

The previous chapter highlighted the global problem of SV; our attempts to better understand it, particularly within the framework of the trauma response model, and the potential 'ripple' effects of this crime on both the women who experience it and their families and wider community. By way of context, the current chapter addresses a number of specific research, policy and practice issues within Ireland, related to the scale and prevalence of this problem (when compared with the UK); current attitudes in Ireland toward rape/sexual assault; the Irish government's attempts to prevent SV; and the work of non-governmental organisations (NGOs) in responding to, and providing support for, the victims.

3.1 Prevalence of sexual violence in Ireland: An overview

The information available to estimate the prevalence and impact of SV in Ireland is considerably limited by the dearth of research undertaken in this area. Furthermore, the nature of the crime and the pervasive fear and social stigma that still tend to be associated with it, means that current figures may underestimate the true scale of the problem due, in large part, to under-reporting and attrition (Regan & Kelly, 2003; Kelly, Regan & Lovett, 2005). While some crime statistics have been collected in relation to rape within Ireland (e.g. Annual Garda Statistics and the Central Statistics Office, *Quarterly National Household Survey, Crime and Victimization*), it is widely acknowledged that this is one of the most under-reported of all crimes (e.g. Crowell & Burgess, 1996; Tjaden & Thoennes, 2006). For instance, current estimates suggest that fewer than one in ten incidents of SV are officially reported to the Gardaí (i.e. the Irish police force) (McGee et al., 2002), whilst only one to two per cent of cases result in a criminal conviction (Regan & Kelly, 2003).

In this chapter, the most recent Irish crime statistics are presented and juxtaposed, for purposes of comparison, with relevant data from the UK (and briefly from some other parts of Europe). More specific results from the first and only epidemiological study of sexual violence conducted in Ireland (i.e. the *SAVI Report* by McGee et al., 2002) will then be outlined, followed by a presentation of some annual statistics from the main

service providers that currently respond to victims of SV. This is followed by an examination of the evidence from the SAVI work with respect to the psychological impact of SV, as well as Irish research that has looked at public attitudes and beliefs towards rape and sexual assault (and comparative UK work in this area). All of this information is presented in relation to experiences of SV *after the age of 16* (i.e. adult sexual assault).

3.1.1 Crime statistics

3.1.1.1 The Irish and UK context

Under Irish law, a number of offences relevant to SV (either to a child or an adult) exist under a range of legislative Acts including: the *Criminal Law Amendment Act*, 1935; the *Criminal Law (Rape) Act*, 1981; the *Criminal Law (Rape) Amendment Act*, 1990; the *Criminal Law (Sexual Offences) Act*, 1993; the *Criminal Law (Sexual Offences) Act*, 2006; and the *Criminal Law (Sexual Offences) (Amendment) Act*, 2007. Additionally, marital rape has been recognised as an offence since 1990 (Bacik et al., 1998). Alleged perpetrators can be prosecuted under a range of offences including: rape of a female; rape section 4; Criminal Law (Sexual Offences) Act 2006; aggravated sexual assault; and sexual assault. The annual crime statistics for each of these categories – within Ireland - are presented in Table 3.1. This shows the recorded numbers of reported sexual offences decreasing in each of the five categories from 2006 to 2007. This represents an overall decrease of approximately 25% in sexual offences during this period. However, this is indicative of a fall in reported offences and cannot, therefore, be equated to a decline in the number of actual committed offences.

Comparable crime statistics from our closest neighbours, the UK, have been sourced from information collected by the British Home Office and the Northern Ireland Office. Precise comparisons across countries are difficult because, historically, questions on SV have not been routinely included in crime surveys. This is compounded by methodological differences and changing legal definitions across different jurisdictions. The two main sources of these data in the UK are the monthly police-recorded crime statistics and the British Crime Survey (*BCS*) – a face-to-face victimisation survey of adults living in private households (Walker, Flatley, Kershaw & Moon, 2009). A report combining both of these sets of statistics for England and Wales, found recorded levels

Table 3.1: Comparison of reported annual Garda crime statistics for sexual offences in Ireland in 2006 and 2007. ¹³

SEXUAL OFFENCE TYPE	2006 n	2007 n
<i>Rape of a female</i> ~ is defined as a man who has had 'sexual intercourse with a woman who does not consent, and at the time he either knows that she does not consent, or is reckless as to whether or not she consents' (Bacik et al., 1998:243).	340	283
<i>Rape Section 4</i> ~ refers to 'sexual assault, which includes penetration (however slight) of the anus of mouth by the penis, or penetration (however slight) of the vagina by any object held or manipulated by another person' (Bacik et al., 1998:243). This offence is gender neutral.	92	70
<i>Criminal Law (Sexual Offences) Act, 2006</i> ~ This Act refers to a range of offences including statutory rape (unlawful sexual contact with a person under 17 years of age) and reckless endangerment of a child.	58	52
<i>Aggravated sexual assault</i> ~ refers to the indecent assault of a male or a female involving serious violence or threat of serious violence	18	17
<i>Sexual Assault</i> (see Aggravated Sexual Assault)	1097	774

rapes of a female (an increase of five per cent on the previous year) and 19,470 sexual assaults of a female (a drop of four per cent on the previous year) (Walker et al., 2009). of the 'most serious sexual offences' (i.e. including rape, sexual assault, and sexual activity with children) to be 40,787 for 2008/2009, a two per cent decrease on the previous year (Walker et al., 2009:54). In the same period, this consisted of 12,165 Based on these figures approximately three per cent of women in England and Wales (aged between 19 and 59 years) had experienced sexual assault (including attempts) in the previous 12 months (Walker et al., 2009). In Northern Ireland, recorded police figures for a range of sexual offences during 2007/2008, amounted to 1822, an increase of 1.1 per cent from the previous period (PSNI, 2008). While the Northern Ireland Crime Survey (NICS) does not appear to provide detail specifically on sexual

¹³ Adapted from the *Annual Report of the Garda Síochána, for 2006 and 2007*.

victimisation crimes, a more recent crime survey, focusing on domestic violence, found that one to two per cent of respondents (N = 2040) between 2001 and 2006/2007 reported being '*forced to have sex*' (Carmichael, 2008).

3.1.1.2 Crime statistics in the context of other European countries

Results from a European transnational study on the burden of crime, suggest that, in the last 10 years, the prevalence of some of the most common crimes (e.g. robberies, thefts, assaults) has decreased significantly across the EU, with the notable exception of Belgium and Ireland (*European Union International Crime Survey (EU ICS)*; van Dijk, et al., 2005). Risks of being assaulted (based on 2004 figures) were highest in countries such as the United Kingdom, Ireland, Belgium, Sweden and Denmark whilst experiences of SV (based on 2005 figures) were reported by more women in Ireland (3.8%), than in a number of other countries including Sweden (3.3%), Germany (2.4%), Hungary (0.1 per cent), and Spain (0.3 per cent (van Dijk et al., 2005). On average, 1.7% of women across 18 European countries reported some form of sexual victimisation (van Dijk et al., 2005). However, it should be noted that the authors advise caution in then interpretation of these figures because assessing the prevalence of sexual victimisation across different contexts can be difficult due, in large part, to the considerable variation in perceptions of acceptable and unacceptable sexual behaviour (van Dijk et al., 2005).

3.1.2 Prevalence of sexual violence: Results from Sexual Abuse and Violence in Ireland: The SAVI Report (McGee et al., 2002)

The *SAVI Report* (McGee et al., 2002) was the first survey of its kind in Ireland to estimate the prevalence of different types of SV in Irish men and women, both in childhood and adulthood. Prior to this study (and in the five years since), attempts at estimating the prevalence of SV in Ireland had been largely non-existent, or at the most, investigated only indirectly. For example, the only large-scale Irish survey (n=1001) that specifically incorporated questions about SV was conducted by Irish Marketing Surveys on behalf of the ISPCC¹⁴ in 1993 (McGee et al., 2002). While their main focus was the experience of, and attitudes towards, disciplining children, questions were also included on experiences of childhood sexual abuse (McGee et al.,

¹⁴ ISPCC is the Irish Society for the Prevention of Cruelty to Children.

2002). Fifteen per cent of women in this survey reported contact sexual abuse during childhood. The only other Irish prevalence data that are currently available, are based on a much smaller scale survey of third level students (n=247) investigating unwanted sexual experiences amongst girls before the age of 16 (Lalor, 1999). This study found rates of 32% in their respondents.

The SAVI study was based on a large national telephone survey (N=3118) and involved the collection of data on a wide range of related topics including: the prevalence of sexual abuse; the profile of those abused; the context of abuse; the pattern of disclosure of abuse to others; and some of the psychological consequences of SV (McGee et al., 2002). Results from this research suggest that one in five (20.4%) Irish women and 1 in 10 Irish men (9.7%) have had an experience of, what may be described as, 'contact sexual assault' (e.g. attempted penetration, or actual penetration, or oral sex) as an adult (i.e. aged 17 years or over) (McGee et al., 2002). When childhood victimisation is taken into account, four out of every ten women (42%) and over one quarter of men (28%) had experienced some form of sexual abuse, or assault in their lifetime (McGee et al., 2002). According to population figures for 2001, 118,000 adult Irish men and women had been exposed to a serious sexual crime as a child (McGee et al., 2002).

3.1.3 National Statistics: Rape Crisis Network of Ireland (RCNI, 2008) and the Dublin Rape Crisis Centre (DRCC, 2009)

The RCNI and DRCC Annual Statistics (based on service-users) - in the absence of national epidemiological figures - provide an additional, fairly reliable indication of the potential prevalence of SV in contemporary Ireland *The RCNI National Statistics* (RCNI, 2008) are based on figures collated in 2007 from 14 Rape Crisis Centres (RCCs) nationwide; these indicate that almost 1700 men and women were face-to-face RCC service users in that year (RCNI, 2008). In the case of sexual abuse in adulthood only, the vast majority were women (86%), aged between 24 and 39 years (51% approximately), and in eight out of ten cases, the perpetrator was known to the survivor (RCNI, 2008).

The DRCC Annual Report (DRCC, 2009) provides more detail, including the number of telephone contacts made to the centre in 2008. They received over 12,000

counselling calls, 9,487 of which were genuine counselling calls (i.e. excluding hoax, obscene, silent and hang-up calls) (DRCC, 2009). Almost 3000 of those callers were calling for the first time and, once again, the great majority were females (86%) and aged between 18 and 39 years (62%) (DRCC, 2009). In approximately half of the cases, the survivor knew the abuser (DRCC, 2009). A total of 4928 individual client-counselling sessions was delivered, approximately one-third of which (32%, 1174/4928) were crisis appointments for men and women who had experienced a rape or sexual assault during the previous 12 months (DRCC, 2009). It is widely accepted that, due to the strong tradition of under-reporting of this type of crime to the police (e.g. SAVI: 9.7% and 7.8% of women for childhood abuse and adult sexual assault respectively), that the above statistics are likely to reflect a more accurate picture of the incidence of SV in Irish society than national crime statistics. Nonetheless, these figures should be treated with some caution as further results from the SAVI found that only six per cent (n=21) had reported their adult assault to a medical professional whilst only 83 participants (63 women and 20 men) had attended a professional psychologist or counsellor (McGee et al., 2002). These relatively low levels of contact with professionals have potentially serious implications in terms of the extent to which services are responding adequately to the problem of SV in Ireland today.

3.2 The psychological consequences of sexual violence in the Irish population

The *SAVI* authors also collected brief data on the psychological consequences of SV in their sample. They used the *PTSD Checklist–Civilian Version* (PCL-C) (Andrykowski, 1998), a brief 17-item measure that screens participants for PTSD symptoms based on the DSM-IV-TR specified criteria (McGee et al., 2002). Whilst the authors indicate that their approach did not permit them to identify clinical cases of PTSD, their results, nonetheless, indicate that 25% of women (138/556) and 16% of men (n=51) reported experiencing symptoms of PTSD at some point in the past. These figures included people who met the criteria for full, and sub-syndromal PTSD) (McGee et al., 2002). Levels of full and sub-syndromal PTSD currently, were found in 17% of women (94/556) and 9% of men (n= 30) (McGee et al., 2002). The authors also discovered that the severity of PTSD (both currently and in the past) was associated with the extent of sexual abuse and that the greater the amount of time that had elapsed since the experience of SV, the less severe the overall symptoms. In addition, those who recounted experiencing penetrative abuse as opposed to ‘non-contact’ abuse (e.g.

indecent exposure), either as a child or as an adult, were more likely to be at risk for more severe PTSD symptoms (McGee et al., 2002).

Qualitative data (n= 190) gathered in the form of open-ended responses, were also explored by McGee et al in order to identify other effects of SV in participants' lives. According to the authors, a content analysis of these data yielded the following four themes: effects on their personal identity; effects on their personal relationships; other symptoms of mental ill health; and effects on their knowledge or awareness of sexual abuse issues (McGee et al., 2002). Some of the psychosocial effects that were identified included: depression/withdrawal; somatic symptoms; alcohol/drug problems; effects on parenting; difficulties with sexuality; trust issues; self blame and guilt; trust issues; and interpersonal relationship difficulties. Several additional brief questions asked participants about their overall quality of life (QoL), their general well being, and if they had ever received medication for anxiety or depression, or been an inpatient in a psychiatric hospital (McGee et al., 2002). Again, 'contact' (particularly penetrative) sexual abuse was associated with significantly lower QoL ratings, poorer mental health scores, increased likelihood of having been prescribed anxiety and/or depression medication (especially women) and increased likelihood of a psychiatric hospital admission (McGee et al., 2002). Importantly, the authors noted that an in-depth examination of the after effects of SV, was beyond the scope and remit of their study and they recommended that alternative methods (e.g. in-depth one-to-one interviews) be used for this purpose.

3.3 Attitudes to sexual violence in Ireland

The perceptions/beliefs around SV amongst the general population is another important factor to consider in the context of SV in Ireland. Prior to the SAVI report, no such information was available within an Irish context. The results from the SAVI study are presented below and juxtaposed with other data, both from Ireland and the UK, in order to provide some insights into the nature and extent of, what would appear to be largely 'rape supportive' attitudes and rape myths amongst the general Irish population.

3.3.1 *The role of rape myths*

Rape myths have been defined as 'prejudicial, stereotyped or false beliefs about rape, rape victims and rapists' (Burt, 1980:1). Some examples of these include: 'Women ask for it'; 'Rapists are sex-starved or insane men who cannot help themselves'; 'All women secretly want to be raped'; or 'Women are only raped in dark alleys by a stranger'. Many women often have difficulty defining what has happened to them as a result of these rape myths. For instance, Kahn et al. (2003:233) report that at least half of all women '*who have had an experience that might meet the definition of rape, do not label themselves as rape victims*'. This clearly presents a significant barrier for these women to accessing appropriate services.

Rape myths have also been found to compound the feelings of self-blame and guilt experienced by women in the aftermath of SV. Here, it is important to examine work that has been conducted elsewhere before. Several early studies in this area have asked participants to make judgements about hypothetical scenarios describing a rape (e.g. Richardson & Campbell, 1982; Jenkins & Dambrot, 1987; Thornton et al., 1988). The results indicate that the responsibility for the rape is often attributed to the woman, particularly if she has violated social norms, such as alcohol consumption, prior to the assault (e.g. Acock & Ireland, 1983; Renner, Wackett, & Ganderton, 1988). Other factors that increase the likelihood of blame being apportioned to a woman include physical attractiveness, or a history of sexual experience (e.g. Calhoun, Selby & Warring, 1976; Cann, Calhoun & Selby, 1979). Guilt and self-blame have also been identified as strong reasons for non-reporting in female victims of acquaintance rape (n=236) (Bachman, 1998). It is clear that such internalised rape myths, in conjunction with women's reluctance to name their experience as SV, may deter women from seeking help.

In a small qualitative study with female rape victims (n=8) in the US, Aherns (2002) found that some of the participants questioned whether, what they had experienced, was rape following negative interactions with support providers. Aherns reported that these negative reactions were rooted largely in rape myths and stereotypes and she identified three 'pathways to silence' including: blaming and insensitive reactions from formal service providers, thereby increasing women's fears of a negative reaction; inappropriate and ineffective informal support, leading to heightened feelings of guilt

and shame; and adherence to rape myths by support providers, leading women to question whether their experience could be described as rape. Participants who had initially disclosed their experience of SV to formal (and informal) support providers also maintained their silence about it for some time after these interactions (Ahrens, 2002). This delay in accessing support may, in turn, impact upon recovery from the effects of the assault and the knock-on consequences on their lives (Herman, 2001). Interestingly, Sable, et al. (2006) found that the concerns of women in the US are still dominated by shame, guilt and embarrassment, despite 30 years of legal reforms and public education campaigns and rape awareness activities on college campuses.

3.3.2 Irish attitudes to rape and sexual assault

3.3.2.1 SAVI results (McGee et al, 2002)

According to McGee et al, approximately half of their respondents were found to be 'seriously wrong' about the frequency of SV in Ireland today; that is, they either underestimated the true figure by at least half, or overestimated it by at least twice the actual figure. A significant proportion of women were more likely to overestimate the frequency of SV whilst the opposite was true for men. Fewer than 10% of the *SAVI* sample reported their experience of SV to the police. However, the public perception of the proportion of people who report their experience to the Gardaí, was substantially more (49.3%), as was their perception of the number of court cases that result in a guilty verdict (45.9%). In fact, Ireland has the lowest conviction rate (1-2% during 1993-2000) for rape and sexual assault in Europe (Regan & Kelly, 2003).

The *SAVI* participants were also asked to indicate whether a number of statements were either 'True' or 'False'. These included statements relating to beliefs about: victims of sexual violence; perpetrators of sexual violence; the causes of sexual violence; the consequences of sexual violence; and reporting sexual violence (McGee et al., 2002). According to the authors, statements which were rated as false, were rated as such because they were 'either clearly untrue or deemed unhelpful by professionals in this area because they either blame the victim or are used as rationalisations by the public to decrease their perceptions of their own risk' (McGee et al., 2002:158). The great majority of participants showed an understanding of a number of common rape myths and misconceptions; for example, 92% agreed with the statement that 'a date rape can be just as traumatic as rape by a stranger' (McGee et al., 2002:156). However, more

than one quarter (29%) also agreed with statements such as '*Women who wear short skirts or tight tops are inviting rape*' or '*Accusations of rape are often false*' (40%) (McGee et al., 2002:157). Overall, a number of significant differences were found between women and men on 12 of the 20 items and men were significantly more likely to agree with the idea that rape victims are usually young and attractive and that most rapists carry out this crime because of an overwhelming sexual desire. According to the authors, a source of particular concern was that significantly more men than women, believed that: '*a person being raped could stop it if they really wanted to*' and that '*when a woman says no, she really means yes*' (McGee et al., 2002:159).

The role of the media in informing and educating the public about SV has also been explored in some work. SAVI respondents were asked about their attitudes towards the media coverage of SV and whether they thought it was damaging, beneficial or had no effect. The results showed that attitudes towards SV were, for the most part, positive with over three quarters (76%; 2191/2884) agreeing that it was '*somewhat*' or '*very beneficial*' (e.g. it increases public awareness). Whilst almost one fifth (17%, 500/2884) felt that the media coverage was '*damaging*' or '*very damaging*', virtually everyone (99%) felt that it did nothing to deter perpetrators.

3.3.2.2 *The Irish media: "Rape: Our blame culture"*

More recent data on attitudes towards SV in Ireland were provided by a poll undertaken by a well-known national newspaper. In January 2008, the *Irish Examiner* commissioned a market research company, *Red C*, to conduct an opinion poll into people's attitudes towards rape and the sentencing of sex crimes. Data were collected from a nationally representative sample of male and female adults aged over 18 (n=1002) (Irish Examiner/Red C, 2008a). Interestingly, the results, which were published over a three-day period in March 2009, sparked considerable controversy and disbelief.

When presented with a number of rape scenarios, respondents in this poll were asked to indicate the extent to which they felt that a female rape victim was 'not at all-', 'partially-', or 'totally responsible' for the crime (Irish Examiner/Red C, 2008a). Substantial proportions of respondents felt that a woman who was drunk, or who had taken illegal drugs, or was wearing 'sexy' or revealing clothes, was 'partially' or 'totally

responsible' for the rape (41% and 26% respectively). While one in ten felt that she would be 'totally' to blame if she had had previous sexual partners, almost half (46%) felt she would be 'somewhat' or 'completely' to blame if she had flirted extensively with a man; this sentiment was expressed by more men than women (Irish Examiner/Red C, 2008a). In relation to some of the other scenarios, 10% more women than men, felt that a woman should be held responsible (totally or in part) for being raped if she walked home through a dangerous or deserted area (Irish Examiner/Red C, 2008a). Over one quarter of the sample felt that the woman would, in some way, be culpable if she went home with a man, but decided not to have sexual intercourse, whilst a further 38% agreed that she would, in some way, be to blame if she had failed to clearly say 'No' (Irish Examiner/Red C, 2008a).

Two earlier surveys, both of which informed the above national poll, were also conducted by Amnesty International in mainland United Kingdom (UK) and in Northern Ireland (NI). The findings reflected similarly worrying trends in public views, and in the general understanding of, rape and sexual assault amongst both the general population (UK) (N=1095) and a sample of university students (NI) (N=715) (Amnesty International UK, 2005; 2008). The findings from both surveys are presented in Figure 3.1). For example, a substantial proportion of UK-based respondents believed that a woman would be 'partially' or 'totally' responsible for being raped if she was drunk (30%), or had behaved in a flirtatious manner (34%) (Amnesty International UK, 2005). While the NI survey of university students (attending the four University of Ulster campuses across NI) inquired about a broader range of issues with respect to VAW, figures were much higher in this sample across all categories (see Figure 3.1) (Amnesty International UK, 2008). For example, 44% of students responded that a woman is 'totally' or 'partially' responsible for being raped if she is drunk while 46% also believed this to be the case if she had acted in a flirtatious manner (Amnesty International UK, 2008).

Similar to the *SAVI*, respondents who took part in the Examiner/Red C poll were also asked about the extent to which men accused of rape receive a criminal conviction. Twenty-six per cent across all age groups felt that a case against a man accused of rape would succeed in securing a conviction (Irish Examiner/Red C, 2008a). Almost one in four (39%) members of the Irish public felt that the most appropriate punishment for a

rapist would be a life sentence (Irish Examiner/Red C, 2008b). A further 48% endorsed sentences of between three and ten years and across every age category, men demanded harsher penalties than women (Irish Examiner/Red C, 2008b).

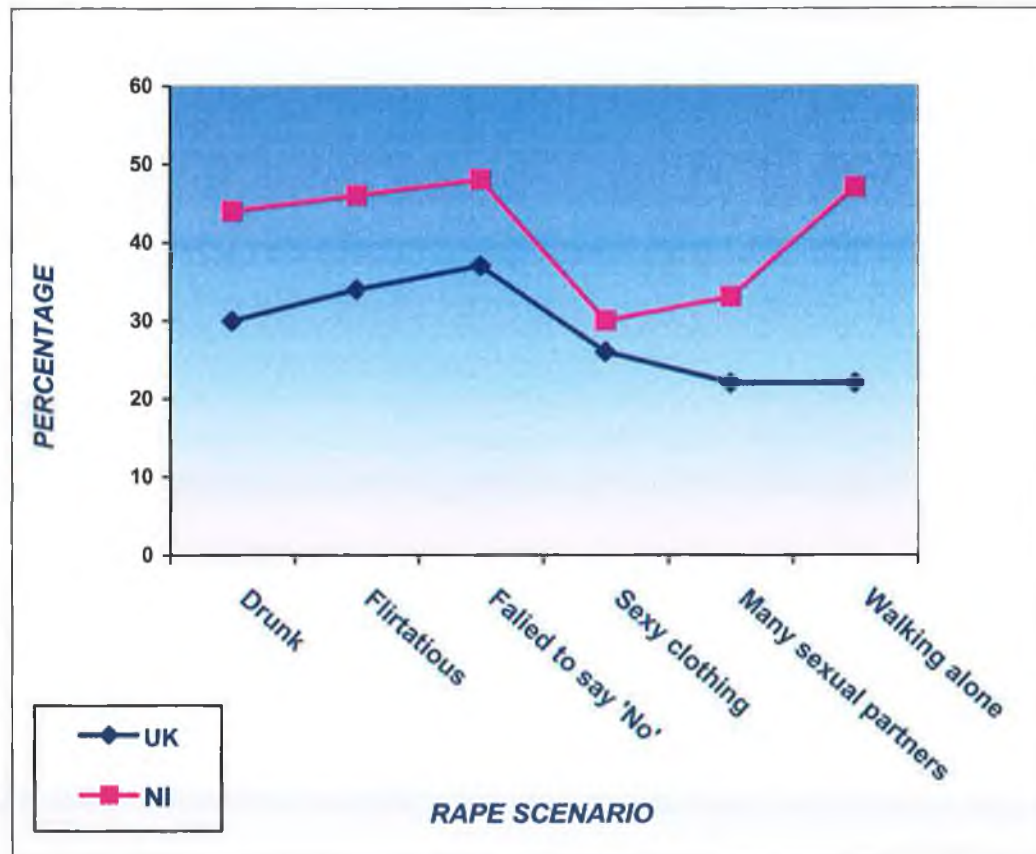


Figure 3.1 Line graph showing results from the two Amnesty International surveys conducted in GB (2005) (n=1095) and Northern Ireland (2008) (n=571) into attitudes towards rape and sexual assault.¹⁵

3.4 Responding to sexual violence in Ireland

Four out of ten women living in Ireland today have had an experience of SV in their lifetime (McGee et al., 2002). Therefore, how we, as a society, respond to them, both formally and informally, is of considerable importance. This point becomes even more salient in view of empirical research to suggest that negative reactions from both formal (e.g. doctors, Gardaí) and informal (e.g. friend, family members) sources of support, can

¹⁵ Adapted from *Sexual Assault Research Summary Report* (Amnesty International UK, 2005) and *Violence Against Women: The perspective of students in Northern Ireland* (Amnesty International UK, 2008).

discourage a woman from disclosing (Ahrens, 2002) whilst also exacerbating the often devastating after-effects of these kinds of crimes (Herman, 2001). As indicated in the previous chapter, victims of sexual violence have been identified as experiencing, for many years after the assault, numerous negative effects on their lives. Therefore, attempts to help women to recover from this type of personal victimisation requires timely, effective and appropriate responses from the point of first contact, whether that is the family member whom she tells for the first time, the Garda representative who responds to the initial complaint, or the doctor who examines the woman as part of the Forensic Medical Examination (FME).

Typically, the main sources of formal support for women in Ireland who have been raped or sexually assaulted (and other forms of SV) include Rape Crisis Centres (RCCs), Sexual Assault Treatment Units (SATUs), and the Criminal Justice System (CJS). RCCs generally offer counselling, advocacy and information and are an option for women irrespective of whether they report the offence to the Gardaí (or police). However, in the majority of cases, SATU services are only available to those who agree to proceed with a criminal prosecution. The Office of the Director of Public Prosecution (DPP) ultimately makes the decision as to whether or not a person will be prosecuted and on the extent to which a case is likely to proceed to trial. The following section briefly examines the responses to SV in Ireland, in the form of national policy reform and the development of RCC and SATU services. Whilst a thorough review of the CJS responses to this crime is beyond the scope of this study, some of the research conducted with rape victims and their contact with the Irish judicial system will be briefly described.

3.4.1 Government responses: Policy and legislation

Awareness of VAW in Ireland and within the Irish legislature began in the burgeoning feminist movement of the 1970s (McKay, 2005). At that time, Ireland had a strong history of traditional gender roles enshrined by constitutional articles and a pervasive Catholic ideology (Horgan, 2001). For example, up until the removal of the *Marriage Bar*¹⁶ in 1973, a woman would have to leave her job in the Civil Service when she got

¹⁶ The Marriage Bar was a requirement that women employed in the private and public sector would resign their position on getting married.

married (Horgan, 2001). Issues such as domestic violence (DV) and rape, much less SV within marriage, were very much taboo subjects, a point that is reflected in the fact that rape within a marriage was not made a criminal offence in Ireland until 1990 (Bacik et al., 1998). While non-governmental organisations (NGOs), such as domestic violence support services, refuges, and RCCs, struggled to meet the ever increasing demands of their growing client numbers, legislative responses and governmental support in the form of statutory funding was less forthcoming.

In 1985, Ireland became a signatory to the United Nations (UN) international human rights treaty, the *Convention for the Elimination of All Forms of Discrimination Against Women* (CEDAW). The articles contained in this treaty provide clear definitions for what constitutes discrimination against women in all its forms. It also delineates an explicit agenda for countries on employing national strategies to put an end to that discrimination. Countries that have ratified the treaty, such as Ireland, are legally bound to implement the proposed strategies and put its provisions into practice; there is an additional requirement to submit a national report every four years detailing the measures (both legislative and otherwise) that have been implemented in order to satisfy Ireland's obligations under the treaty. The convention is aimed at ensuring equality for women in all spheres of society, as well as affirming the reproductive rights of women. It also highlights the role of culture and traditional practices as key shaping influences in the identification of gender roles and family relations.

Ten years later, the Irish government also signed up to the *Beijing Platform for Action* (1995), an agenda inaugurated at the United Nations Fourth World Conference on Women that highlighted 12 areas of critical concern to women throughout the world (United Nations, 1995). This inter-country agreement was designed to empower women by promoting their equality in all spheres of social, cultural, economic and political life (United Nations, 1995). With mounting pressure from NGOs and following a Department of Health publication, which identified domestic violence (DV) as a major issue (Kelleher & O' Connor, 1995), a Government Task Force on Violence Against Women was finally established in 1996 (Watson & Parsons, 2005:29). The first report of this task force outlined a national strategy for the country covering a wide range of issues and incorporating several recommendations for improving the effective and appropriate management of the problem of DV including: gaps in current support

services; the role of the Gardaí; legal issues such as eligibility criteria for legal aid, legislative changes and sentencing policies; health and social services including sexual assault treatment units (SATUs); intervention programmes for violent men; and preventative strategies (Government of Ireland, 1997).

The first report of the Task Force included an entire chapter devoted to the issue of rape and sexual assault – a distinction that has also been reflected in the development of services in Ireland (Government of Ireland, 1997). The key recommendations of the Task Force, which were concerned with legislation, the Gardaí and support services, included: the development of clear policies, practices, and training procedures for the Gardaí with regard to the treatment of victims of SV; the application of custodial sentences in all cases of rape; and the ready availability of information on counselling and support services for all victims (Government of Ireland, 1997). As a direct result of this work, a National Steering Committee on Violence Against Women (VAW) was established with a remit '*to provide a multi-disciplinary, multi-agency and cohesive response to the problem of violence against women*' (Government of Ireland, 1999). Under this committee, a further eight Regional Planning Committees (RPCs) (based on the old health board regions) were convened, the membership of which included a range of public, community and voluntary sector representatives including a representative, in each case, from a local RCC (Government of Ireland, 1999).

According to a report by the Irish branch of Amnesty International, a national strategy designed to effectively respond to VAW has not yet been implemented because the Task Force report "*...within its limited remit, remains inadequate, since it lacks the benchmarks, time-bound targets, and specified budget allocations that a strategy would entail*" (Crowley, 2005:8). However, on a more positive note, an executive office of the Department of Justice, Equality and Law Reform (DJELR) was set up in June 2007 for the prevention of domestic, sexual and gender-based violence. The mission of this office, - known as *Cosc* (an Irish word meaning to 'stop' or 'prevent') – is to '*improve the delivery of a well-coordinated effective response to domestic, sexual and gender-based violence*'. Just recently (December 2008), *Cosc* completed a series of nationwide consultation meetings with key stakeholders who provide relevant services in these areas, with a view to developing and hopefully implementing a national strategy to combat VAW in all its forms.

3.4.2 Support responses: Rape Crisis Centres (RCCs)

3.4.2.1 The origin of Rape Crisis Centres (RCCs) in Ireland

During the late 1970s, the ongoing desire and demand for an effective, co-ordinated response to the needs of women in Ireland who had been sexually violated, culminated in a march in Dublin on the 13th October 1978, when almost 5000 women from all over Ireland took part in a protest at the brutal gang rape of a 16-year old girl by eight men (McKay, 2005). This march took place against a backdrop of hard-won social change for Irish women (e.g. Irish women only won the right to sit on juries in 1976) and the beginnings of a re-definition of the role of women in Irish society. Several months later, in February 1979, the Dublin Rape Crisis Centre (DRCC) - the first rape crisis centre (RCC) in Ireland - announced its opening, with a 'staff' of 19 volunteers (McKay, 2005). Over a year later, in August 1980, they officially opened their doors on foot of a grant of £5000 from the Eastern Health Board (McKay, 2005).

The DCC, in its first report, detailed the purpose of its work and the type of support the staff intended to offer women (McKay, 2005). One of their fundamental goals was to help women '*to regain their confidence and self-determination*' after being raped, through the provision of counselling in the form of non-professional support and advice from committed and sympathetic feminists (McKay, 2005:26). This report also proposed that the centre aimed to operate 24 hours a day, seven days a week, had the full support of the Gardaí who would be involved in referring women to the service and that when necessary, they would provide a counsellor who could accompany the women to the doctor, to the Gardaí and even to their court cases (McKay, 2005). In their first year, volunteers at the DRCC saw 126 women, most of whom were aged between 16 and 35 years (McKay, 2005). An analysis of information collected on 95 of these women, revealed that 60% were raped by someone known to them (e.g. a husband or a lover (12%), or a friend or neighbour (16%)), whilst an alarming 70% had never reported the crime to the Gardaí (McKay, 2005). Shortly after the establishment of the DRCC, a similar centre was opened in Limerick (LRCC), and both centres provided the blueprint for the establishment of a further 14 similar facilities throughout the country.

3.4.2.2 The Rape Crisis Network of Ireland (RCNI)

The Rape Crisis Network of Ireland (RCNI) was set up in 1985 to act as the national umbrella organisation for the then six RCCs (RCNI, 2005). The aim of the RCNI is to

pool available expertise, exchange information between RCCs and unite these organisations in lobbying for social and judicial change. Having initially received funding from the Department of Health and Children (DOHC) in 1999, the RCNI currently represents the 16 RCCs nationwide.

The RCNI operates under a member-owned and member-driven¹⁷ ethos and its aim/vision is to create: '*...a society where rape and all other forms of sexual violence no longer exist*'. It strives to achieve its goal by supporting member RCCs, developing and providing training for RCC staff and volunteers, and undertaking research on the causes, nature and extent of SV in Ireland. Each RCC operates independently within the RCNI and the community, and they all offer a range of services including: one-to-one crisis counselling; long-term counselling; accompaniment to Sexual Assault Treatment Units (SATUs) and court appearances; and advocacy and information. Several centres also provide community outreach services, education and training and community awareness raising initiatives. All RCCs engage in fundraising in order to sustain and develop their services in view of the lack, or absence of appropriate public sector funding and they vary in the number of staff (both paid and voluntary), their opening hours and phone-line operating hours (where applicable). The Dublin Rape Crisis Centre (DRCC), which is the largest in Ireland, also operates the only 24-hour help-line available to men and women who have experienced sexual violence.

The work of the RCCs, despite what their title may suggest, is not strictly limited to recent rapes or 'rape crises' per se. In fact, traditionally, their work has reflected the most pressing issues affecting Irish society including the disclosure of clerical and institutional abuse in Ireland during the mid-late 1990s. It is this variation in client profiles that has prompted many of the centres to include 'sexual abuse' within their remit in order to more accurately reflect the work that they do (McKay, 2005). In fact, one additional centre, which is not currently a member of the RCNI, is the Cork Sexual Violence Centre (CSVV). This centre provides services that are virtually identical to those offered by other RCCs, but in 2004, the Board of Management decided to change

¹⁷ Member-owned and member-driven means that the RCNI Board of Directors is comprised of a representatives nominated from member RCCs. This Board oversees the implementation of the Strategic Plan, which has been developed through high-level consultations with these members, as well as other stakeholders.

the name of the centre to reflect the changes that they had experienced over the years and to better represent the work that they do.

3.4.3 Forensic/medical responses: Sexual Assault Treatment Units (SATUs)

Sexual Assault Treatment Units (SATUs) are facilities designed to gather forensic material from a victim of SV for the purpose of being used as evidence in the criminal prosecution of an alleged perpetrator (O' Shea, 2006). In addition, some of these units provide screening for sexually transmitted infections (STIs) and emergency contraception (O' Shea, 2006). The first SATU in Ireland opened in the Rotunda Hospital, Dublin (East) in 1985, and was the first of its kind in Europe; it is estimated that an average of 300 forensic medical examinations (FMEs) are conducted here annually (O' Shea, 2006). Further units opened in Letterkenny (North-West) in 1998, Cork (South) in 2001 and Waterford (South-East) in 2004 (O' Shea, 2006). The Cork SATU is the only service that has secured statutory funding and 115 clients are seen every year, while staff at the Waterford and Letterkenny SATUs see approximately 60-80 and 25 service-users respectively (O' Shea, 2006). The Letterkenny and Dublin services access funding through the main hospital budget while the Waterford SATU is funded under the community care budget (O' Shea, 2006).

While all of these SATUs offer forensic and/or medical services within local or national hospitals, they vary widely with respect to management, staffing and scope of service provision (O'Shea, 2006). For example, unless a service-user is prepared to report the crime to the Gardaí, she cannot avail of the services of the Waterford SATU and can only attend the Dublin SATU during the day and by appointment only (O' Shea, 2006). While the majority of the SATUs have a roster of doctors that operate on an on-call basis, many of them have ongoing problems in recruiting and retaining an adequate supply of trained doctors which, in some cases (e.g. Letterkenny), means that the SATU is staffed on an ad hoc basis only (O' Shea, 2006). Three of the SATUs employ Nurse Managers for their unit either on a part-time or full-time basis while the North-Western SATU service (located at Letterkenny General Hospital) is co-ordinated by the Nursing Manager from the Accident and Emergency (A&E) Department (O' Shea, 2006). A rota of nurse volunteers from the main adjacent hospital provide nursing cover for out-of-hours services in all but Dublin; the Dublin-based service relies on the availability of

nursing staff from the Gynaecological ward of the adjacent hospital to co-ordinate and deliver the service (O' Shea, 2006).

A recent review of SATU services suggests that they have developed in a relatively fragmented way and as such, their availability fluctuates considerably across the country (O' Shea, 2006:39). Furthermore, differences in local policies and practices can sometimes preclude the delivery of the holistic and multi-agency approach on which these services are based (O' Shea, 2006). It is important to note, though, that, since this study began, plans to establish a further two SATUs have been announced – one for the Midlands region in Mullingar, and a second in Galway, servicing the west of the country (Health Service Executive (HSE), 2007). These developments have come in timely response to the national review (O' Shea, 2006). Nonetheless, there is still considerable scope for improvement and for implementing some of the other key recommendations in the O' Shea report, such as standardising existing services and commissioning needs-led research (O'Shea, 2006).

3.4.4 Legal responses: The Irish Criminal Justice System (ICJS)

As previously mentioned, a comprehensive review of the complex legal response to SV in Ireland is beyond the scope of this study. Moreover, a relevant study in this respect was commissioned by the RCNI in conjunction with the Department of Law, National University of Ireland, Galway (NUIG) to examine Ireland's strikingly low attrition rates; the findings of this study are due to be launched later this year (2009). However, the CJS information that is most relevant to the current study, relates to how the various agencies therein, respond to women who have been raped (and experienced other forms of SV) and the precise nature and quality of interaction that a woman can expect if she chooses to engage with the system. The following section outlines the small pool of research that has been undertaken in this area in Ireland. This has identified the factors that influence the reporting of rape as well as elucidating some of the experiences that women have had when engaging with the police.

While a number of reforms have taken place in relation to the laws on rape and sexual assault in the last decade, several reports have contained a number of criticisms of the CJS as it is currently configured (e.g. Report of the Task Force on Violence Against Women (1997); The Legal Process and Victims of Rape (Bacik et al., 1998); and The

Law on Sexual Offences Discussion Paper (1998)). These include: the legal definition of rape; the lack of a definition of 'consent'; rules governing the admission of past sexual history in evidence; separate legal representation for the rape victim; information and consultation; and court facilities and procedures (Leane et al., 2001). The following section describes the process that an Irish rape victim might typically undergo if she decides to report an incident of rape; this has been adapted, for the most part, from a recent guide to the CJS for victims (produced by the CSVc) (Crilly, 2007).

3.4.4.1 Reporting sexual violence in Ireland: The process for the victim

Once a woman decides to lodge an official complaint, the first, most likely, agency that she will encounter is the Garda Síochána (the national Irish police force or 'Gardaí' for short). The Gardaí are then obliged to investigate, to document evidence (forensic and written), and to prepare a file on the case for the Office of the Director of Public Prosecution (DPP). In order to accurately collect the forensic evidence, the woman, accompanied by the Gardaí, must agree to have a FME, which normally takes place during the first 72 hours after an assault. For the most part, the FME is carried out in a SATU by a trained medical professional and involves a detailed physical examination, (including the collection of swabs and forensic material) which may often take up to two hours or more. In many (but not all) cases, it is SATU policy to call the local RCC for a support worker with whom the client then has the option to speak if they so wish. In order to preserve the chain of evidence, a police officer (usually female) must be present at all times during this examination (normally behind a curtain) and the evidence is passed to her directly and sealed in appropriate bags. Once all of the appropriate evidence is collected and the necessary statements prepared, a file is forwarded for the Office of the DPP (i.e. the office in charge of prosecuting criminal offences in Ireland) who will then decide if there is sufficient evidence to proceed with a case.

Under current legislation, if the DPP decides not to proceed with a case, they are under no obligation to provide any reason for that decision, although recent changes to this policy have been made in relation to murder cases. If the DPP decides to prosecute someone for rape, this is carried out on behalf of the 'greater public good'; therefore the rape victim essentially acts as a State witness in the case. This means that, although the main investigating Garda is responsible for informing the victim of progress in the case,

there is essentially no obligation on their part to do so, although this is common practice in rape cases. Once a trial date has been set, with an average waiting time of up to two years (Leane et al., 2001), the victims of rape will then engage with the actual court process, during which they encounter a series of key actors for the first time, including the State solicitor, the defence solicitor for the accused and the judge.

3.4.4.2 Experiences of the Irish Criminal Justice System by Irish rape victims

Only one study has been conducted, to date, to examine the experiences of the CJS by rape victims in Ireland. This qualitative study, conducted by Leane and colleagues (2001), involved a series of one-to-one interviews with eight rape survivors, all of whom were recruited from the RCCs. The women were asked specifically about their: experiences of: disclosure; the CJS and its personnel; the FME and medical personnel; support services and support personnel; and experiences of the media portrayal of sexual crime and actual sexual assault offence cases (Leane et al., 2001). Some of the findings are summarised below.

The initial contact with the Gardaí was found to be a critical point in encouraging a woman to proceed with a case, as a positive experience will assuage any doubts that she may be having about proceeding with the complaint. Overall, the majority of victims in this study (n=6) were pleased with the level of support that they had received from, and their treatment by, the Gardaí during this stage of the process, although levels of satisfaction dropped dramatically with regard to receiving adequate information on the progress of the case while they were waiting for their case to come to trial. All of the victims who went to court (n = 4) reported receiving some degree of preparation before the actual court case, such as being shown around the courtroom. However, the court facilities (e.g. having to share the same waiting room as the accused and his family and friends), were a source of extreme distress for several of the victims and the authors concluded that the *'court facilities can play a significant role in reducing or increasing the level of distress experienced by victims during the trial stage'* (Leane et al., 2001:115).

Three of the victims, whose cases actually went to trial, had only limited contact with the state prosecutor and solicitor prior to the court date and this generally occurred on the morning of the trial. They all gave evidence and while conceding that the defence

lawyers they encountered had a job to do, all of the participants were dissatisfied with the manner in which they were treated by them and described their attitude overall as negative, insensitive, overbearing, rude and patronising. The victims' experiences of the judge presiding over their cases contrasted sharply with their experiences of other legal personnel with whom they had come into contact. Overall, they felt that they were afforded the opportunity to tell their side of the story, with one reporting that she felt that the judge was on her side and that he believed her. Nonetheless, the four victims who progressed through each stage of the Irish legal system viewed it in a very negative light and three strongly expressed the opinion that they would not encourage somebody else to proceed with a case based on their experiences. They highlighted, in particular, the insensitive treatment of victims and the high standard of proof required for a conviction; only one of these cases resulted in a conviction.

Of the eight victims who took part in this study, seven were seen by either a GP or the forensic medical examiner after their experience, while three of them had seen both. Of the four who completed a FME, all were accompanied by a member of the Gardaí, and all commented on how difficult they had found the examination procedure. The author notes that the victims' assessment and experience of the examination appeared to be directly associated with the attitude and approach of the medical examiner. In spite of this being an clearly distressing experience almost all (three out of the four) of the participant's felt that the FME was important.

While the findings above are based on the subjective experiences of only eight rape victims, they nonetheless provide some useful insights into the experiences of the CJS by women who have reported a sexual offence. They also raise some concerns that ought to be considered when developing and operating services such as these. Five years after the publication of the above study, the Department of Justice, Equality and Law Reform (DJELR) and the DOHC produced a set of *National Guidelines on Referral and Forensic Clinical Examination in Ireland* for victims of rape and sexual assault (2006). These guidelines clearly illustrate the referral procedure when a victim presents to either the Gardaí, or to a GP and they also describe the process of conducting a FME, as well as guidelines for the Forensic Laboratory in the handling and analysis of evidence (DJELR & DOHC, 2006). Further sections are devoted to the

psychological support of the client, including the role of the support worker and STI screening (DJELR & DOHC, 2006).

3.5 Conclusion

This chapter began with a review of the data on the scale of SV in Ireland. SV is a significant reality for over 20% of the adult female population of Ireland. Pervasive societal myths and attitudes, such as those reported above, stand in stark contrast to official statistics, which indicate that only a minority of Irish women are assaulted in a public place or outdoors (24%) and that the assault is often carried out by someone who is already known to the victim (79%) (McGee et al., 2002). Additionally, the true impact on victims of SV of societal beliefs/attitudes have been shown by *SAVI* research. Forty-seven per cent of *SAVI* participants had never told anyone about their experience of SV prior to taking part in the research and only one in 12 women sexually assaulted as an adult, had reported it to the Gardai (McGee et al., 2002). Over one third of those women, who had never told anyone about their experience of SV, maintained their silence because they felt either: (i) ashamed or embarrassed; (ii) that nobody would believe them; or (iii) that they blamed themselves for the assault or felt that others would (McGee et al., 2002).

After a woman has been raped or sexually assaulted, she is then faced with the decision of whether or not she should report the crime to the authorities – a decision which is often complicated by a range of factors such as: self blame and guilt; relationship to the perpetrator; fear of people knowing what happened or of not being believed; feelings of shame and embarrassment; and pressure to keep quiet from friends and/or family members. Ireland's response to SV has been gradual with the production of task force and committee reports and recommendations that have, for the most part, not been implemented. However, it is reassuring to see that some progress is taking place and the recent opening of the Cosc office is most certainly a step in the right direction. In the interim, the RCCs continue their work of the last two decades in responding to the needs of victims of SV while attempts by SATU services to standardise and maintain their services, continue to be under-resourced.

Chapter Four

**Method I: Methodological
Overview and
Method I: Stage I**

CHAPTER FOUR

METHOD I

(A) Methodological overview and (B) Stage One method

This chapter is in two sections. The first, Section A, provides a brief introduction to the epistemological approach underpinning this research and the overall study design. This section also outlines how some key general methodological and ethical issues across all three stages of the study were addressed. The second section provides full methodological details pertaining to Stage One of this research; this stage formed an important preliminary part of the study. Further more specific information on the methodological and ethical procedures employed in Stages Two and Three of the research, are provided later in Chapters Six and Eight respectively.

SECTION A: METHODOLOGICAL OVERVIEW

4.1 Ontological and epistemological framework

In order to understand the foundations on which a research project is based and its underlying assumptions, it is important to be aware of its ontological and epistemological position. Knowledge of the philosophical and methodological assumptions of a study provides a clear rationale for the chosen methods of data collection and analysis and justifies the interpretation and findings reported (Grix, 2004). Researchers may follow a number of different paradigms. For example, *positivism* views the social world it seeks to study, as having causes and consequences similar to the natural world and is amenable, therefore, to scientific methods designed to explain rather than understand phenomena (Grix, 2004). Positivist researchers aim to be objective and neutral in their approach and emphasise the value of explanation, and ultimately prediction, in their study of the social world (Grix, 2004). For positivists, the world is not socially constructed, but regular and predictable and can be documented using theory to generate hypotheses, and tested through direct observation (Grix, 2004). By contrast, *interpretivism* posits that the world we live in is socially constructed through the discourse and interaction of individuals and is, therefore, dynamic and

subject to change. Interpretivists favour methods and techniques (e.g. participant observation, semi-structured interviews) that are designed to elicit the true experience of the participant from their perspective and which openly acknowledge the role of the researcher in constructing the very social reality they seek to research (Grix, 2004).

The current study was guided and driven, in large part, by a third research paradigm known as *pragmatism*. Pragmatism claims that knowledge about the world around us comes from actions, situations and consequences rather than pre-existing conditions (as in post-positivism) (Creswell, 2003). In fact, pragmatists '*reject the forced choice between post-positivism and constructivism with regard to logic and epistemology...and embrace both points of view (or a position between the two opposing viewpoints)*' (Tashakkori & Teddlie, 2003:21). Pragmatists believe that the research question is more important than the chosen method, or the paradigm underlying that method; thus, appropriate techniques can be selected and applied from both the quantitative and qualitative domains without question (Tashakkori & Teddlie, 2003). This overall stance provides researchers with a freedom of choice with respect to methods of data collection and analysis, while still claiming epistemological coherence. Consequently, this paradigm has proven to be a popular choice with mixed method researchers (Tashakkori & Teddlie, 2003).

The qualitative element of the current study was guided by a fourth research paradigm known as *critical realism*, which, like pragmatism, is situated (on a continuum) between interpretivism and positivism. Emerging from the work of Bhasker (1989), critical realism essentially complements pragmatism in positing that, while the methods open to natural science are also available to the study of social science, it is necessary to move away from these methods and incorporate an interpretative (i.e. qualitative) understanding and approach (Sayer, 2000). The goal of the qualitative elements of the current study, as in critical realist research, is to seek to '*not only understand, but also explain the social world*' (Grix, 2004:86). This paradigm is particularly suited to this study as the approach allows for the acceptance of the existence of social structures (e.g. sexual violence, PTSD) which, whilst not directly observable, '*are admissible on the grounds that their effects are observable*' (Bryman, 2004:12). At the core of the critical realist approach is the premise that something can be defined as real if it has a causal effect (Howitt, 2010).

Thus, from a critical realism stance, SV as a social artefact is measurable in terms of the effects it has both on the individual and in the social world within which it exists. Thus, this paradigm provides an ideal framework within which to justify the application of qualitative methods to the study of SV. As indicated earlier in Chapter Two, PTSD has also emerged in the literature, as a quantifiable and widely accepted effect of SV and it is the presence of both of these empirically supported concepts that provides the basis for the theoretical framework of the study. This framework can be comfortably accommodated within the two complementary paradigms of pragmatism and critical realism described here, both of which provide a sound rationale for the choice and integration of both quantitative and qualitative methods. Some of the strengths and limitations of mixed methods research are described below.

4.1.1 Mixed methods research

Mixed methods research, as utilised in this study, has grown in popularity in recent times (Johnson, Onwuegbuzie, & Turner, 2007) to the extent that some authors have suggested that studies that use *only* quantitative *or* qualitative techniques, are insufficient on their own (e.g. Creswell, 2003). Mixed methods have distinct advantages over single method studies, as they often provide a better opportunity to address the research questions by means of multiple methods (Tashakkori & Teddlie, 2003). For example, a mixed methods approach can simultaneously address a range of confirmatory and exploratory questions. While qualitative research questions are exploratory in nature (i.e. concerned with generating information about aspects of a phenomenon that may be relatively unknown for the purpose of theory generation), quantitative research questions are confirmatory, as they are aimed at testing theoretical propositions (i.e. theory verification) (Punch, 1998). Thus, mixed methods research allows the researcher to simultaneously ask confirmatory and exploratory questions, thereby helping to both generate and verify theory within the same study. Furthermore, the mixed method design allows researchers to demonstrate that a particular variable will have a predicted effect on (or relationship with) another variable and to answer exploratory questions about how and why that predicted relationship occurred (Teddlie & Tashakkori, 2009).

A second advantage of a mixed methods approach is the ability to make better (and stronger) inferences from the data than with a single-method design (Creswell, 2003).

While the results of a study comprise the outcomes of data collection (e.g. the numerical statement of relationships between variables through statistical tests or the creation of themes through data reduction), inferences *'are based on the investigators' interpretation and expansion of such results'* (Tashakkori & Teddlie, 2003:35). The current study (particularly Stages Two and Three) followed the 'triangulation model' of mixed methods research where two methods are used to corroborate, confirm or cross-validate the findings (Creswell, 2003). According to Creswell, the advantage of this traditional mixed methods approach is that *'it is familiar to most researchers and can result in well-validated and substantiated findings'* (2003:217). Thus, combining methods in one research study serves to maximise their inherent strengths without compounding the in-built weaknesses of any one particular technique (Tashakkori & Teddlie, 2003).

Mixed methods research can broaden our understanding and allow us to obtain a more complete picture of the phenomenon under investigation whilst also helping to address more complex questions (Tashakkori & Teddlie, 2003). However, this approach is not without its disadvantages and can often be: costly and resource intensive; require training and expertise in both quantitative and qualitative methods; increase the burden of data collection on both participants and researchers; and may be difficult to publish as the research may be seen by some more 'purist' researchers as involving incompatible paradigms (Tashakkori & Teddlie, 2003; Payne, 2007). However, in the context of the current study, a mixed methods approach was a logical epistemological choice and made intuitive sense given the sensitive nature and complexity of the topic under investigation. It was also important to the overall achievement of the study goals. For example the inclusion of a detailed qualitative assessment in Stage Three of the study served to support, amplify and extend the findings from Stage Two. The three stages of this research are outlined below, followed by more detailed information on the quantitative and qualitative techniques employed in the study.

4.2 Study Design: An overview

As indicated in Chapter One, this research was carried out in three discrete, but inter-related stages involving the use of both quantitative and qualitative methods. The choice of research methods was determined largely by the overall aims of the study (See Figure 4.1). The selected methods included the use of: postal and face-to-face questionnaires as

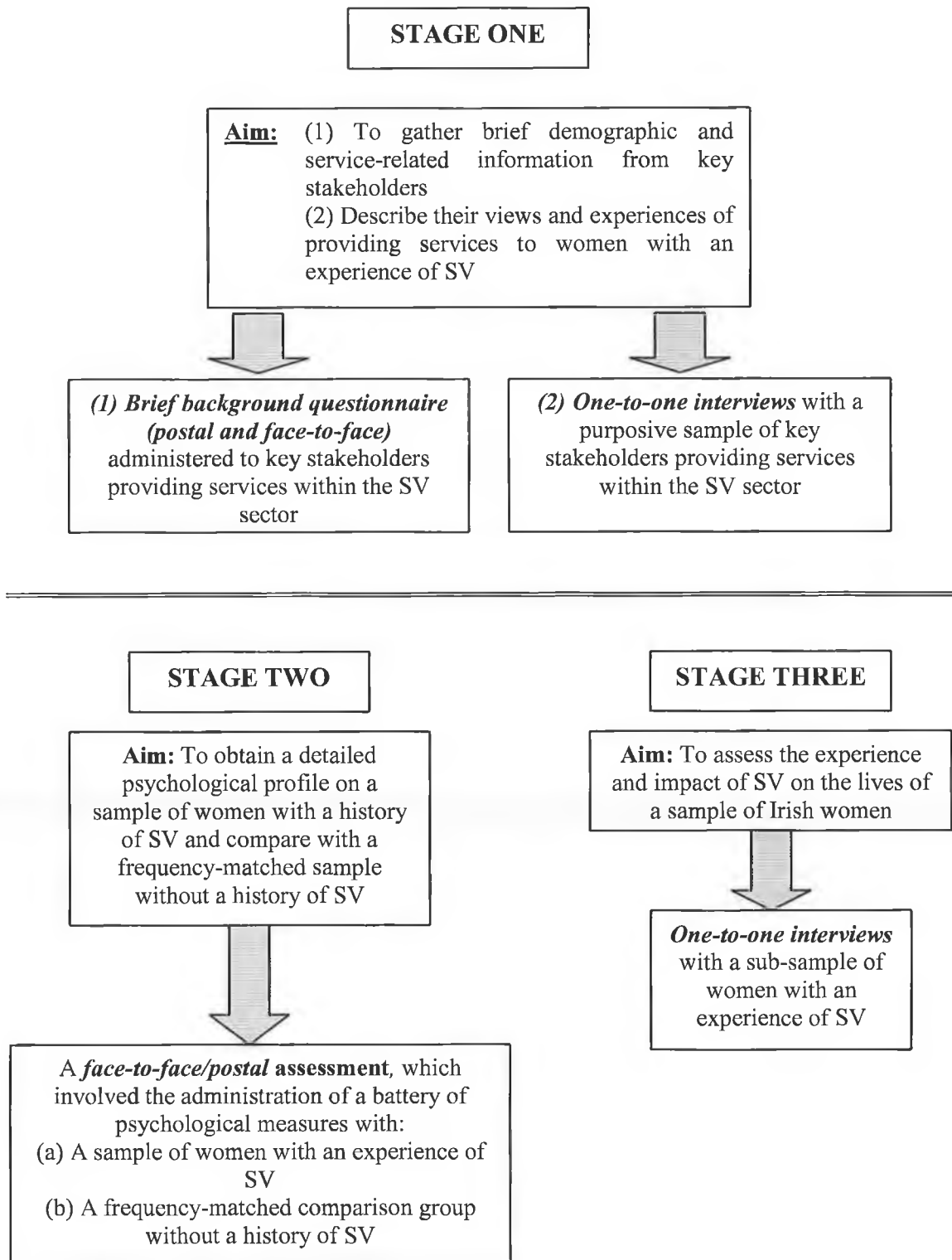


Figure 4.1: A graphical summary of the methods used in Stages 1, 2 and 3 of this study.

well as semi-structured, one-to-one interviews with a range of stakeholders; the administration of a battery of measures to women with an experience of SV followed by a smaller number of one-to-one interviews with a sub-sample of these women. A frequency-matched control sample of women, with no history of SV, also completed a selection of the measures by means of a postal survey. The quantitative techniques utilised in Stage Two were designed to provide detailed insights into the impact of sexual violence on a sample of women with an experience of SV, and to compare them with a frequency-matched sample of women without a similar experience.

4.3 Ensuring validity and reliability in qualitative research

Stages One and Three of the current study were based on qualitative methods. The concepts of reliability and validity are as important in qualitative as in quantitative research and strategies have been developed by qualitative researchers to help ensure that these concepts adhere to the various philosophical assumptions of most research paradigms (Merriam, 2002). These are briefly discussed here within the context of Stages One and Three of the current study.

One of the critical, and inherently problematic issues with regard to the reliability of qualitative research, is the extent to which findings can be replicated (Merriam, 2002). As human behaviour, by its very nature, is dynamic, qualitative research would be unlikely to replicate the results of a particular study. Thus, reliability in qualitative research is more concerned with the degree to which the findings are consistent with the data collected (Merriam, 2002). The establishment of a clear audit trail allows the reader to verify this degree of consistency (and therefore reliability), as does the provision of adequate training and practice for the researcher in the chosen method of analysis (Merriam, 2002). With regard to the former, it is possible to authenticate the findings by providing a detailed description (as in the context of this study) of the research process - from how the data were collected to how themes were derived. Furthermore, during June 2008, the researcher participated in several workshops run by Dr. Jonathan Smith, the developer of IPA, to ensure adherence and fidelity to this method of analysis.

Another important issue in qualitative research is the extent to which it is possible to generalise the findings, both to the wider population and other similar contexts. According to Merriam (2002), establishing external validity is problematic due to the often, small non-random samples. Therefore, according to Merriam, it is necessary to refer to a concept known as ‘reader generalisability’ where the reader determines ‘*the extent to which the findings from a study can be applied to their context*’ (2002:29). The responsibility of the researcher, therefore, lies in the provision of adequate and complete context and description to facilitate such generalisability (Merriam, 2002). Internal validity, on the other hand, is concerned with the accurate and truthful representation of the participant’s reality (Holloway, 2005). Ways to establish this include member checks (i.e. where the participant is provided with a transcript of their interview and comments on the accuracy of it) and the provision of a detailed description of the audit trail (Holloway, 2005).

Merrimam (2002) and other authors (e.g. Holloway, 2005; Patton, 2002) suggest a number of additional strategies that may be employed to enhance the reliability and validity of qualitative research including:

- Triangulation (i.e. the use of multiple methods of data collection and analysis)
- Member checks or respondent validation (i.e. participant feedback on preliminary interpretations of data)
- Peer review/examination (through discussion with colleagues)
- Reflexivity (dealt with in more detail below)
- Adequate engagement in data collection (i.e. to ensure information saturation)
- Maximum variation (e.g. purposefully seeking diversity in the sample selection)
- Audit trail (i.e. a detailed account of methods, procedures and decision points in carrying out the research)

The current study included all but one of the above (i.e. member checks) in an attempt to enhance the reliability and validity of the findings. A brief description of one of these - reflexivity - is provided later in Chapter Eight (Method III), due to its importance in that stage of the research.

4.4 General ethical issues and safeguards

The study was carried out in accordance with the codes of conduct of both the British Psychological Society (BPS) and the Psychological Society of Ireland. Ethical approval was also secured from the NUI Maynooth Ethics Committee prior to data collection. There are many potentially complex ethical challenges when undertaking research with vulnerable populations. Thus, the women who took part in this study, whilst all self-selecting, may be considered to be more susceptible than the average participant (e.g. based on their previous trauma history) to potential emotional upset, or distress as a result of taking part in this kind of research. Therefore, the study was guided and informed by a careful consideration of ethical factors at every stage from inception to write up. These general ethical issues and safeguards are discussed below. Further more specific information on the ethical issues relating to each stage of the research, is provided in Chapters Six and Eight.

4.4.1 Participant comfort and welfare: General issues

The emotional, psychological and physical safety of the participants is paramount when conducting this kind of research and researchers have an ethical obligation to ensure that participants are safeguarded insofar as possible in this respect. An extensive review of the literature on conducting research with vulnerable populations was undertaken prior to data collection, in order to appropriately inform the ethical procedures employed in the current study. This focused, in particular, on studies related to women with experiences of SV and/or domestic violence. More specific guidelines stipulated in a relevant World Health Organisation report (*Putting Women First: Ethical and safety recommendations for research on domestic violence against women*) (Watts, Heise, Ellsberg & Garcia-Moreno, 2001) – were also consulted during all stages of data collection. Furthermore, one of the secondary objectives of Stage One was to ensure that the views of service providers were taken into account with regard to how to conduct ethically sensitive research with women who had experienced SV (and with whom they had regular contact). The feedback gathered during this stage was invaluable in informing certain aspects of the remaining stages of the research, such as the use and design of the posters and leaflets, the referral of participants for further support if required and the management of contact before, during and after participation.

During the recruitment process and, based on correspondence and conversations with prospective participants, it became apparent that confidentiality and anonymity were two key concerns. Thus, the materials designed for Stage Two, in particular (e.g. posters and leaflets; consent form) repeatedly emphasised the protection of the participant's identity during all stages of the research process (see Chapter Six).

All questionnaires and interview schedules used in the study were assigned a unique identification number and any identifying information (i.e. contact details, consent forms, follow-up interview cards¹⁸) on each participant was stored in a separate and secure location within the department. Any tapes and transcripts that were used were also anonymised and fictitious names were used for purpose of reporting the findings. Communication with participants, in all its forms, was largely participant-led and the participant's preferred mode of contact was used when possible. Furthermore, in cases where phone calls were arranged for certain times, this arrangement was re-checked (usually by text message) prior to any direct phone contact being made. This was to ensure that the women could speak freely on receipt of the phone call.

4.4.2 Researcher welfare

Research has shown that there is a bi-directional relationship in conducting research with vulnerable populations (Campbell, 2002b). Thus, researchers may also be affected and/or emotionally distressed during and after the research process. It was important in the current study, that the researcher was sensitive to this possibility and that she had consulted appropriate literature highlighting the relevant issues (e.g. Campbell, 2002b; Schwartz, 1997). When necessary, researcher debriefing was conducted with the research supervisor and this was supplemented by support offered by the university counselling service. Importantly, in preparation for data collection, the researcher participated in area-specific training offered by the Dublin RCC, entitled *Issues in the Aftermath of Rape* (November, 2006). This served the dual purpose of alerting the researcher to typical reactions and feelings of women in the immediate aftermath of an experience of SV, while also becoming aware of the potential impact that meeting these women may have from a personal perspective. With respect to the physical safety of the researcher, specific departmental guidelines in relation to working alone were consulted

¹⁸ Participants in Stage Two were asked to complete Follow-up Interview cards upon completion of their questionnaires in order to provide consent to be contacted for Stage Three of the research.

and adhered to (see Appendix 1). For example, appropriate ‘check-in’ procedures after each face-to-face data collection/interview, were put in place prior to commencing data collection.

SECTION B: STAGE ONE METHOD

4.5 Stage One: Overview

The first stage of the research was designed to inform, at least in part, the remainder of the study and was undertaken for two reasons. Firstly, in view of the largely ‘hidden’ nature of the target population, it was considered important to make contact with frontline service providers in the area of sexual violence (SV), in the first instance, in order to: (a) inform them about the research; and (b) subsequently seek their advice on the most effective and sensitive way of accessing and recruiting prospective participants. Although considerably time-consuming and labour intensive, this first stage of the research was crucial in identifying and recruiting a suitable sample of women to take part in the remaining stages of the study. Secondly, the paucity of research on service providers in this area suggested that it would be of considerable interest to assess their views and experiences on the impact of SV on women, in order to complement those provided by the women themselves in the later stages of the research. These interviews were also aimed at identifying any barriers to, or gaps in, service provision, from a service provider perspective.

4.6 Participants and settings

Individuals (e.g. service directors) in 19 organisations were initially contacted and invited to take part in the research, four of whom either did not respond, or declined to participate. Subsequently, 18 key stakeholders who were working at the ‘frontline’ of service provision in the SV sector, agreed to take part in the study. These 18 participants represented a total of 15 organisations providing a range of support, information and medical services to women who have experienced SV in Ireland. This is a small, closely knit network of organisations and therefore, further information on the precise affiliation of individuals is not provided here due to concerns about confidentiality.

Suitable organisations were identified using two criteria: (1) they provided support/information services to the target population and; (2) they provided these

services in either rural or urban areas across all regions of Ireland. Umbrella organisations for sexual and domestic violence services in Ireland were also included in the sampling frame, as were the four nationwide SATUs. A maximum variation purposive sampling technique was used in view of the necessity to include a wide range of participants with experience of providing specific services to women survivors of SV. Additionally, deliberate attempts were made to select organisations that served rural and urban areas and that represented a good cross-section of the spread of services across the country. Therefore, the final sample was deemed to be a fair representation of the selection of services and resources available to these women, while also showing a reasonably good geographical spread. The sample included individuals of varying experience, who were working and/or providing counselling in rape crisis centres (RCCs) or other SV services (n=14), SATUs (n=3) and domestic violence agencies (n = 1), located in a range of urban and rural settings; for example, agencies/organisations from the South, West, North-West, North-East, East, South-East and Midlands region of Ireland were included. Interviews were conducted in a quiet location on, or near, the premises of the participating organisation.

4.7 Interview Schedules

A number of materials were designed for purposes of this stage of the research, the details of which are presented below.

4.7.1 Stakeholder Background Questionnaire

First, participants completed a brief *Stakeholder Background Questionnaire (SBQ)* (Appendix 2) either prior to, or at the time of, meeting with the researcher. This was designed to elicit brief information on: age; current job title/position and related duties/responsibilities; and the extent of their experience in the area. A selection of open-ended and closed questions was also included in order to explore experiences and views on a number of other issues which included: the main barriers for women in accessing appropriate services; the most significant gaps in services for women in Ireland today; how they would rate the services currently available to women who have experienced sexual violence; and the amount of stigma associated with sexual violence. This questionnaire also helped to focus attention on some of the issues that would be explored in more detail during the interview.

4.7.2 Interview Schedules A-D

Following an extensive review of the SV literature, a number of semi-structured interview schedules were devised. A single interview schedule was drawn up, in the first instance, to include questions relating to: the nature of services currently provided by each organisation; the main challenges and difficulties faced by women after the assault; the barriers to accessing services; and the current gaps in service provision. Further questions relating to the process of the research (e.g. concerns they might have with this kind of research, the sensitive recruitment of participants into the study) were also included. Then, based on the nature of the services offered by the organisation (e.g. the services offered by a SATU are significantly different to those offered by a RCC), this interview schedule was modified to include organisation-specific questions. For example, RCC interviewees were asked about their staffing arrangements including volunteers, whereas SATUs do not routinely operate with the help of volunteers; thus, this question was omitted. This process of amendment and revision resulted in a total of six versions of the *Service Provider Interview Schedule* (SPIS) for use in the interviews (SPIS A-D) (Appendix 3).

4.8 Procedure

The identification of key individuals who were working in the SV sector was initially facilitated by a face-to-face meeting with staff from the Rape Crisis Network of Ireland (RCNI). Following this, and based on the criteria specified earlier, potential participants within each target organisation were contacted by the researcher, informed about the study and invited to take part. During a 10-month period in 2006, the researcher coordinated, arranged and carried out face-to-face interviews in a variety of geographical locations around Ireland. In order to be as inclusive as possible, prospective participants were also informed about the study through a short article prepared by the researcher and submitted for inclusion in the monthly RCNI Newsletter, which is distributed to all Irish RCCs (see Appendix 4). Other relevant organisations outside of the RCNI (e.g. domestic violence agency, SATU services nationwide) were contacted individually and interviews arranged accordingly.

In most cases (n=14), the Interview Schedule was forwarded to participants in advance of the interview. This was generally at the participant's request to help them focus their

thoughts prior to the interview, but also in some cases, to satisfy ethical requirements within the organisation. For example, one of the SATU participants needed approval from her manager before taking part and a copy of the proposed Interview Schedule was forwarded and approved prior to her participation. Participants were also furnished with an Information Sheet and SBQ in advance of the meeting and prior to the recording of the interview, the researcher addressed any questions they may have had. The Information Sheet (see Appendix 5) stated the purpose of the study and what would be involved if they decided to participate. Other information included: who was funding the research; who had approved it; what would happen to the results; and whom to contact with any questions. Participants were also informed that any information shared with the researcher would be treated confidentially and securely stored at all times. In addition, they were reassured that their organisation would not have access to their responses/data at any time. This information was also conveyed verbally, both before and at the time of the interview, before asking participants to provide their informed written consent to take part and to allow the interview to be recorded (see Appendix 6 for a sample Consent Form). For those who did not wish the interview to be recorded (n=4), extensive field notes were taken, both during and immediately after, the interviews. The duration of the interviews varied from 45 minutes to two hours.

4.9 Data analysis

All audio-recorded interviews (n=14) (excluding the four participants who declined) were transcribed verbatim by the researcher. The transcripts varied in length from 6 to 28 pages. These were edited for purposes of clarity and meaning only and, upon completion of the transcription and a final listening, each was judged to be an accurate reflection of the content of the interviews. Each individual interview was then read through in its entirety and any items of interest, such as those relating to the questions in the Interview Schedule, were noted. As one of the goals of this stage was to assess stakeholders' views on a range of issues (e.g. the impact of SV, barriers to services etc.), an atheoretical approach was adopted in the analysis, whereby transcripts were subjected to a standard thematic analysis (Hayes et al., 2000).

This involved identifying and exploring key themes or recurrent ideas, or topics and consisted of a number of different sequential stages (Hayes et al., 2000). Thus, once each transcript had been read several times, any items of interest, were colour-coded

and organised into proto-themes, which were carefully examined, and an initial definition of the theme attempted. This stage of the process was facilitated by using the structure of the Interview Schedules as an initial guide to organising the material. A secondary examination of the transcripts was then carried out using this provisional 'theme guide' and relevant material to each theme was identified, colour coded, and organised accordingly. Once this was completed, it was possible to construct each theme in its final form which consisted of a name, definition and supporting data. The field notes from those interviews that were not recorded, were initially set aside and examined, only after the 14 transcriptions had been analysed; any new material from these, that was considered pertinent to each of the themes, was then included in the final analysis.

The following chapter reports the qualitative findings from Stage One.

Chapter Five

Results I: Stage I

CHAPTER FIVE

Results I: Stage One

As indicated in the previous chapter, the results for Stage One were derived from a series of one-to-one semi-structured interviews (n=18) conducted with stakeholders working in a range of services within the sexual violence (SV) sector in Ireland during 2006 – 2007. As outlined earlier in Chapter One, the key objectives of this stage of the study were to: (1) assess the nature of current service provision and the extent of service utilisation by survivors/victims of SV; (2) identify the key issues and challenges for therapists and other service providers working with these vulnerable women; and (3) to seek the advice of service providers on the most effective and sensitive ways of identifying and recruiting women for participation in the research. Additional questions sought service providers' opinions on the impact of SV, based on their experiences of working directly with clients/service-users.

5.1 Participant profile

All of the participants (n=18) were female, ranging in age from 30 to 59 years¹⁹ and all had been working in the sexual violence sector, in a range of capacities, for an average of 8.5 years. These included individuals who were working in, and/or providing counselling in, a number of both urban and rural settings, including rape crisis centres (RCCs) or other SV services (n=14), SATUs (n=3), and domestic violence agencies (n=1). The sample comprised: counselling therapists (n=10); nurses (n=2); a doctor/consultant (n=1); and management/administration staff (n=5). Half of the respondents rated current service supports for women who have experienced SV as only 'fair' to 'poor' whilst 90% indicated that the amount of stigma associated with this crime is considerable (i.e. 'a lot').

5.2 Key themes and issues

Three key themes were identified and/or emerged from the analysis, within which a further 10 sub-themes were identified (Table 5.1).

¹⁹ Information on exact age was not collected due to the potential sensitivity of this kind of information within a one-to-one interview with a professional.

5.2.1 Barriers to service provision

5.2.1.1 Survivors' shame and guilt

A powerful and recurring theme – and one mentioned by all of the participants – related to the shame and guilt felt by many women after being raped or sexually assaulted; this appeared to pose one of the most significant barriers to accessing appropriate support and reporting to the police. For example, one participant commented:

'I think the main difficulty...that everybody has, is the whole stigma and shame. It's a combination of stigma and shame and a lack of awareness among women of what sexual assault actually is.' RCC service provider (4 years' experience)

Participants also alluded to the negative experiences of disclosure amongst some women and how this may compound existing levels of guilt. Thus, if women feel a sense of responsibility for the incident, the effects of disclosing to someone who may, in their eyes, reinforce these feelings, may prevent them from disclosing in the future, or from identifying themselves as in need of support services. For example, two participants commented:

'Quite a lot of clients will self-blame...that is definitely predominant. The clients that come in here still feel that they are to blame for what has happened even though they know...part of their brain is telling them... 'No, he was wrong'...' SATU service provider (2 years' experience)

'They definitely have a huge guilt thing that you know... 'God, was it something I did?'' SATU service provider (5 years' experience)

Feelings of shame, guilt and self-blame are common following an experience of SV and frequently give victims some sense of control over their world (Petra & Hedge, 2002). The service provider respondents in the current study highlighted a number of important obstacles to women when accessing formal or informal support. These included, in many cases, the shame related to their perceived responsibility for the attack, how much they resisted it, and concerns about the attitudes of friends and family. The findings presented here, suggest that, unless these kinds of issues can be addressed at an individual and societal level, essential support services will remain under-utilised and under-funded into the future.

Table 5.1: List of themes and sub-themes including descriptions.

Theme 1: Barriers to services	
Sub-theme name	Description of sub-theme
<i>1.1 Survivors' shame and guilt</i>	Feelings of guilt and shame post-assault act as a barrier to survivors in accessing services
<i>1.2 Naming/acknowledgement of the incident</i>	Victim reluctance to name the incident as 'sexual violence' means they fail to identify themselves as eligible for services
<i>1.3 Societal myths around rape</i>	Persistent societal myths around rape facilitate further self-blame in victims
Theme 2: Current gaps in service provision	
Sub-theme name	Description of sub-theme
<i>2.1 Education and awareness</i>	Lack of public awareness around services and the prevalence and effects of sexual violence
<i>2.2 The Criminal Justice System</i>	Gaps exist in the CJS which can affect the likelihood of a woman proceeding with a case
<i>2.3 Availability of Sexual Assault Treatment Units</i>	Issues around the geographic spread of SATU services and the operation of a 'true' 24-hour service
<i>2.4 Specialised services for vulnerable sub-groups</i>	Particular issues for a number of vulnerable groups (e.g. Traveller women, asylum seekers, disabled women, teenage girls) that make access to services difficult or impossible (i.e. not available to them)
Theme 3: The perceived impact of sexual violence	
Sub-theme name	Description of sub-theme
<i>3.1 Post-traumatic reactions</i>	Typical post-traumatic symptoms reported by women after an experience of sexual assault
<i>3.2 Physical and mental health consequences</i>	The serious and often long-term physical and mental consequences experienced by service-users
<i>3.3 Emotional and social effects of sexual violence</i>	Women who have been raped experience intense emotional upheaval and can often experience real-life consequences in their interpersonal relationships and education

5.2.1.2 Naming/acknowledgement of the incident

Arguably, in order for women to see themselves in need of, or suitable for, the services provided by RCCs or SATUs, they must first recognise that what they have experienced is SV or rape, or a crime. This naming or acknowledgement of the incident was another recurring sub-theme; for example, one participant reported:

'...for a lot of women who have experienced unwanted sexual contact or, coercion into having sex...they may not name that as 'rape'...' RCC service provider (12 years' experience)

This, commonly reported reluctance by women to name what has happened to them, may lead to a sustained silence during which they may struggle with many negative emotions. Another stakeholder emphasised the effect on women of this lack of clarity and understanding around rape/sexual assault; in her opinion, a recognition that the experience constitutes rape/sexual assault, was the single most significant barrier to accessing appropriate support:

'I wasn't dragged down a dark alley therefore it wasn't really rape!' It's a combination of stigma and shame and a lack of awareness among women of what sexual assault actually is...that I would say is their biggest difficult. Cos other than that...the number is reasonably accessible if somebody wants to speak with us. If they want to find us they'll find us you know.' RCC service provider (18 years experience)

Furthermore, this may have serious implications for service providers who are trying to reach out to vulnerable women. For example, use of the 'wrong' language (e.g. rape, sexual violence, a crime) may prevent a woman from seeing herself as someone in need of such services. This is illustrated by the following comment:

'An awful lot of people won't...don't identify with that word [rape] because they see it as... 'Well rape means someone dragging you down an alleyway, sticking a knife to your throat and beating the crap outta ya!' Domestic violence service provider (12 years' experience)

Therefore a key message emanating from the interviews, related to the need for service providers to balance their desire to inform women of their services through the use of carefully selected language, images and media, whilst ensuring that they do not alienate an already marginalized and vulnerable population:

'There would be issues for immigrant women...we know that for example Traveller²⁰ women do not access our services and they tend to be over-represented in refuges...it's difficult. You've always got that delicate balance between wanting to advertise your services so that women get the number and then making sure that you're actually able to answer the phone.' Domestic violence service provider (12 years' experience)

However, even when women do access services, the process of naming the incident, as 'rape', is often not straightforward:

'I have a client and she was describing what had happened to her...an absolutely awful rape...it was named as rape [by the therapist]...and it was like 'Yeah I was raped'...but I think if it hadn't been named [in this way] that this is what it is...and you've survived it...that girl found it really hard for me to call it rape...' RCC service provider (6 years' experience)

5.2.1.3 Societal myths around rape

Several participants alluded to the numerous myths that still persist in today's society around rape and, in particular, the prevailing stereotypes about who is a 'victim' and who is a 'perpetrator'. The consequences of experiencing SV outside of these parameters often leads to a high degree of self blame amongst women; as a result, they tend to feel that they are not entitled to access support services, or to bring the perpetrator to justice. The following highlights some of the typical misconceptions that women must overcome in order to access services:

'We have a notion in this society that rape is a stranger who jumps out of a bush when a woman is walking home. Certainly she doesn't know him, she doesn't go on a date with him, she never kissed him and she's NOT married to him....so that makes it much more difficult for women who are raped in those circumstances.' RCC service provider (13 years' experience)

Furthermore, the potential likelihood that a woman will not be believed by those around her, is often a significant barrier to disclosure and subsequent service utilisation, but this is perhaps no more salient than when the rape or sexual assault occurs within an intimate partnership or marriage – as illustrated by the following comment:

'Well, you're in the relationship with him so you must have said something then to provoke this!' It's really difficult for women to feel that they're going to be taken

²⁰ The term 'Traveller' refers to a member of the Travelling community, a nomadic Irish ethnic group. (www.pavepoint.ie - accessed 25th October 2009).

seriously and that they're going to be believed.' RCC service provider (2 years' experience)

This finding is consistent with quantitative research that suggests that marital rape is experienced by about 10-14 per cent of all married women and by about 40-50 percent of battered women (Martin, et al., 2007). These kinds of misinformed attitudes may extend beyond a woman's immediate family circle and close friendships and may have consequences in many areas including the treatment of women within the Criminal Justice System (CJS). For example, one participant reported:

'I've had loads of women who have said to me... 'Oh the judge said I don't look like a victim'...like you may not fit the judge's idea of the traumatised victim because you're having to survive on a daily basis.' RCC service provider (3 years' experience)

The potential difficulties with the CJS and its treatment of victims of SV is explored in more detail in a related sub-theme (2.1) in the following section.

5.2.2 Current gaps in service provision

5.2.2.1 Education and awareness

Participants repeatedly stressed the need for, and the importance of, education and awareness raising. Some commented that several women, whom they had encountered either directly through their service, or external to it, had been unaware of their local services. The following two comments highlight the experience of these participants in delivering these types of services in the community:

'I mean people say to me when I say to them I work in the Rape Crisis Centre...they say I didn't know it even existed. There has to be an awareness around counselling...that it works, that people need counselling...there wouldn't be awareness among a lot of people.' RCC service provider (5 years' experience)

'I suppose women knowing that we exist here... Having the information about the services...that's a big challenge for us is to actually be able to target these people [who are unaware of the existence of a local RCC]...' RCC service provider (Number of years experience not available)

Several participants also mentioned the tensions inherent in promoting their service whilst ensuring a safe, confidential and therapeutic 'space' for women – in other words, providing a place of sanctuary where women felt sufficiently secure to confide in

someone. For example, one RCC worker felt that, if more women were accessing the service, some might feel more easily identifiable when entering and exiting the RCC premises, thereby compromising their confidentiality. Nonetheless, a therapeutic 'space' that is safe physically, emotionally and psychologically, was considered by the majority of RCC workers, to be essential to the recovery of their clients. However, all were also acutely aware of the need for public education initiatives around these issues, including what constitutes consent, and inappropriate or unhelpful reactions to disclosure, as illustrated by the following selection of comments:

'One of the biggest things is education and information. I think that teaching young people about consent is absolutely essential... 'What does consent mean? How do you know if someone is consenting? Do they have to say 'Yes' or 'No'?' RCC service provider (6 years' experience)

'Supposing in the event of a young girl or somebody going home like and going 'Oh God if I go home now and my mother hears that this is after happening to me I'll never be left out again' or other ones that say like 'My mother...I was attacked on my way home and the first thing she ask me is how drunk was I?'' RCC service provider (18 years' experience)

Participants were very clear about the need to increase awareness of the seriousness and impact of SV and to improve the public's understanding of the difficulties faced by women when trying to access support (as illustrated by the first comment below). Other common responses to victims of SV, often influenced by societal norms and stereotypes, were also seen by one participant as being particularly unhelpful:

'I think until you've actually worked with them [rape victims] or dealt with them you do not have an idea how 'wiped out' people are...what they've gone through is horrendous and even coming in here...we try to make it as caring as we can but it's still a horrible experience...' SATU service provider (5 years' experience)

*'What was she wearing? Why was she there? Why did she go with him? That's a natural thing [to ask those questions] but in some ways it's a societal thing...it has to be seen that...**nobody ever chooses this** [rape – emphasis added]' RCC service provider (12 years' experience)*

Worryingly, wider society was seen by some participants to be characterised by a 'rape-supportive' culture. It was suggested that, without effective national education and awareness raising programmes - similar to the 'Don't Drink and Drive' campaigns run by the Irish Road Safety Authority and the Department of Transport - women who

experience SV will have to continue to decipher the mixed messages and information they receive before accessing services. This was mentioned by several interviewees and is illustrated well by the following comments:

'There's a huge gap in services...how is it that people know first of all that sexual violence is wrong because we [society] don't hand out that message...and if you've experienced sexual violence, how do you know that the services are accessible to you?' RCC service provider (13 years' experience)

'Teenagers experiment...the task of adolescence is to become a person and to experiment. I think they're not allowed to be safe in that because they're criticised so much for their drinking, and there is nowhere for them to go. They go to hospitals, they present, they report and then they get treated like absolute...and they come back [to the RCC] and say 'They thought I was a slut'...where did they get that message from - d'you know?' RCC service provider (12 years' experience)

5.2.2.2 The Criminal Justice System

Several interviewees expressed disappointment and frustration with the CJS and particularly the manner in which women are treated if they decide to proceed with a case. The findings reported here, suggest that the experience for women who intend to prosecute the alleged perpetrator is, at best stressful, and at worst, re-victimising. Participants expressed particular frustration with the length of waiting time for a case to come to court, and with the treatment of the victim as a 'state witness'. This can often mean that the victim is not always kept informed of developments in the case. As one participant reported:

'The biggest stumbling block in rape cases is the justice side of it from what I can gather...like they're [rape victims] only witnesses²¹' SATU service provider (5 years' experience)

Another issue with the Irish CJS is the current Director of Public Prosecution's (DPP) policy, whereby there is no obligation to provide a reason for a decision to abandon a case. The decision by the victim to proceed with a case is, at best, a difficult one, but to have a case dropped for no reason must be even more frustrating. Remarkably, one

²¹ The CJS is not legally obliged to keep a witness informed of progress in the case, although in many cases they try to.

participant, whose job involved, collecting the forensic evidence used in these cases, commented:

'You do hear things from people [about the CJS]...that's where I'd see the biggest gap in the service...not so much at this level [SATU] but I think from here on in, it's horrendous...like maybe the fortunate ones are the ones that don't go to court.' SATU service provider (2 years' experience)

According to some participants, the attitudes of CJS personnel may sometimes be far from understanding and supportive, even when a case reaches court. Furthermore, the myths and stereotypes surrounding rape that influence attitudes and beliefs, are not peculiar to the general public, and this can frequently make the trial a harrowing experience, as illustrated by the following comments:

'...the fourth [court accompaniment by an RCC volunteer] one was just a 'not guilty' plea...and just how that girl was treated by the judge, by the Garda [the Gardai – the Irish police force]...you're kind of going 'Is this still the Dark Ages?'' RCC service provider (8 years' experience)

'...and then there's the court case...and that is the most traumatic thing that will ever happen to them...clients have told us that that was worse than the abuse... they actually got the perpetrator imprisoned...but they came back and said that it was the worst experience of their life and that if we wanted them to talk to people to turn them off going [to court]' RCC service provider (5 years' experience)

5.2.2.3 Availability of Sexual Assault Treatment Units (SATUs)

An urgent need for an increase in the number of appropriate and accessible SATUs was highlighted throughout the interviews. Additionally, several participants emphasised both the medical and forensic needs of women:

'I think the biggest [gap in services]...is obviously the fact that the [SATU] services aren't available 24 hours...what I would like to see is that the SATUs were more available.' RCC service provider (18 years' experience)

'I mean, in a dream service, I would have more doctors and that we could offer a service to women who have had an incident, but who do not want to report to the police...that would be ideal.' SATU service provider (16 years' experience)

Some SATUs only provide services to victims if they are willing to proceed with a case and to have a Forensic Medical Examination (FME). Funding issues and difficulties in

securing and retaining qualified doctors to carry out the FMEs, also affect service availability. Several service providers, particularly from rural areas, spoke about women having to remain in the same clothes they had been wearing at the time of the assault, for up to two and three days afterwards, while waiting for a suitably qualified FME. The likely occurrence of this appears to be determined largely by a woman's proximity to a SATU. As one participant commented:

'The SATU...we're quite far away from Dublin and that fact that we don't have the personnel to offer a 24-hour service. There are four social workers who are really keen for a SATU unit to be put in XX [name withheld]...that's not going to happen for a very long time.' RCC service provider (6 years' experience)

Further comments were made about the uneven geographical spread of SATU services within Ireland. According to a national review, SATU services in Ireland *'have developed in a relatively fragmented way rather than as a co-ordinated strategy'* (O'Shea, 2006:39). Consequently, a large portion of the population is under-served. As one service provider remarked:

'I think if you look at the [SATU] services....in general in the West of Ireland, in the Midlands and in the Northern part of the country, the border part of the country...they are a scandal.' SATU service provider (16 years' experience)

Many of these issues require an urgent and speedy response whilst others, such as public attitudes and behavioural change, will require a more carefully constructed and co-ordinated, inter-agency approach in the longer term.

5.2.2.4 Specialised services for vulnerable sub-groups

Several participants commented on the need for a range of services to meet the unique needs of various vulnerable sub-groups (e.g. Traveller women, immigrants, disabled women and teenage girls). For example, historically, Traveller women are over-represented in domestic violence refuges in Ireland and under-represented in other non-residential support services, such as domestic violence drop-in services and RCCs. One participant highlighted a number of complex issues associated with delivering services to these women:

'Gaps in services are around meeting the needs of the whole range of sexual violence survivors...Traveller women use refuges way more than they use Rape Crisis Centres...but part of that is...we have this notion that here's this centre or women's support service and you have to come to our centre to get services...that's not really...you don't have a choice [if you want our services]' RCC service provider (13 years' experience)

Another vulnerable sub-group in Ireland and one that has been dramatically affected by the Irish government's policy (Immigration Act, 1999) on the national dispersal of refugees and immigrants is asylum seekers. This has led, in recent years, to dramatic changes in the client profile of many of the organisations represented in this study. For many of these women, the desire, or need, to deal with sexual violence-related issues is overshadowed by the pressing uncertainty of their living conditions and status, and the sometimes blatant disregard for the effects of this kind of experience. This theme is succinctly illustrated by the following comments:

'If you're coming from the Congo and you were faced with female genital mutilation, [and] you were raped by the security forces when you tried to leave the country...culturally sitting down and doing counselling in the way that we do it may make no sense to you at all if you don't [even] know if you are going to be deported next week or next month.' RCC service provider (3 year' experience)

'About asylum seekers...the traumatization is just not recognised at all. You know, they'll be coming to us and they'll have seen solicitors, they'll have seen psychiatrists and nobody has picked up that they're traumatized.' RCC service provider (12 years' experience)

While not all of the RCCs had to deal with this particular issue on a similar scale, virtually all were aware of the language and cultural differences between these communities and our traditional Western methods of counselling; as indicated above, these are often inappropriate for these women, effectively leaving them with limited, if any, options for treatment and support. This, coupled with the frequent need for interpreters in many of these cases, led one participant to comment:

'Doing something like counselling or even sorting out what somebody needs through an interpreter is not a great way to have to do it and often, if you're talking about a small community, the people who are available to interpret may be somebody that you don't want to know your business anyway.' RCC service provider (13 years' experience)

Another interviewee indicated that many of the RCCs were not wheelchair accessible, nor had they basic facilities for women who are hard of hearing, or who have other disabilities. Two participants also alluded to the fact that many of the limitations and obstacles faced by SV survivors in accessing services are compounded by the presence of a physical disability/ impairment:

'There would be particular types of barriers to particular groups of women. We find that the kind of profile [of service users] would be fairly homogenous – white, Irish women and non-disabled.' Domestic violence service provider (12 years' experience)

'The difficulties and challenges [in accessing services post-assault] depend on if you are a member of the class that's perceived as the norm. If you're white, middle class, Irish born...not disabled, not lesbian...a lot of centres have arrangements with other premises to see somebody...but often in small towns, that means it's the local branch of the Wheelchair Association [WA] and you might not want your business known to your local branch of the WA.' RCC service provider (3 years' experience)

Many of the organisations to which participants were affiliated, had a lower age limit of 18 years for their services. In some cases, younger girls of 16 and 14, with their parent's permission, had attended for counselling, although this would not be the norm, according to one director of a RCC. Work in the community and talks in local schools given by staff, in addition to almost weekly (in some places) direct contact from young girls reporting experiences of SV, had alerted many of the interviewees to the chronic lack of appropriate services for teenage girls. The experience of SV while still at school often has immediate consequences for these young women in terms of completing their education, thereby also affecting their future job prospects. As one experienced RCC provider commented:

'Education would be a massive one for us...nearly everyone we've worked with [who still is] in school has stopped their education and not done their Leaving Cert²².' RCC service provider (12 years' experience)

In addition, the lack of age-appropriate services, coupled with the fear of their parents finding out about what has happened to them, can often mean that these young women are left struggling to cope:

²² The Leaving Certificate is the final examination taken by Irish students leaving secondary school.

'We've had young girls on the phone who were raped and never told a sinner and they were absolutely 'at their wits end' trying to do their Leaving Cert.' RCC service provider (5 years' experience)

These gaps in services effectively leave a number of specific and significant minority groups either without, or with limited, access to services. The issues raised here are worthy of further attention, particularly since participants' experiences are rooted in frontline contact with these women.

5.2.3 The perceived impact of sexual violence

The main focus of the present study was to assess the impact of SV from the perspective of Irish women who have experienced it firsthand. Nonetheless, it was considered important and interesting, during this first phase of the study, to also elicit views on the perceived impact of SV, from the service providers who work with these women on a day-to-day basis. This constituted the third theme identified here. Again, a number of sub-themes also emerged, each of which is described below.

5.2.3.1 Physical and mental health consequences

Many of the participants described the typical reactions of women whom they had seen, as involving post-traumatic symptoms, such as hypervigilance, anxiety, numbing, and avoidant behaviours. For instance, participants reported that some of the women were: constantly fearful (e.g. of people finding out or of being assaulted again); had withdrawn from their family and friends and sometimes their children in the aftermath of the assault; avoided talking with friends about what happened; had immediately returned to work or college in an attempt to normalize and/or minimise their experience; and had reported sleep disturbance, nightmares and terrifying flashbacks. These are illustrated by the following selection of comments:

'Well immediately it's ...like hypervigilance and nervousness...I think then there is shock...definitely. There would be that sense of shock and disbelief and did it really happen? Well, I'm going to work, I can have a drink after work, I can have dinner and ring my friends and it didn't happen did it?' RCC service provider (6 years' experience)

'A lot of people will say...it's almost like denial... 'If I don't talk about it maybe it didn't happen'' RCC service provider (Number of years' experience unavailable)

'One of the things we'd often notice here...is the sense...that the perpetrator... he's somewhere, he's around. I'm thinking about a young person I worked with last year.'

Her reality was so fractured...[and] it stuns me how many get up and go into work and then 3 days later, it's like they're falling apart.' RCC service provider (12 years' experience)

Many of these findings indicate that sexual violence has very real, direct and indirect effects on both physical and mental health. The participants described a wide range of physical and mental health symptoms in their clients. Furthermore, some of the coping methods frequently used by victims of rape (e.g. alcohol or drug use or other risk taking behaviour) were considered by some to have a potentially negative impact on overall health and well being. While only a small number of participants mentioned physical injury as a direct result of the assault, others highlighted physical consequences and concerns in their clients, such as unwanted pregnancy and STIs. For example, one participant, providing SATU services in one part of the country, commented:

'Primarily, their major concerns after an alleged assault... pregnancy and STIs... that is fundamentally...and AIDS obviously... they think about what they have got from the alleged assault.' SATU service provider (2 years' experience)

Interestingly, one respondent felt that the physical pain caused by internal injuries might often be underestimated, or its importance inadvertently diminished, due to the overwhelming emotional upheaval following this kind of experience. This may also mean that routine physical and medical examinations, in the future, serve as a constant reminder of what they have experienced:

'There can be internal injuries you know. I know we talk about emotional all the time but there can be physical [trauma] and physical pain so in those situations they're going to their GP and then they're being examined and...[it's a] constant reminder.' RCC service provider (6 years experience)

An additional comment by another SATU service provider, illustrates the severe and potentially long-term physical consequences of rape:

'Where you see the long-term consequences are... within a gynae [gynaecological] clinic... and we do see it in our clinics...painful periods, psychosexual difficulties...they are not uncommon sequelae after something like this.' SATU service provider (16 years' experience)

In relation to post-assault mental health issues, one participant reported that the women whom she (and her colleagues) had encountered frequently had psychiatric problems in

the form of anxiety, eating disorders, manic depression, agoraphobia, and addictions. In addition, some of the women had experienced suicidal ideation and/or had engaged in self-harming behaviours. According to several of the participants, excessive alcohol consumption, the use of illegal drugs and risk-taking behaviours (e.g. multiple sexual partners, poor contraceptive use) were common responses in women who had been sexually victimised. Prolonged alcohol abuse and substance abuse present a host of other problems, whilst sexually 'risky' encounters can also expose these women to increased risk of STIs, unwanted pregnancy and gynaecological problems. Some illustrative quotes are provided below:

'They're often involved with psychiatric services and they're on anxiety pills. Some would develop eating disorders...they don't want to actually physically look like a woman so they stop developing...and the clients in XX [name withheld] had all severe psychiatric problems...they were manic depressive...they had been suicidal, severe depression...everything.' RCC service provider (Number of years' experience unavailable)

'There can be the coping mechanisms in drink and drugs... prescription or otherwise... mental health issues... like my background is in psychiatric nursing and I would definitely have come into contact with patients in that world that...it's [sexual violence] in their history.' RCC service provider (6 years' experience)

'I would say the other thing, is perhaps risky behaviour, if it's not sorted...particularly sexually...I'd see sexually risk-taking behaviours.' RCC service provider (12 years experience)

5.2.3.2 The emotional and social effects of sexual violence

A recurring sub-theme throughout the interviews referred to the loss of trust experienced by victims of SV both in the people and world around them, irrespective of whether the perpetrator was known to them or not. According to interviewees, in cases where the perpetrator was known to the victim, the women described a particularly debilitating loss of trust in the people around them and in their own personal sense of intuition. Furthermore, their clients explained that their sense of safety in the world around them had been irrevocably compromised:

'One of the things I think...is literally their ability to move around is deeply affected...I can't go to a car park, I can't go there...just their freedom, their personal space...just [their] ability to go to the shop, to just trust in the world.' RCC service provider (12 years experience)

This loss of trust was considered by interviewees to impact considerably on the extent to which women feel safe and comfortable in disclosing to others and is frequently accompanied by considerable shame, guilt, and self-blame and, sometimes anger. According to some participants, the sense of shame and self-blame tends to be compounded by negative reactions and the social stigma and stereotypes that surround sexual violence and other issues, such as the amount of alcohol consumed at the time of the incident:

'The shame of what has happened to them keeps a lot of people away... huge shame. They're blaming themselves for what happened... [and] with a young girl I suppose... a teenager going to a disco in a mini skirt and having a few drinks... society will blame her.' RCC service provider (8 years' experience)

'You've got the stigma attached to rape... [and] for a woman with a lot of alcohol on board and not being able to recall accurately and recount accurately what happened... it's quite difficult then for them to proceed onwards and come forward to the guards.' SATU service provider (2 years' experience)

'Girls are still blamed... it is still... 'You asked for it'. I think it's a natural thing for parents to say 'Why was she there? That's a natural thing but in some ways that's a societal thing.' RCC service provider (12 years' experience)

Furthermore, according to respondents, the violation of trust experienced by these women has, in some cases, affected their relationships with people to whom they were previously close. For example, participants described difficulties in their clients' current relationships with friends and family members including parents, who had not believed them when they disclosed their experience. This only served to increase their sense of diminishing trust in the people and world around them and further compounded their sense of isolation. As one participant stated, even after they have disclosed their experience, it is still not easy to talk to friends about it:

'And people would say to you... how their friends find it very hard to talk to them about it and how they themselves find that very hard to talk back to their friends [about it]. They find that difficult to accept... it's like if you have taken the first little step, you want everyone else to kind of take that step with you if you're the victim.' SATU service provider (2 years' experience)

It was also clear from some of the comments offered by participants, that an experience of SV can often exert a considerable negative toll on the self-esteem and self-confidence of these women. For instance, one interviewee felt that this, more than any other factor,

had often led women into substance abuse and suicide. Furthermore, these effects sometimes did not materialise in a real and meaningful way until the women had their own children, at which stage, they tended to question their ability as parents. Moreover, emotional and physical withdrawal for these women, often mean that, even the simplest intimate interactions, become problematic. The following excerpt succinctly captures this:

'All of the clients I've worked with had problems with intimacy. Avoiding sex, avoiding closeness. I had a client who was married... and she could do lunch with her husband but she couldn't do a candlelit dinner... a candlelit dinner was very romantic plus the possibility that the husband perhaps wanting to make love afterwards.' RCC service provider, (6 years' experience)

Problems with completing education were also evident in the clients of one RCC participant who had dealt with a number of younger women in recent years. Fortunately, as illustrated in the following comment, one young woman managed to continue with her college course with the support of her parents:

'Another girl was raped by her cousin's boyfriend... two weeks before she was due to start her first year in college... and she wasn't going to start but her parents were like 'Come on!'...and then she finished her exams and she worked really hard.' RCC service provider (5 years' experience)

It is clear from the evidence presented here that the women being seen by these service providers, are experiencing a range of physical, mental, emotional and social consequences (both direct and indirect) as a result of their experience of SV. While some of these appear more obvious and intuitive (e.g. physical injuries or depression), others are perhaps more complex and insidious in terms of their impact on women's lives.

5.3 Conclusion

An analysis of the data presented here, provides useful insights into the key issues affecting victims and the experiences of service providers who have frontline contact with these women. The service provider participants identified a range of barriers to services such as, survivor shame and guilt, whilst also highlighting a number of gaps in current service provision, particularly within the Irish CJS and in the availability of SATUs. The participants also reported a range of physical, mental health, emotional and

social consequences in the women with whom they have had one-to-one contact in the course of their work. Stages Two and Three of this study explored these kinds of issues and themes and sub-themes in more detail from the perspective of the women themselves.

The results presented here suggest a distinct, yet subtle interplay between the various themes and sub-themes identified. For example, is the shame and guilt that women feel after an experience of SV, influenced by societal rape myths? Are the barriers identified here in some way related to the gaps in existing services? How can we successfully address these? These and other questions will be discussed later in Chapter Ten in the context of the collective findings emanating from all three stages of the research.

Chapter Six

Method II: Stage II

CHAPTER SIX

Method II: Stage Two

6.1 Stage Two: An overview

This chapter presents methodological details for Stage Two. This was, in many ways, the most challenging and perhaps the most important element of the study. From the outset, and from speaking to the service providers during Stage One, it was anticipated that it would be extremely difficult to identify and recruit an adequate and representative sample of women to take part in the research, due to the inherently hidden nature of this target group. For example, the SAVI research showed that only one quarter of female victims of sexual assault/abuse (26%; 63/244) make contact with formal counselling support services, while just 8% (19/244) of adult female victims reported the crime to the Gardaí (McGee et al., 2002). Therefore, extensive preliminary work was involved, in the first instance, in promoting and advertising the study as widely as possible, in order to recruit participants and to manage sensitively, the process of contacting eligible women.

The quantitative methods utilised in Stage Two were designed to provide detailed insights into the impact of sexual violence on a sample of women with an experience of SV, and to compare these with a frequency-matched sample of women without a similar experience. The cross-sectional comparative study was undertaken using a variety of psychometrically robust measures which were administered in part, or whole, to the following two groups of women: (1) the sexual violence sample (SV sample) comprising women who had experienced SV and; (2) a frequency-matched comparison group (COM group) of women without any history of SV. Details of the SV sample are outlined first, followed by information on the frequency-matched COM group.

A battery of measures was used to provide a detailed description and assessment of: the sociodemographic and background characteristics of participants; their mental health/psychological well-being including depression and trauma symptoms (only the SV sample completed the trauma measure); their physical health status; the extent of alcohol and drug/substance abuse; overall quality of life (QoL); interpersonal support;

and the nature and extent of their service utilisation and needs. As indicated in Chapters One and Two, all of these have been identified in the literature as potentially relevant factors in the investigation of the psychosocial impact of sexual violence. These also provided a comprehensive profile of the true impact of this crime in a woman's life. A detailed description of the measures used in this stage of the study is provided later in this chapter.

6.2 The Sexual Violence sample (SV sample)

6.2.1 Participants and settings

A purposive sample of women (N=65) who fulfilled the following eligibility criteria, were recruited for this stage of the study:

- Irish, Caucasian, English speaking females
- Aged 18 or over
- Have had an experience of sexual violence since the age of 16

A total of 84 potential participants made contact with the researcher, all but seven of whom were self-selected (these seven were referred directly by support agencies). Recruitment and participation details are presented graphically in Figure 6.1 In most cases; a substantial amount of time was spent communicating with prospective participants prior to securing their consent to proceed. Following several face-to-face meetings with participants to complete questionnaires, a number of women requested that they be allowed to complete the questionnaires by means of a postal survey. After careful consideration and discussion, this option was made available to those who requested it (n = 50). For those women who agreed to meet with the researcher to complete the questionnaires (n=29), 14 interviews were conducted in their own homes whilst the remainder were carried out in a public place of the participants' choice (e.g. a quiet bar/café or restaurant (n = 11), or in the building of the referring organisation (n = 4). Due to the personal and sensitive nature of the subject matter, the duration of the interviews ranged in length from one to three hours.

6.2.2 Recruitment materials

As indicated earlier, Stage Two of this research involved the administration of a number of well-established psychometrically robust measures in order to assess a wide range of constructs in the two subgroups of women (SV sample and COM group). However, as in Stage One, a number of materials had to be devised first, for use during the lengthy promotion and recruitment phase of the study. The materials designed for the SV sample are outlined below. Similar information for the COM group is provided later in section 6.3.

As stated above, the recruitment phase of Stage Two was a necessarily lengthy and ongoing process and involved continuous efforts to promote the study, to inform relevant organisations and the target population about the study, and to follow-up contacts and prospective participants by means of email, phone and text messages. This process was crucial to achieving an adequate sample size and ensuring that all aspects of the research were managed appropriately and sensitively. To this end, a range of materials was developed during this phase of the study, including posters and leaflets, information sheets for interested organisations and business cards. A departmental website page was also devised and a research mobile phone procured specifically for the study. These are described in more detail below.

6.2.2.1 Posters and leaflets

The feedback provided from Stage One suggested that the best way to promote the study and reach as wide a pool of prospective participants as possible - in the most sensitive and non-intrusive manner - was by means of posters and leaflets placed prominently in a variety of suitable locations (e.g. RCCs) (Appendix 7). Initial drafts were sent to several of the Stage One stakeholder participants (n=5) (with their consent), in order to seek their views on a specially designed *Feedback Form* (Appendix 8). These service providers were asked to comment on: the appropriateness of the colours, picture and layout used; the suitability of the language and tone; and the relevancy of the information provided. The information provided and the tone and language, in which it was conveyed, had to be considered carefully for several reasons. The feedback from the Stage One interviews indicated that direct references to 'rape', 'sexual assault', 'crime' and 'sexual violence' were deliberately avoided, as

STAGE TWO

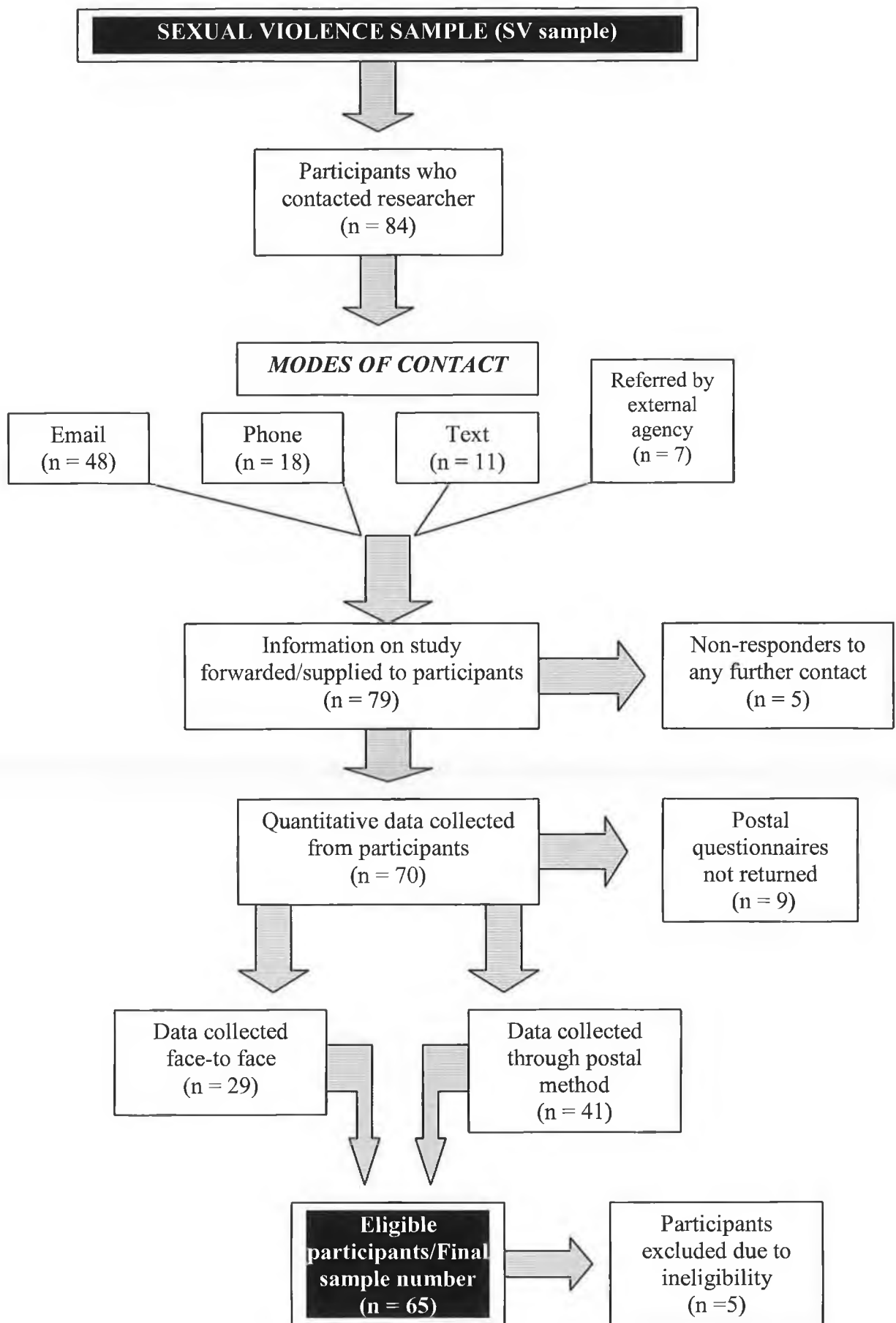


Figure 6.1: Recruitment and participation rates for SV sample in Stage Two: Graphical summary

many women do not classify the experiences they have had in these terms. Therefore, it was important to minimise the possibility of potential participants excluding themselves from the study, based on the language used. The poster also had to be appropriately eye-catching in order to attract attention and the information provided had to be detailed, yet concise. All of these factors were given due consideration prior to the posters and leaflets going to print.

The posters were A4 size, colour printed and included an outline of the study criteria and extensive contact details, as well as assuring participants of confidentiality and anonymity (see Appendix 7). Details on a departmental website page (<http://psychology.nuim.ie/CarolineKelleherResearch.shtml>) (please see below) were also provided in order that women could access further information on both the researcher and the study. The leaflets contained similar information supplemented by further detail on what was involved in participation and why the research was important. Thus, women were provided with a range of options to participate, including a contact number with times to call, a postal address, an email address and a website they could visit for further information (see below). These materials were distributed to all of the organisations, which had participated in Stage One, together with a letter requesting them to display them on their premises (Appendix 9).

6.2.2.2 Information Sheets for organisations

Representatives from organisations, which did not take part in Stage One, were also contacted, and/or contacted the researcher during the course of the research. Therefore, it was necessary to prepare a number of additional information documents for these organisations for distribution via their national networks (Appendix 10); some of these were umbrella organisations with many member organisations throughout Ireland. This was a useful way of disseminating information about the research and of recruiting a small number of participants. The additional promotional material (i.e. posters and leaflets) was then sent to these organisations for display on their premises.

6.2.2.3 Other materials

The researcher also had business cards printed in order to encourage as many women as possible to take part in the study (Appendix 11). There was no identifying information on the cards to suggest the nature of the research; these were forwarded to all

participating organisations and served as a discreet way for prospective participants to carry the researcher contact details in their pocket or purse. A research mobile phone was also obtained so that prospective participants could contact the researcher directly either via a phone call or a text message. The details provided on all of the promotional material, indicated that the researcher could be contacted on three different days of the week, at which time she was available to take calls in a private and confidential setting. A range of time slots was specifically chosen to maximise the potential for participant recruitment; these included one evening (7pm-10pm) and two morning-to-early afternoon slots (10am-3pm). This phone line was in operation for the duration of participant recruitment and data collection phases of the study.

The researcher also designed a website page (attached to her profile on the departmental website) in order to provide potential participants with as much information as possible about the study (and researcher) and in as discreet a manner as possible. This allowed prospective participants to access all relevant information from the safety of their personal computers, thereby preserving their anonymity and privacy. The departmental website was fully accessible as soon as the first posters and leaflets were distributed.

6.2.3 Measures

One of the principal objectives of this study was to capture the 'hidden' impact of SV. Therefore, it was important that the measures selected were comprehensive, robust and useful. Another important consideration was the number and length of the self-report questionnaires (i.e. in order to avoid participant fatigue) and their suitability to the population in question. The range of selected measures was identified from a comprehensive review of the literature and all were considered central to this kind of research and to the population under investigation. These assessed a range of constructs including: mental health; QoL; perceived social support; other trauma history; experience of trauma symptoms; and alcohol or drug use. All of the measures were copied, where possible, onto different coloured paper, thereby making it easier to distinguish between them. All are listed below and described in more detail in the section that follows.

- The *Background, Experiences and Services Questionnaire (BESQ)* (devised by the researcher)
- The *Rapid Alcohol Problems Screen – 4 (RAPS4)* – (Cherpitel, 2002) and the *Rapid Drug Problem Screen (RDPS)* (Cherpitel & Borges, 2004) – these were two brief measures of alcohol and drug use that were incorporated into the BESQ
- The 12-item *General Health Questionnaire (GHQ-12)* (Goldberg, 1978)
- The *Life Experiences Survey – Modified version (LES-M)* (Sarason, Johnson & Siegel, 1978)
- The *Trauma Symptom Inventory (TSI)* (Briere, 1995)
- The brief version of the *World Health Organisation Quality of Life (WHOQOL-BREF)* (The WHOQoL Group, 2004)
- The *Interpersonal Support Evaluation List (ISEL)* (Cohen & Wills, 1985b)

6.2.3.1 *The Background, Experiences and Services Questionnaire (BESQ)*

The 68-item *Background, Experiences and Services Questionnaire (BESQ)* was specifically designed for purposes of this study in order to elicit a wide range of information on the participants' experience of SV, their experience of, and utilisation of, SV services (if any), the impact of SV on their education and employment and on their relationships and health and basic sociodemographic details (see Appendix 12). The BESQ was devised following a comprehensive review of the literature and incorporates six separate sections and a mix of closed and open-ended questions. It also has subsumed within it, two brief measures designed to screen for alcohol and drug problems (see below). Some (nine) questions were adapted from previous work undertaken by McGee et al., 2002, 2005). Descriptions and instructions (where necessary) were inserted before each section and many items offered multiple-choice responses. In cases where women had experienced more than one incident of SV, they were asked, at the beginning of the questionnaire, to keep only the most recent incident in mind while responding. Each section of the questionnaire – plus the two screening measures – are described in more detail next.

Section A: About your experience of sexual violence

Section A of the BESQ (seven items) enquires briefly about the participants' experience of SV (e.g. *What was your relationship to the person who did this to you?*) Importantly, women are also asked to indicate if they had ever experienced SV or sexual abuse before the age of 16 (this is not covered in any of the other questionnaires).

Section B: Your experience of accessing services

Items included in Section B (11 items) deal with participants' experiences of accessing support, disclosure of the incident, and the range of services used (if any). Further questions relate specifically to participants' experiences of using the RCC services (e.g. counselling) given that these are the main providers of support and counselling in this sector in Ireland.

Section C: The impact on your life: Education and employment

Section C (eight items) was designed to gather information of the impact of SV (if any) on participants' education and/or employment at the time of, and since, the incident.

Section D: The impact on your life: Relationships and health

In this six-item section, respondents were asked to rate the impact of SV on their close relationships, and their ability to form close friendships and intimate relationships. Subsequent items gathered information on their use of health services, both in the first three months after the incident and on a regular basis. Participants were also asked about mental health problems, diagnoses received (if any), and the length of time since diagnosis and any treatment received. The two brief alcohol and drug measures were also embedded in this section (see below). Participants were also asked, in this section, to rate the impact of SV on a range of areas of their lives using a 7-point scale (ranging from 'very positive' (+3) to 'very negative' (-3), as well as the overall negative and positive impact (if any) of SV on their lives.

Section E: Conclusions

Section E was the final section of the questionnaire to examine specifically the experience of SV. Here, respondents were asked: (1) to describe the services or assistance they would have liked to have availed of immediately after, or in the weeks and months that followed, their experience of SV; and (2) to briefly state what kinds of

things (if any) had prevented them from accessing the help that they felt they needed after their experience.

Section F: About you

The final section of the BESQ gathered brief sociodemographic information on respondents. It was deliberately placed at the end of the questionnaire in order to maximise the potential for completion by participants. In view of the sensitivities surrounding this research and the need for anonymity and confidentiality, it was important that a close rapport, within the interview situation, had been established before the women were asked to volunteer personal information. Similarly, in the context of postal completion, these questions were considered to be more appropriately placed at the end of the questionnaire. The items included: age; country of origin; number of children (where applicable); current marital status; current occupation; and educational attainment.

Rapid Alcohol Problems Screen – 4 (RAPS4) (Cherpitel, 2002)

Two brief screening measures of alcohol and drug use were subsumed within the BESQ in order to assess the extent to which these problems were present in the current sample. Both have been highlighted in the literature as potentially problematic in women who have been exposed to SV (Burnam et al., 1988; Coid et al., 2001; Messman-Moore, Brown, Ward, 2009). The *Rapid Alcohol Problems Screen-4 (RAPS4)* was originally developed as a brief screening measure for alcohol problems and was selected here for its brevity and ease of administration (bearing in mind the large number of measures used). Other similar measures, such as the AUDIT (Alcohol Use Disorders Identification Test (AUDIT); Saunders, J.B., Aasland, O.G., Babor, T.F., et al., 1993) were deemed to be unnecessarily detailed and lengthy for the objectives of this study.

The initial version of the RAPS4 (RAPS) was a five-item measure consisting of a set of questions derived from a number of other alcohol screening measures (e.g. the AUDIT); the rationale underpinning the selection of these five items is described elsewhere in Schafer & Cherpitel, (1995). The RAPS4 is a mnemonic derived from the four items of the measure as follows: (1) During the last year have you had a feeling of guilt or remorse after drinking? (**R**emorse); (2) During the last year, has a friend of family member ever told you about things you said or did while you were drinking that you

could not remember? (Amnesia, also called blackouts); (3) During the last year, have you failed to do what was normally expected from you because of drinking? (Perform); and (4) Do you sometimes take a drink when you first get up in the morning? (Starter) (Cherpitel, 2002).

Gate questions at the beginning the section pertaining to alcohol use, ascertain whether or not the respondent currently uses alcohol. Thus, a negative response precludes the respondent from completing the reminder of that section. The simplicity of the RAPS4 allows for straightforward scoring and interpretation. Respondents circle a 'Yes' or 'No' response to each of the questions (scored from 0-4) and a single positive response is interpreted as indicative of problem drinking in the previous 12 months.

The validity of this type of screening instrument is generally assessed by its ability to identify problem drinkers in clinical settings and, in particular, its sensitivity and specificity (Cherpitel, 1997). Sensitivity refers to the percentage of patients/participants 'with a condition (e.g. alcoholism) who are correctly identified by the instrument as having a condition' (Cherpitel, 1997:349). Specificity pertains to the percentage correctly identified 'without a condition when they do not have that condition' (Cherpitel, 1997:349). In practice settings, the importance of identifying all potential problem drinkers (even while falsely identifying non-problem drinkers) means that the sensitivity of an instrument is largely viewed as more important than its specificity (Cherpitel, 1997). In a general population sample (n=7612), Cherpitel (2002) found that the RAPS4 outperformed the CAGE (Ewing, 1984) for identifying alcohol dependence by displaying a higher sensitivity (0.86 versus 0.67) in spite of similar specificity (0.95 versus 0.98). Furthermore, the sensitivity of the CAGE was lower for females whereas the RAPS4 performed equally well for females and males (0.88 versus 0.85) (Cherpitel, 2002). Cross-national studies using data from 13 countries also found the RAPS4 to display good specificity and sensitivity (Cherpitel et al., 2005).

Rapid Drug Problems Screen (RDPS) (Cherpitel & Borges, 2004)

The *Rapid Drug Problems Screen (RDPS)* was included in this study in order to briefly screen for drug problems. The relationship between sexual assault and drug abuse or dependence is well-established in the literature (Resick, 2001). Therefore, it was considered important to include a measure that takes account of the possibility of this in the lives of participants. Once again, for reasons of brevity and participant fatigue, this

measure was chosen in preference to more detailed instruments in the field (e.g. Drug Abuse Screening Test (DAST); Skinner, 1982).

Derived from the RAPS4, the RDPS consists of the same four questions, but in the context of drug use (i.e. the words 'drink' and 'drinking' above are substituted with the words 'drugs' and 'drug use'). Similar gate questions (as those used for RAPS4) are included whilst the scoring is also identical; that is, respondents select a 'Yes' or 'No' response to each of the questions (scored from 0-4) and a single positive response indicates problem drug use in the previous 12 months.

There is very little available research on brief screening instruments for identifying individuals who meet diagnostic criteria for drug dependence or abuse (Cherpitel & Borges, 2004). The RDPS performed well when evaluated against the DSM-IV and ICD-10 criteria for drug dependence and for dependence or abuse and it correctly identified 91% and 96% respectively for dependence and 93% and 96% respectively for dependence or abuse (Cherpitel & Borges, 2004). While neither of the two female participants in the above study was identified by the RDPS, the authors refer to the data on the RAPS4 with respect to females (reported earlier) and recommend that further research with a larger number of females 'is needed to more accurately determine the performance of the RDPS among women' (Cherpitel & Borges, 2004:174). Nonetheless, it was included in the present study for the reasons stated earlier and was an appropriate companion measure to the RAPS4.

Both the RAPS and RDPS were further supplemented by questions within the BESQ pertaining to the frequency of alcohol and/or drug use, the amount of drinks consumed, on average, in one sitting (i.e. to assess binge drinking) and the types of drugs ordinarily used.

6.2.3.2 General Health Questionnaire (GHQ-12) (Goldberg, 1978)

The 12-item version of the *General Health Questionnaire (GHQ-12)* (Appendix 13) was used to assess minor psychiatric morbidity, or overall levels of psychological well being in the sample during the previous few weeks. This is a brief, widely used and psychometrically robust measure which can be completed in a few minutes and which assesses changes in an individual's ability to carry out normal daily functions and the emergence of any new psychological phenomena of a distressing nature (Goldberg &

Williams, 1991). The GHQ-12 can be completed in only a few minutes and its brevity was a key factor in its selection for inclusion.

Respondents use a four-point Likert scale to rate the extent to which they have experienced each of 12 particular symptoms or behaviours during the previous few weeks. The responses may be scored in different ways, but for purposes of the present study, the GHQ scoring method was used. This method is used for case identification and is a simple and convenient bimodal response format (i.e. responses are scored either as 0 or 1 with a maximum score of 12). 'Caseness' may be defined as short-term psychiatric disturbance of a non-psychotic nature, which would benefit from formal mental health intervention (Goldberg & Williams, 1991). The identification of a 'case' is determined by the threshold or cut-off point. A number of threshold scores have been reported by the authors ranging from 1 to 4 (Goldberg & Williams, 1991). It was expected that the participants in this sample, in view of their traumatic history, would have a high likelihood of being identified as 'cases'; therefore, after a review of the literature, the threshold score was set at four. Consequently, women who obtained scores of four or more were identified as 'cases' and would possibly benefit from formal mental health intervention.

The psychometric properties of the *GHQ-12* are well established in a range of languages and populations (Goldberg & Williams, 1991). For example, six validity studies of the *GHQ-12* reported by Goldberg and Williams (1991), revealed sensitivity rates of between 71% and 91% and specificity rates of 71% to 93%. More recent validity studies found similarly high values with overall sensitivity and specificity of 83.4% and 76.3% respectively (Goldberg et al., 1997). In an early study, Banks et al., (1980) used the GHQ scoring method and found high internal consistency with Cronbach α values ranging from 0.82 to 0.90. The same authors also reported some construct validity data and found that the *GHQ-12* was sensitive to employment status, thereby providing some support for the negative psychological consequences of unemployment. Good content validity has also been reported, as demonstrated by the ability of each item to successfully identify participants who did/did not have levels of psychological distress (Banks et al., 1980). The assessment of test-retest reliability on this measure is difficult, given the highly variable nature of the construct being tested (Goldberg & Williams, 1991). Unsurprisingly therefore, studies that have attempted this have produced

divergent results (Dale, Sævareid, & Söderhamn, 2009; Goldberg & Williams, 1991; Piccinelli, Bisoffi, Bon & Cunico et al., 1993). The robust psychometric properties of this measure have also been confirmed in more recent studies with a sample of pregnant women (n=154) (Ip & Martin, 2006) and a sample of women suffering from post-natal depression (n=1453) (Navarro et al., 2007).

6.2.3.3 *The Life Experiences Survey – Modified version (LES-M) (Sarason et al, 1978)*

It was also considered necessary to include a measure that would take an account of life events or changes in the last six months and which may have had either a negative or positive impact on participants' lives. The *Life Experiences Survey – Modified version (LES-M)* (Appendix 14) is an abbreviated, 28-item, self-report measure developed from the original 57-item version (Sarason et al., 1978). According to the authors, a range of items was chosen from the longer version, partly on the basis of pre-existing life stress measures, to '*represent life changes frequently experienced by individuals in the general population*' (Sarason et al., 1978: 934). The abbreviated version of the LES lists 25 life events plus three blank spaces where participants can record any unlisted events that they may have experienced. It takes approximately 10 minutes to complete.

While it is generally understood that life changes can often be stressful, research suggests that the degree of any psychological distress is determined by the individual's perception of the life change; that is, if the person *perceives* the life change event to be negative, then s/he will report more psychological distress (Smith, Johnson & Sarason, 1978). Thus, it was considered important in the current study to include a measure to record life experiences/events in order to take account of, or control for, any potentially negative stressful events that participants had experienced during the previous six months; this was particularly important given that both QoL and psychological distress were also being measured (using the *WHOQOL-BREF* and *GHQ-12* respectively). The *LES-M* was chosen because it was brief yet comprehensive. In addition to providing information on the types of events that participants have experienced during the previous six months, it also allows them to subjectively rate the type (i.e. positive or negative) and level of impact of the event in their lives.

Respondents are asked to indicate whether they have experienced a particular event in the last six months and for each item that they endorse, they are also asked to rate the

extent to which the impact of the event was positive or negative *at the time of the occurrence*. Ratings are on a 7-point scale ranging from extremely positive (+3) to extremely negative (-3). There is also an option to record 'No impact' (0). A *positive change score* is derived by summing the impact ratings of those events marked as positive (scores ranging from 0 to 84). Likewise, summing the negative impact ratings from those events designated as negative, generates a *negative change score* (scores ranging from 0 to 84). High scores indicate high levels of both positive and negative life events in the recent past. Finally, a *total change score* (scores ranging from 0 to 168) is obtained by adding these two values. This value represents the total amount of rated change (desirable and undesirable) experienced by the participant during the last six months (Sarason et al., 1985a).

The negative change score (i.e. LES-N) has been shown to correlate significantly with mental health measures including anxiety, depression, and general psychological distress (Sarason, Sarason, Potter, & Antoni, 1985b) as well as with the occurrence of myocardial infarctions (Pancheri et al., 1980), illness severity (Michaels & Deffenbacher, 1980) and menstrual discomfort (Siegel, Johnson, & Sarason, 1979). Therefore, this was deemed to be the more important and relevant value to the population being studied here. Furthermore, the test developers suggest that if the focus of interest is the degree of 'life stress', then the negative change measure should be used (Sarason et al., 1978).

The *LES* has demonstrated moderate test-retest reliability in both the positive change score (.19 and .53; $p < .001$) and negative and total change scores (.56 and .88; $p < .001$; .63 and .64; $p < .001$ respectively), albeit with some variability (Sarason et al., 1978). However, the authors assert that test-retest reliability coefficients are likely to underestimate reliability in these types of measures due to the fact that respondents could actually experience a range of positive and negative events in the interval period that may impact on the responses recorded at the time of re-testing (Sarason et al., 1978). Correlations with other measures (i.e. demonstrating discriminant validity) have also been found, including some of the scales of the Psychological Screening Inventory (PSI: Lanyon, 1970, 1973) (Sarason et al., 1978). For example, significant negative correlations have been found between the negative change score of the *LES* and the Social Nonconformity (.26, $p < .05$) and the Discomfort scales (.25, $p < .05$) of the PSI,

suggesting a relationship between negative change (as assessed by the LES) and certain types of personal maladjustment (Sarason et al., 1978). A similar significant relationship has also been found between the negative change score of the LES and the Beck Depression Inventory (BDI: Beck et al., 1961) (.24, $p < .05$) in a small sample of college undergraduates ($n = 64$) (Rotter, 1966); this was later supported by findings reported by Vinkour and Selzer (1975) (Sarason et al., 1978).

6.2.3.4 *Trauma Symptom Inventory (TSI) (Briere, 1995)*

The *Trauma Symptom Inventory (TSI)* (Appendix 15) is a 100-item self-report measure of post-traumatic stress and other psychological sequelae of traumatic events (Briere, 1995). It takes approximately 20 minutes to complete and was the longest measure administered in this study, but also one of the most important, as it provides a detailed assessment of trauma symptoms and the sexual functioning of participants (Note: This measure was completed by the SV sample only). It was chosen in preference to other briefer PTSD measures, precisely because of its level of detail. For example, another 86-item version of the TSI which omits the two scales relating to '*Sexual Concerns*' (SC) and '*Dysfunctional Sexual Behaviour*' (DSB) was not used, as it was felt that the inclusion of these scales was important in achieving the main aim of this study, which is to illuminate the true impact of SV. Thus, the TSI provides a comprehensive and psychometrically sound measure of the widespread impact of trauma in an individual's life.

The TSI comprises 10 clinical subscales and 3 validity scales designed to assess acute and chronic trauma symptoms arising from a wide range of events including: natural disasters; physical assault; major accidents; combat; spousal abuse; and rape (Briere, 1995). For descriptive purposes, these 10 subscales may be subsumed under the following four broad categories:

1. Dysphoric mood (Anxious Arousal, Depression and Anger/Irritability)
2. Post-traumatic stress (Intrusive Experiences, Defensive Avoidance and Dissociation)
3. Sexual difficulties (Sexual Concerns and Dysfunctional Sexual Behaviour)
4. Self-dysfunction (Impaired Self-Reference and Tension Reduction Behaviour (and to some extent Dysfunctional Sexual Behaviour)).

Five of the clinical subscales measure symptoms closely related to those of PTSD as described in DSM-IV-TR. These include: *Anxious Arousal (AA)*; *Depression (D)*; *Anger/Irritability (AI)*; *Intrusive Experiences (IE)*; and *Defensive Avoidance (DA)* (McDevitt-Murphy et al., 2005). The *AA* is related to the hyperarousal dimension of the DSM-IV-TR diagnosis of PTSD. This subscale specifically measures symptoms of anxiety, such as jumpiness and tension, which are indicative of PTSD-associated hyperarousal. The *D* subscale measures the extent to which participants are experiencing a depressed mood and depressive thoughts. High scores on this scale indicate feelings of unhappiness and sadness on a relatively regular basis. The *AI* measures symptoms in terms of the frequency of angry feelings, thoughts and behaviour. This would include regular feelings of irritability, annoyance or bad temper, and over-reacting to minor difficulties or frustrations.

The *IE* subscale incorporates symptoms, such as nightmares, sudden sensory flashbacks of a traumatic event and upsetting memories that are often easily triggered by current events. Individuals may report experiencing high levels of these events and feeling out of control and in some cases thinking that they are psychotic. They may also report repetitive and unwanted, unpleasant thoughts of their previous experience(s) that can occur unexpectedly, which can leave them feeling very distressed and shaken. The *DA* subscale is also linked with one of the hallmark signs of PTSD, and describes the degree of cognitive and behavioural avoidance (as opposed to other psychological defences, such as dissociation or repression) in which an individual may engage. Avoidant behaviours and thoughts, as defined by the *DA* scale, refer to attempts by the participant to eliminate painful thoughts or memories from conscious awareness and/or avoiding environments and stimuli that remind them of the traumatic event/memory.

The remaining five clinical scales assess a wide range of intra- and interpersonal difficulties frequently present in trauma survivors including: *Dissociation (DIS)*; *Sexual Concerns (SC)*; *Dysfunctional Sexual Behaviour (DSB)*; *Impaired Self-Reference (ISR)*; and *Tension-Reduction Behaviour (TRB)* (McDevitt-Murphy, Weathers, & Adkins, 2005). The *DIS* subscale measures a range of common types of behaviour in which an individual engages (albeit at the unconscious level) including emotional numbing, cognitive disengagement, depersonalisation and out-of-body experiences. High responders on the *SC* subscale would invariably report conflict in their sexual

relationships, sexual dysfunction, and general sexual dissatisfaction (e.g. an inability to enjoy sex). The nature of the items on the DSB subscale may be a source of concern in that high scorers are often engaging in sexual behaviour that is, in some way, dysfunctional or problematic. This problematic sexual behaviour may take the form of indiscriminate sexual contact with potentially dangerous or dysfunctional individuals, or practising unsafe sex.

The ISR subscale assesses the frequency of a range of difficulties typical of someone with a damaged or impaired sense of self and personal identity. Typically high scorers in this group report experiencing problems in discriminating their needs and issues from those of others and confusion with their own identity and goals in life during the previous six-month period. Impairment in an individual's ability to self-reference may manifest in less self-understanding and self-confidence than others, they may also be more easily influenced by others, and when in groups, may function less well under stress when compared to their counterparts. The TRB subscale measures the frequency with which an individual turns to external methods of reducing internal tension or distress. This may include behaviours, such as starting arguments with people to vent their anger, or engaging in sexual relationships to feel powerful, or to keep from being alone.

The three 'validity scales' (Response Level (RL), Inconsistent Response (INC) and Atypical Response (ATR)) facilitate the identification of participants who tend to deny or exaggerate symptoms, or who respond in an inconsistent or unusual manner (Briere, 1995). A further 12 'Critical Items' (e.g. self-mutilatory behaviour, substance abuse, and psychotic symptoms) are also incorporated into the TSI which, if endorsed, alert the clinician to a range of problems that may warrant follow-up evaluation or intervention (Briere, 1995). As the TSI is often used in clinical settings, endorsement of these items can inform treatment and intervention programmes for clients with pressing psychological issues (Briere, 1995). However, with respect to its use with a non-clinical sample, as in the present study, it was considered appropriate to follow-up and debrief each participant and refer them on, where necessary, to relevant support agencies.

The TSI can be administered and scored by individuals/researchers who have carefully studied the procedures detailed in the manual (Briere, 1995). Participants choose from a

four-point scale, based on the frequency of occurrence of each symptom item over the last six months (i.e. 0 = *Never; it has not happened at all in the last 6 months*; 1 or 2 = *it has happened in the last 6 months but not often*; 3 = *Often; it has happened often in the last 6 months*) and responses are recorded on a separate answer sheet. The answer sheet is backed by a Scoring Sheet in order to facilitate ease of scoring. Total raw scores are generated for each of the 10 clinical subscales by summing the items for each scale. The two exceptions to this scoring procedure are the RL and INC scales. The number of RL endorsed with a zero (or left blank) are summed to generate a total RL score whereas the INC total score is calculated by subtracting the ten-paired INC items from each other and summing the absolute values (see Briere, 1995) for a full explanation of these scoring procedures). Raw scores can also be used to determine *T* scores, thereby facilitating a comparison of respondents' level of symptomatology with normative scores from the general population. Those 'Critical items' that have been endorsed, are recorded separately on the back of the answer sheet. If an answer sheet is missing 10 or more values, it is deemed to be invalid.

The TSI Professional Manual (Briere, 1995) provides detailed information on the interpretation of the individual scores of the subscales and on relevant normative samples. The main normative group (n=291) chosen for comparison with the findings from this study, was from a stratified random sample from the general population (N=836) that had been used in two separate studies (N=836) (Elliot, 1993; Elliott & Briere, 1994). This sub-sample was considered the most appropriate because they were all female and aged 18 to 54 years (i.e. similar to the current sample). For the purposes of fully contextualising the findings, some comparisons were also made with a clinical normative sample of females (n=261) who had been psychiatric inpatients and outpatients and who had a known trauma history (Briere, Elliott, Harris & Cotman, 1995).

While interpretive guidelines are presented for each sub-scale, the authors recommend examining the relationships between the subscales when interpreting scores. For instance, high scores on the three validity subscales (RL, INC, ATR) alert the researcher to inconsistency in responding, unusual or atypical responding and honesty in responding (e.g. reluctant test-takers). ATR *T* scores of 90 or more should be considered invalid as should *T* scores of 73 or higher for the RL subscale and 75 or higher for INC.

Higher raw scores and higher *T* scores on the 10 clinical scales of the TSI, indicate greater degrees of symptomatology whilst *T* scores of 65 or above are considered to be clinically significant (Briere, 1995).

The subscales of the TSI have demonstrated sound internal consistency in a range of samples. For example, Cronbach α values ranged from 0.75 to 0.90 with a mean of 0.86 (Briere, 1995) in four studies (i.e. a standardisation sample (n=828), a university sample (n=279), a clinical sample (n=371) and a Navy recruit sample (n =3659)), Significant correlations between TSI scales were also found (N=836) ranging from 0.43 between the AA and the DSB subscales to 0.83 between the IE and the DA subscales (Briere, 1995). Reasonable convergent, predictive and incremental validity have also been reported (Briere, 1995). For example, TSI scales predicted PTSD (as determined by other measures) in over 90% of cases in a standardisation sub-sample (n=49) whilst in a clinical sample of psychiatric inpatients, 89% of those independently diagnosed with Borderline Personality Disorder were also identified by the TSI (Briere et al., 1996). Further more recent research has found good convergent validity of the TSI in a sample of trauma-exposed community residents when compared with a range of other self-report PTSD measures (McDevitt-Murphy et al., 2005).

6.2.3.5 World Health Organisation Quality of Life – Brief version (*WHOQOL-BREF*) (The WHOQoL Group, 2004)

The *WHOQOL-BREF* (Appendix 16) was chosen to assess the subjective well-being or Quality of Life (QoL) of participants and has been used with a range of populations and age groups (e.g. O' Carroll, Smith, Couston, Cossar & Hayes, 2000; Taylor, Myers, Simpson, McPherson & Weatherall, 2004; von Steinbüchel, Lischetzke, Gurny, & Eid, 2006). This brief, self-report measure, which was developed and widely tested by the World Health Organisation (WHO), is an abbreviated version of the *WHOQOL-100* quality of life assessment (The WHOQOL Group, 1998a). It incorporates an assessment of several areas of a participant's life, such as the quality of their personal relationships, their psychological well-being and their physical environment. Therefore, it provides an assessment that goes beyond merely the absence of ill-health (i.e. as in a typical health-related QoL measure, such as the SF-36), or the presence of economic or material stability. Hence, a more complete picture of QoL is provided that is rooted in the person's own values and experience of their life (Hawthorne, Herrman, & Murphy,

2006). Since its development, the *WHOQOL-BREF* has proven to be an excellent cross-culturally valid assessment of QoL, and its brevity (approximately 10 minutes to complete) and ease of administration made it highly suitable for inclusion in the present study (Skevington, Lofty, & O'Connell, 2004).

The *WHOQOL-BREF* comprises 26-items designed to assess four QoL domains including: *Physical health/capacity* (7 items); *Psychological* (6 items); *Social relationships* (3 items); and *Environment* (8 items) (WHOQOL Group, 2004). Several important aspects of QoL are assessed within these domains including, for example: dependence on medicinal substances and medical aids; energy and fatigue; mobility (all within the *Physical domain*); bodily image and appearance; self-esteem; memory/concentration (*Psychological domain*); personal relationships; social support; sexual activity (*Social relationships domain*); financial resources; home environment; and physical environment (pollution/noise/traffic/climate) (*Environment domain*). An additional two global items, allow participants to indicate their overall rating of their QoL and their general satisfaction with their health.

Participants indicate their responses on a five-point Likert scale such that scores on each of the four domains denote an individual's perceived QoL. Domain scores (ranging from 3 to 40) are scaled in a positive direction with higher scores denoting better QoL. Raw domain scores are generated by adding the items within each scale and then calculating the mean. Mean scores are multiplied by four in order to make them comparable with the scores used in the *WHOQOL-100* (WHOQOL, 1998). The two global items included in the *WHOQOL-BREF* are examined separately. Here, higher scores also indicate better QoL. More recently, preliminary population norms and effect sizes have been published, which help in the overall interpretation of scores (Hawthorne et al., 2006).

The robust psychometric properties of the *WHOQOL-BREF* have been cross-culturally supported throughout the literature with a wide range of populations, medical illnesses and psychological disorders (Barros da Silva Lima, Fleck, Pechansky, de Boni & Sukop, 2005; Hanestad, Rustoen, Knudsen, Lerdal & Wahl, 2004; Hawthorne et al., 2006; Howgego et al., 2005; Hsiung et al., 2004; Skevington et al., 2004; Taylor et al., 2004). More recently, von Steinbüchel et al. (2006) found that the *WHOQOL-BREF* demonstrated high test-retest reliability in their samples (N=71 and N=262

respectively). In another very large study, Skevington et al (2004) (N=11,830) reported acceptable Cronbach's α values (>0.7) for three of the domains (i.e. Physical health domain 0.82; Psychological domain 0.81; and Environment domain 0.80). While the value for the Social relationships domain was marginal (0.68), the authors note that Cronbach's alpha is sensitive to the number of scale items and therefore lower values were not entirely unexpected on this scale due to its small number of items (i.e. three versus six to eight on the others) (Skevington et al., 2004). O' Carroll et al. (2000) recommend using the lengthier WHOQOL-100 if researchers are particularly interested in the social dimension of QoL. However, this was not considered necessary in the context of the current study because an additional comprehensive measure of interpersonal support was included (see on).

The validity of the *WHOQOL-BREF* has also been widely reported in the literature. Discriminant validity was demonstrated in a recent study by Chachamovich, Trentini, and Fleck (2007) with all domain scores showing significant differences when compared across groups. Concurrent validity was also established using the *Beck Depression Inventory (BDI)* and the *Beck Hopelessness Scale (BHS)*, with statistically significant correlation coefficients ranging from -0.406 (BHS score versus Physical domain) to -0.612 (BDI score versus Psychological domain) (Chachamovich et al., 2007). The above study by von Steinbüchel et al. (2006) reported similarly strong levels of validity whilst the developers of the WHOQOL-BREF reported good discriminant and content validity (The WHOQOL Group, 1998b).

6.2.3.6 *Interpersonal Support Evaluation List (ISEL)* (Cohen & Wills, 1985)

The quality of the social support experienced by participants in the current study was considered an important dimension, particularly given the well-documented negative impact of SV on social functioning, and social support (e.g. Olley, 2003; Schumm et al., 2006). The *Interpersonal Support Evaluation List (ISEL)* (Appendix 17) is a 40-item measure designed to assess the perceived availability of potential social resources in four separate functions of social support (Cohen & Wills, 1985). The appeal of this measure lay in its brevity, its relative ease of administration and its reasonably strong psychometric status. It takes approximately 10 minutes to complete and has been previously used with a sample that was quite similar to that used in the current study

(i.e. to facilitate the development of effective interventions with women experiencing abuse) (n=40) (Crane and Constantino, 2003).

Four 10-item scales assess the perceived availability of: material aid ('Tangible' items); someone to talk to about one's problems ('Appraisal' items); a positive comparison when comparing oneself to others ('Self esteem' items); and the perceived availability of people with whom to do things ('Belonging' items) (Cohen et al., 1985). The 40 statements in this measure are counterbalanced for desirability and negativity. Thus, half of the items are positive statements about social relationships (e.g. *Most people I know think highly of me*) while the other half are negative (e.g. *I don't often get invited to do things with others*). Participants select one of the following four possible Likert scale responses: (0) *Definitely false*; (1) *Probably false*; (2) *Probably true*; (3) *Definitely true* – indicating whether a statement is true or false about them. This scoring method (also developed by the authors of the measure) is slightly different to that developed for their original version of the measure (which gave participants a choice of True or False to statements) and it is, therefore, considered to be a more sensitive instrument as a result (Turner-Cobb et al., 2000). The 10 items in each scale are summed to generate total subscale scores and high scores (ranging from 0 to 30) indicate high levels of perceived availability of social resources. A 'total ISEL' score is then derived by summing the four subscale scores (ranging from 0 to 120).

The reliability and validity of the *ISEL* have been reasonably well supported in the literature. Adequate internal consistency of the subscales has been recorded in a number of studies. For example, Cronbach α scores for the total *ISEL* range from 0.88 (Cohen & Wills, 1985) to 0.90 (Cohen, Kamarack, & Mermelstein, 1983; Mermelstein, Lichenstein, & McIntyre, 1983) (Cohen et al., 1985). For the same studies, the following alpha values were reported for each of the individual subscales of the *ISEL*: *Appraisal* 0.70 - 0.82; *Self-esteem* 0.62 - 0.73; *Belonging* 0.73 - 0.78; and *Tangible* 0.73 - 0.81 (Cohen et al., 1985). Mermelstein et al. (1983) also reported coefficients for test-retest reliability of 0.74 for the 'Total *ISEL*'; 0.49 for the *Tangible* subscale; 0.54 for the *Self-esteem* subscale; 0.68 for the *Belonging* subscale; and 0.60 for the *Appraisal* subscale (Cohen et al., 1985). Similar to the *LES-M*, these data suggest that social support changes over time and is not always stable (Cohen et al., 1985). More recent

data have demonstrated reliability coefficients ranging from 0.62 to 0.85 for the scales of the *ISEL* (over a one-week interval) (Bates & Toro, 1999).

Cohen et al. (1985) report a range of studies that have found significant negative correlations (ranging from small (-0.14) to large (-0.51)) between the *ISEL* and other instruments used to measure psychological symptomatology, such as the *Centre for Epidemiological Study of Depression Scale* (CES-D) and the Beck Depression Inventory (BDI). Therefore, increases in *ISEL* scores tend to be associated with decreases in symptomatology. Significant moderate correlations (0.30) have also been found between the *ISEL* and the *Moos Family Environment Scales* (FES: Moos & Moos, 1981) – a well known/ social support measure – and the *Partner Adjustment Scale* (0.31) (Mermelstein et al., 1983), a measure assessing the quality of marital or living partner relationships (Cohen et al., 1985). More recently, Rogers, Anthony and Lyass (2004) also found good reliability and validity for the *ISEL* when used with a population of individuals with severe mental illness (n=147).

6.2.4 Procedure

6.2.4.1 Recruitment phase

As outlined earlier – and due to the ‘hidden’ nature of the target population - a number of recruitment materials were designed in order to effectively and sensitively promote/advertise the study. This was crucial in attempting to maximise the response rate. The promotion of the study was also facilitated by including the study information on a website called Activelink (www.activelink.ie) which issues a weekly bulletin to all its members. This website (and bulletin) provides information and opportunities for volunteering in Ireland as well as information on upcoming events, training and workshops in the voluntary and non-governmental sector. This resource proved to be a very valuable source of participants and was used on an ongoing basis throughout the entire process of data collection.

A number of relevant organisations (e.g. the Women’s Health Council (WHC); the Irish Nurses Organisation (INO; all Community Health nurses) also became aware of the study as a result of the above and subsequently contacted the researcher to seek more information. An additional one-page information/study outline sheet was devised

following feedback from these agencies. Following advice from the Stage One stakeholders – and in order to maximise awareness of the study - this information sheet was also distributed through the National Network of Women’s Refuges and Support Services (NNWRSS; 38 member organisations nationwide), and the National Women’s Council of Ireland (NWCII; 165 member organisations nationally). It was hoped that, as a result, those working in the area of service provision would encourage women whom they knew to take part. The Rape Crisis Network of Ireland (RCNI) also included study information in two issues of their internal monthly newsletter (approximately one year apart).

6.2.4.2 Participant contact and data collection

a. Face-to-face participation

Potential participants made contact with the researcher in a range of ways. The least popular way was a direct phone call initiated by them. Generally, initial contact was made by means of email or text message. Frequently, multiple contacts were made in this manner before the researcher actually spoke to a woman on the phone. The management of this process before, during and after participation was perhaps the most time consuming and labour intensive element of this stage. As described earlier in Chapter Four, the pace of this process was largely dictated by the participants. For some women they were ready to meet immediately, while others required more time and more contact before agreeing to meet. Generally this contact comprised a mix of emails, phone calls and text messages, after which an arrangement was made to, meet and complete the questionnaires with xx women.

In virtually all cases, the researcher travelled to the participants’ hometown, or locality, and administered the questionnaires either in their house, or at another suitable location nearby (e.g. quiet pub/restaurant). The researcher initially attempted to put participants at their ease by making light conversation and asking them about their feelings leading up to this moment. They were then given an Information Sheet (A) (Appendix 18) and asked to read it, after which any questions they may have had, were addressed. Once they were happy to proceed, they were then asked to provide their written informed consent (see Appendix 19). The questionnaires were then introduced in a specific order, moving from general to more specific and potentially more sensitive questions. The WHOQOL, GHQ-12 and LES were presented first (and were stapled together). A brief

description and instruction sheet preceded each questionnaire. The researcher briefly explained what to expect with the first set of three questionnaires and after checking once again that the participant was happy to proceed, questionnaire completion began. The researcher remained silent throughout data collection unless the participant had a specific question or required clarification. Responses to questions were kept succinct in order not to influence any responses or interrupt the process. The researcher 'checked in' with the participants regularly and upon completion of each questionnaire. Before being presented with the next questionnaire, the ISEL, the researcher inquired about the participants' feelings on the questionnaires just completed in order to monitor for any distress. After the ISEL, participants completed the TSI followed by the BESQ. All participants completed the questionnaires in this order. This allowed the researcher an opportunity to monitor for any distress and therefore, omit certain questionnaires or terminate data collection, if necessary. However, at no point was this ever required.

Following completion of the questionnaires, participants were thanked and debriefed. Discussions often arose at this stage (and on occasion between questionnaires) about some of the issues raised by the questions, such as their recent health, and their current behaviours/reactions compared to those immediately after the assault. Again, the pace and nature of this exchange was generally dictated by the participant. All participants also completed the Follow-up Interview card (Appendix 20). They were reassured that this and the Consent Form, would be stored separately from their completed questionnaires. They were also informed that only a selection of interviews would be carried out in Stage 3 so they may, or may not be contacted in the future. The closing conversation included asking about any plans for the rest of the day or the weekend etc.

A follow-up phone call (or text message or email where preferred) was arranged before leaving and usually this was delivered two days after participation. This provided participants with an opportunity to reflect on their participation before talking with the researcher again. Participants were contacted as arranged, thanked again for their help and co-operation, and asked how they had felt about taking part in the research. Generally, these conversations were quite brief and the majority did not report any negative effects in the interim. For those who did report some distress, they emphasised that this was mild in nature and not entirely unanticipated and all were quick to reassure the researcher that they were still glad to have taken part in the study.

b. Postal participation

After speaking with a number of prospective participants, it became clear that some of them preferred *not* to meet with a researcher, although they requested that they be allowed to complete the questionnaires by post. Consequently, after completing a number of face-to-face interviews, during which the researcher was certain that participants were not experiencing any undue upset or emotional distress, a postal protocol was developed. For the remainder of data collection, participants were informed of this option, after which they made their own decision as to which they preferred.

The protocol document included a detailed checklist of all questionnaires and other questionnaires/documents enclosed, general instructions and step-by-step guidelines for each participant (see Appendix 21). Following the face-to face interviews, it was considered necessary to include specific instructions for some of the questionnaires including the *LES*, the *TSI*, and the *BESQ*. Participants were reassured of confidentiality and anonymity and once again provided with the phone number for the national rape crisis 24-hour helpline. Instructions on returning the completed questionnaires to the researcher were also included as was a stamped addressed envelope for this purpose.

For those women who expressed the desire to participate by post (n=50), contact by phone was secured prior to forwarding any material. Alternatively, where this was not possible, or where the participant was reluctant to speak on the phone, contact was made via email. This contact was important in order to ascertain the support needs and resources of each participant before sending them any material. These issues were discussed with all prospective participants and postal addresses obtained. Participants were invited to complete and return the questionnaires within two weeks. Anyone who took longer were re-contacted and gently reminded and asked if they were experiencing any difficulty completing them. Return of the completed questionnaires was deemed to imply consent. Nine of the 50 sets of questionnaires that were posted to participants were not returned (80% response rate). Non-responders were followed up at least once considering the contact was initiated by them, but due to the sensitive and personal nature of the research, the researcher did not wish to be intrusive by making repeated contacts. Unfortunately, due to the nature of this interaction (i.e. participant guided), limited, or no information on the non-responders was collected. Once the questionnaires

were received by the researcher, a follow-up contact (text/phone call/email) was initiated to 'check in' again with the participant and debrief them. Participants were then thanked for participating and any emerging issues (e.g. questions or comments about the items in the questionnaires, what the study findings will be used for, their reasons for taking part) were briefly discussed. Further details on the ethical aspects of this part of the study are provided later in section 6.5.

6.3 The Comparison Group (COM group)

6.3.1 Participants and settings

6.3.1.1 Sampling and recruitment

A number of sampling techniques were used to recruit a comparison group of women who had never had an experience of SV, although most of this group were recruited using snowball sampling. While official figures suggest that one in five women in Ireland have experienced sexual violence (McGee et al., 2002), these figures are based only on the women who come forward to report the assault. Therefore, there is the possibility that *more* than one in five women have had an experience of SV. For this reason, snowball sampling was considered to be the most appropriate, sensitive and efficient technique to use in the context of this study. Acquaintances and friends of the researcher were asked to take part in the research and also to identify friends and other women whom they thought might be interested in participating.

It was necessary to ensure that women, who were being invited to take part, by their friends/family, could respond in a protected and confidential manner. Thus, each set of questionnaires was supplied to the potential participants along with a SAE in which they could be returned directly to the researcher. A total of 80 questionnaires were distributed, 59 (74%) of which were completed in full and returned. Of those, two were deemed unusable due to the participants indicating that they had had an experience of SV either as a child or as an adult; therefore, the final sample number for this group was 57.

6.3.1.2 Frequency-distribution matching sampling

In order to obtain an approximate equivalence between the two groups, a number of key variables were controlled for using a technique known as frequency distribution control. The three most important control variables were considered to include 'age', 'marital

status' and 'level of education'; these were used as a basis on which to select the most appropriate comparison group. These variables are known to influence the severity, frequency and/or longevity of post-traumatic symptoms in the aftermath of a traumatic incident (e.g. Iverson et al., 2008; Kessler et al., 2005; Ozer et al., 2003). For example, the *Age* variable in the SV sample was divided into 10-year bands and COM participants were then recruited accordingly (e.g. the SV sample included 22 women aged 30-39 years compared to 20 in the COM group). In the same way, participants were 'frequency distribution matched' to the main sample as closely as possible on both marital status and level of education (e.g. 17 women in the SV sample had a university degree compared with 18 women in the COM group). Further details are provided in Appendix 22.

6.3.2 Measures and materials

The COM group women (n=57) completed similar measures to the SV group, although the *BESQ* was slightly modified and abbreviated to become a *Health and Background Questionnaire (HBQ)* (see below). All of the other measures described earlier were also administered, with the exception of the TSI. This measure was not considered appropriate for completion by respondents with no history of SV. Adapted (and re-named) versions of the Information Sheet (B), Consent Form (B) and Postal Instructions (B) used previously with the SV sample, were also administered here (see Appendix 23).

6.3.2.1. Health and Background Questionnaire (HBQ)

At the beginning of the HBQ, was a brief information paragraph followed by two questions inquiring whether or not the prospective participant had ever experienced (i) sexual violence and (ii) sexual abuse either as a child or as an adult. Participants were requested not to complete any further sections/questionnaires if they had responded 'Yes' to either question. Additionally, women who responded affirmatively were invited to participate in the main part of the study and researcher contact information was provided. While two indicated, on returned questionnaires that they had had a previous experience of SV, neither offered to participate in the study. The remainder of the *HBQ* contained identical sections as in the *BESQ*.

6.4 Procedure

All participants were provided with an SAE allowing them to return the completed questionnaires directly to the researcher. After reading the Postal Instructions sheet B, participants were then asked to read the Information Sheet B (see below). Although a Consent Form B was prepared and provided with the questionnaires, return of the completed questionnaires was deemed to imply consent. The order of presentation of the questionnaires was identical for all participants. Thus, after completing the HBQ, participants went on to complete the LES, the WHOQOL-Bréf the GHQ-12, and the ISEL. Once completed, participants returned the set of questionnaires directly to the researcher (via the SAE) or via their friends/families in a sealed envelope. This ensured their anonymity and confidentiality. The questionnaires were then compiled in preparation for analysis (see below).

6.5 Ethical considerations

The Information Sheet used in this stage (with both the SV and COM groups), provided detailed information in an clear, easy-to-understand 'question and answer' format and attempted to address key ethical issues including: confidentiality and anonymity; the participant's right to withdraw from the study at any time (and withdraw their data at any time); secure storage of all data; and the right not to answer any question with which they might feel uncomfortable. SV participants were also advised, both verbally and in writing, that the content of the questionnaires included questions on topics such as violence, alcohol and drug use, and sexual function. Given the nature of the research, additional sections of the Information Sheet administered to the SV group, included material that related to the potential for the participant to become upset or distressed during, or after taking part in, the research; the national freephone helpline for victims of SV was included for this purpose. Participants were also reminded that their participation in the research did not constitute any form of counselling or therapeutic intervention.

Those women in the SV group who participated by post (n=41) received either a telephone or email contact with the researcher prior to receiving any material. As part of this process, participants were asked if they had access to support should they feel the need for it. They were reassured that they would have further contact with the researcher (with their permission) after they had completed the questionnaires when

they would have an opportunity to discuss the content and any other issues as required. Therefore, all postal participants were debriefed (again by phone or email) after participation and their feelings and thoughts about the process were then sought and discussed. This also provided the researcher with an opportunity to suggest that support be sought, where necessary, from the RCC (see below).

Those women who completed questionnaires on a face-to-face basis (n=29), SV sample only) met with the researcher mainly in their home, or another location of their choice (e.g. the lobby of a nearby hotel). While the researcher was careful to monitor the participant throughout this process some women (approximately 4-5) did become distressed (e.g. were tearful) at times (this usually occurred during conversation about the actual incident rather than as a result of completing the questionnaires). However, none, when asked, expressed a wish to withdraw from the study. As might be expected, some women managed to complete the questionnaires more quickly and effectively than others, but the pace and duration of each interview was tailored to individual need.

Where it was felt necessary, SV participants were referred onto their local RCC (by providing contact details), or were offered the free-phone national RCC help line for advice and support. However, it should be noted that many of these women had previously received support/counselling and were comfortable talking about their experience. Follow up phone calls were conducted two days after participation in order to give women some time to reflect on their participation. As with the 'postal' group participants, any pertinent issues relating to the research were briefly discussed and addressed at this juncture. Each stage of this interaction was designed to empower participants and ensure that they felt in control of their progression through each step of the research (i.e. from first contact, to meeting up, to completing each questionnaire and follow-up). In addition, the order of the questionnaires (as previously described) was strictly adhered to, with all participants moving from questions, which were considered to be relatively innocuous to perhaps those that might be considered potentially more sensitive. This allowed the researcher an opportunity to assess the situation before introducing the next questionnaire.

6.6 Data analysis SV sample and COM group

Separate SPSS files were set up for both the SV sample and the COM group with respect to each of the measures. All of the quantitative data, for both groups, were entered onto computer using *SPSS (Version 17.0)* and were carefully 'screened and cleaned' in preparation for a full descriptive and statistical analysis. Total scores were calculated where necessary and preliminary analyses undertaken to assess for, normality and outliers. A mix of parametric and non-parametric tests was used to explore the associations between the key variables and to assess (where possible) relevant subgroup differences. Additionally, a series of comparisons were made between the SV and COM groups on each of the measures included in the study, in order to test for any statistically significant differences. Data gathered from the open-ended questions included on the BESQ were collected separately and subjected to a standard thematic analysis. The results from these were incorporated into the results from Stage Three.

The results from Stage Two are presented in the following chapter.

Chapter Seven

Results II: Stage II

CHAPTER SEVEN

Results II: Stage Two

As indicated earlier, Stage Two involved a cross-sectional comparative study designed to assess the psychosocial impact of an experience of sexual violence (SV) on a sample of women. The questionnaire responses for the SV and comparison groups were entered onto computer and analysed using *SPSS (Version 17.0)*. All of the data sets were carefully inspected for errors before total scores were calculated. This ‘screening and cleaning’ also involved checking the number of valid and missing cases and basic descriptive statistics. Normality was assessed on all measures whilst outliers were also checked on all relevant scales and appropriate action taken where necessary. The need to remove extreme values, in some cases, accounts for the variation in sample numbers in the results reported below.

This chapter is in two sections. The larger section, Section A, presents all of the findings pertaining to the SV and COM groups. The descriptive data for the sexual violence (SV) sample (n=65) are presented first, together with some within-group analysis; this is followed by similar information for the frequency-matched comparison (COM) group (n=57). Means and total scores are also presented for the SV sample and, where appropriate, these are juxtaposed with similar results for the COM group. Finally, a number of inferential statistical tests were used to assess any differences between the two groups. Section B includes two descriptive case studies based on high and low TSI scorers in order to generate detailed illustrative and comparative profiles for two women who have been affected by SV.

SECTION A: FINDINGS ON THE SEXUAL VIOLENCE AND COMPARISON GROUPS

7.1 Descriptive Analysis: Sexual Violence (SV) sample

7.1.1 Demographic profile of participants

The women in the SV sample were all Caucasian females who were typically aged in their late thirties (M = 36.69, SD = 9.28; range 19-57yrs). While they were all currently living in Ireland, three had been born in the UK and had moved to Ireland as children.

Approximately half (49%; 32/65) had children, most of whom (75%; 24/32) had one to two children. Over half of the women (55%; 36/65) were either single (25/36) or separated/divorced (9/36) and a substantial proportion (60%; 39/65) was educated to university level (undergraduate 17/65; postgraduate 22/65) (see Table 7.1)

7.1.2 Mental health status

Over half of the sample (54%; 35/65) had been formally diagnosed with a mental health problem(s) at some stage in their lifetime. While more than half (54%; 19/35) had received their first (or only) diagnosis at least 7 years previously, participants had received a formal diagnosis, on average, approximately four years previously ($M=4.27$; $SD=7.26$). Eleven women in this sample had received multiple diagnoses over the years and approximately three quarters (74%, 25/34) had been diagnosed with some form of depression (e.g. 'mild'; 'clinical'; 'chronic'; 'severe'; 'manic'; 'bipolar'; 'postnatal'). A further 10 women reported a diagnosis of anxiety whilst the other less commonly reported mental health problems included: PTSD (18%, 6/34); anorexia (1/34); borderline personality disorder (1/34); drug addiction (1/34) and work-related stress (1/34).

Many of the women had pursued multiple treatment options in order to address their mental health issues, but only two women had not taken anti-depressants, or other forms of prescribed mental health medication. Forty-three per cent (15/34) indicated that they had attended for counselling or psychotherapy whilst complementary therapies or other sources of support were also used by a smaller proportion (21%, 7/34) of participants. These included: electro-convulsive therapy (ECT); art therapy; occupational therapy; Alcoholics Anonymous (AA); residential drug rehabilitation; reflexology; Reiki (ancient Japanese stress reduction technique); massage; meditation; and yoga.

7.1.3 Alcohol and drug use

Almost all of the women in this sample (88%; 56/64) indicated that they consumed alcohol, the largest proportion of which (59%; 33/56) reported that they did so every few days ($n=19$), or on a weekly basis ($n=14$). Only two indicated that they consumed alcohol on a daily basis, whilst equal numbers said that they drank alcohol either fortnightly, monthly or only on special occasions ($n = 7$). On average, women reported consuming just over four alcoholic drinks ($M = 4.22$, $SD = 4.02$) per sitting.

Table 7.1 Demographic characteristics of the SV sample (n=65)

Variable	SV sample n (%)
<i>Number of children</i>	
<i>None</i>	33 (51)
<i>One to two children</i>	24 (75)
<i>Three to five children</i>	8 (25)
<i>Current marital status</i>	
<i>Single</i>	25 (39)
<i>Steady relationship</i>	10 (15)
<i>Living w/partner</i>	10 (15)
<i>Married</i>	8 (12)
<i>Separated/Divorced</i>	9 (13)
<i>Other</i>	3 (6)
<i>Education level</i>	
<i>Junior Certificate</i>	1 (2)
<i>Leaving Certificate</i>	8 (12)
<i>Post Leaving Cert/RTC</i>	11 (17)
<i>University degree</i>	17 (26)
<i>Post-graduate qualification</i>	22 (34)
<i>Other</i>	6 (9)

Note. SV = Sexual violence; RTC = Regional Technical College.

One in five of (13/65) the participants reported that they were currently using non-prescription drugs. However, a further 37% (24/65) indicated that they had used drugs at some stage in the past. The most popular drug of choice for those currently using drugs, was marijuana (i.e. hash, weed, cannabis, grass) (62%; 8/13) whilst others

mentioned over-the-counter medications such as *Neurofen Plus*, or *Solpadeine* (4/13) and ecstasy (1/13). The largest proportion reported using these drugs on a daily basis (39%; 5/13) while the others ranged from every few days (1/13) to sporadic use for weeks at a time (2/13). Four women used their drug of choice on a weekly (2/13), fortnightly (1/13) or monthly basis (1/13).

7.1.4 Sexual and reproductive health

The SEBQ also elicited information on the use of sexual and reproductive health services. More than two thirds of participants (68%, 44/65) indicated that they attended for regular cervical smear screening whilst one in five (13/65) reported receiving routine check-ups for sexually-transmitted infections (STIs). Furthermore, in the time since their experience of SV, many of the women had availed of a range of other services with respect to their sexual health. For example, 13% (8/62) had attended psycho-sexual counselling whilst approximately 27% had either attended a fertility clinic (8%, 5/62) or an Early Pregnancy Unit (EPU)²⁶ (19%) 12/62). Approximately one quarter (26%; 17/65) had also attended a colposcopy clinic (i.e. clinics to which women with abnormal cervical smear results are referred).

7.1.5 Experience of sexual violence

The women in this sample were also asked to provide details of their most recent experience of SV (i.e. since the age of 16), their relationship to the perpetrator and any injuries they may have received as a result of the assault. Here, a substantial proportion of respondents recorded multiple responses (i.e. to questions A3, A4 and A5 of the *BESQ*). This included women who had experienced multiple incidents in the one assault and/or were raped/sexually assaulted by multiple perpetrators. For example, when asked to tick which of the options (provided in question A3 of the *BESQ*), best described what had happened to them, more than four in ten women (42%; 27/65) indicated that they had experienced more than one. Multiple responses such as these were managed in the following way. The first response recorded by a woman was included in the figures for the main sample (i.e. if a woman reported both 'minor' and 'severe injuries' to question A5, she was included in the main sample figures by her first response (i.e. only minor injuries). Further analysis involving the women who recorded multiple responses to

²⁶ For the detection of any problems early on in a pregnancy, often after a previous miscarriage.

these questions was conducted separately and these findings are presented later, immediately after those for the entire sample.

As mentioned earlier, respondents were asked to indicate their experience of SV only since the age of 16. At the time of their most recent experience of SV, participants were aged, on average, 23 years ($M = 22.94$, $SD = 7.71$), although one woman was aged 44 years. The great majority (81%; 51/63) had experienced SV before the age of 30; that is, during the years when they would likely to be at their most vital and dynamic in terms of their education and/or career, their reproduction and physical and mental health. An average of 12 years and nine months had passed since the participants had experienced SV. Six of the women (9%) had been raped or sexually assaulted in the 12 months prior to the study. Approximately one third of the sample (34%; 22/64) had been assaulted at least 17 years previously and one 53-year-old woman had been raped/assaulted 38 years prior to the study.

It was clear from talking to the service providers in Stage One (and also from reviewing the literature), that women may differ in their understanding of the term 'sexual violence'. Consequently, participants were asked to provide information about their experience of sexual violence *and* their experience of sexual abuse (where applicable) before the age of 16. It was hoped that both of these terms (i.e. sexual violence and sexual abuse) would encompass the wide range of experiences women may have had before the age of 16, thereby providing an accurate reflection of any history of SV prior to that age. For purposes of interpretation, and when questioned by participants who requested further clarification on this point, the researcher explained that SV before the age of 16 should be interpreted as a single 'one-off' incident whereas sexual abuse before the age of 16, may signify multiple incidents over a period of time by one or more perpetrators. The results in this respect showed that one third of the women in this sample (21/64) had experienced an incident of SV before the age of 16 whilst a similar proportion (37%; 24/65) reported experiencing sexual abuse while still underage.

7.1.5.1 Type of incident

When asked to describe the nature of their most recent incident of SV (i.e. from the five options provided), eight out of ten participants (51/64) reported that they had been forced to have vaginal sex against their will (i.e. rape). Smaller numbers experienced

other incidents such as, being forced to have oral sex (3/64) or anal sex (4/64) without giving their consent, or having someone put their fingers (5/64) or an object (1/64) in their vagina without their consent. As indicated earlier, almost half of the women (42%; 27/64) endorsed more than one incident in relation their most recent experience of SV. Closer inspection of this sub-group (n=27) showed that 60% had experienced between two and three incidents of SV; for example, Participant 42 was forced to have vaginal and oral sex against her will; the remainder (11/27) had experienced either four, or all five of the incidents described during the assault. Figure 7.1 illustrates the number and range of experiences of SV reported by this sub-sample.

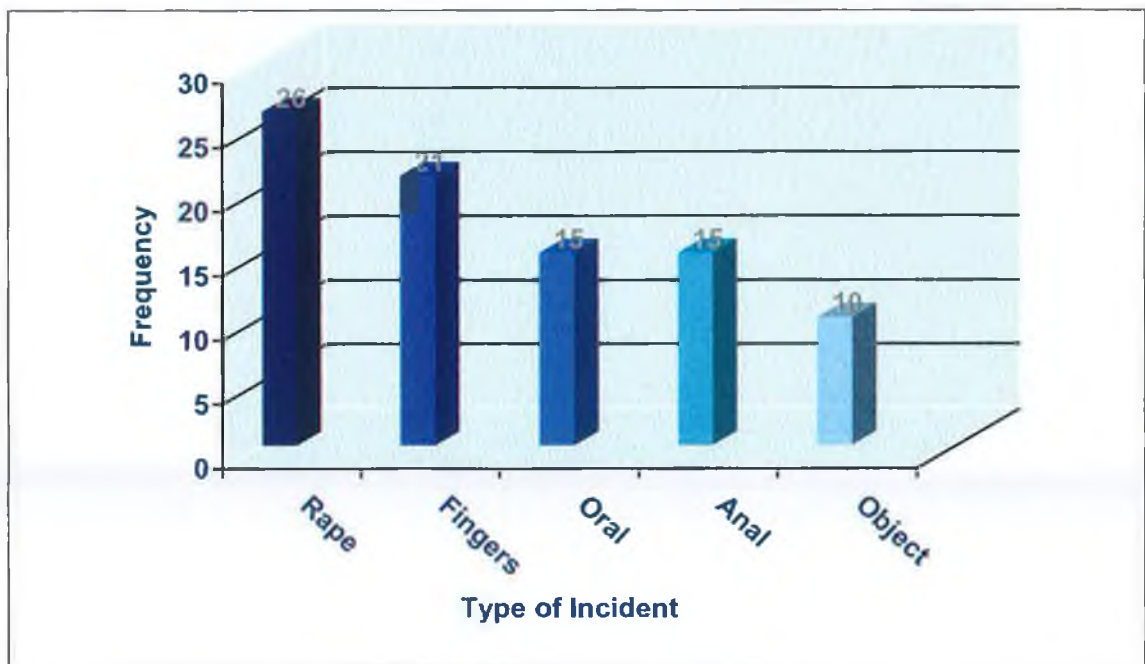


Figure 7.1: Bar chart illustrating the type and frequency of multiple incidents of sexual violence experienced by a sub-sample of women (n = 27).

7.1.5.2 Relationship to the perpetrator

It is clear from the first three of the five options provided on the BESQ that the perpetrators were all male, although the last two options/incidents - involving penetration of the vagina with fingers or an object - are gender neutral. Nonetheless, it would be reasonable to assume that *all* of the perpetrators in this study were male in view of: (a) figures from the World Health Organisation (WHO, 2002) to indicate that the majority of perpetrators of SV against women are male; and (b) that, where the option was given, participants did not indicate that the person was female. A total of 15

participants indicated that their relationship to the perpetrator fell into the 'Other' category and again, it was safe to assume in all but two cases²⁴, that the offender was male.

More than eight women in every ten (83%; 54/65) knew the perpetrator, to a greater or lesser degree. For example, more than one quarter (27%; 15/54) were raped or sexually assaulted by an acquaintance (e.g. someone they had met at a party or the man for whom they did babysitting). One in every five women (20%; 11/54) had experienced SV during the course of an intimate relationship (i.e. by a boyfriend or spouse/partner) whilst approximately one in ten (9%; 5/54) were assaulted by an ex-boyfriend or ex-spouse/partner (see Figure 7.2).

Nine women (14%) were raped or sexually assaulted by more than one perpetrator; in more than half of those cases (5/9), two perpetrators were involved in the assault while four women were assaulted by three (n=2) and five perpetrators (n=2) respectively. Again, the great majority of this sub-sample knew those who had raped or sexually assaulted them. In fact, all but two of the 26 perpetrators involved in the rape and/or sexual assault of these nine women were known to the victim. In at least three of these cases, the assault was carried out by a current boyfriend or partner and one (or more) of their friends.

7.1.5.3 Physical injuries/ consequences of the assault

The women were also asked if they had sustained any physical injuries/consequences as a direct result of their experience. Approximately four in ten (43%; 28/65) reported none whilst more than one third (35%, 23/65) indicated that any injuries, which they had received, were minor in nature (e.g. bruises, cuts, scratches). With regard to the remaining women in the sample (n=14), seven had received severe injuries, such as being knocked unconscious, broken bones or internal injuries, whilst one reported receiving a cut to her clitoris. A further four women had fallen pregnant (n=2) or contracted an STI (n=2). The remaining three cited other physical consequences (e.g. a cut to the hand).

²⁴ In these two cases, participants indicated that they had experienced sexual assault incidents four and five by: (1) a care recipient; and (2) a cousin respectively. Perpetrator gender was not specified and impossible to determine by the nature of the incident alone.

Almost one in ten (9%; 6/65) reported more than one type of physical injury or consequence as a result of being raped or sexually assaulted. Half (3/6) had received at least two types of injury or consequence (e.g. minor and STI), whilst the other half (3/6) indicated they had received three types of injury or consequence (e.g. minor, severe, and

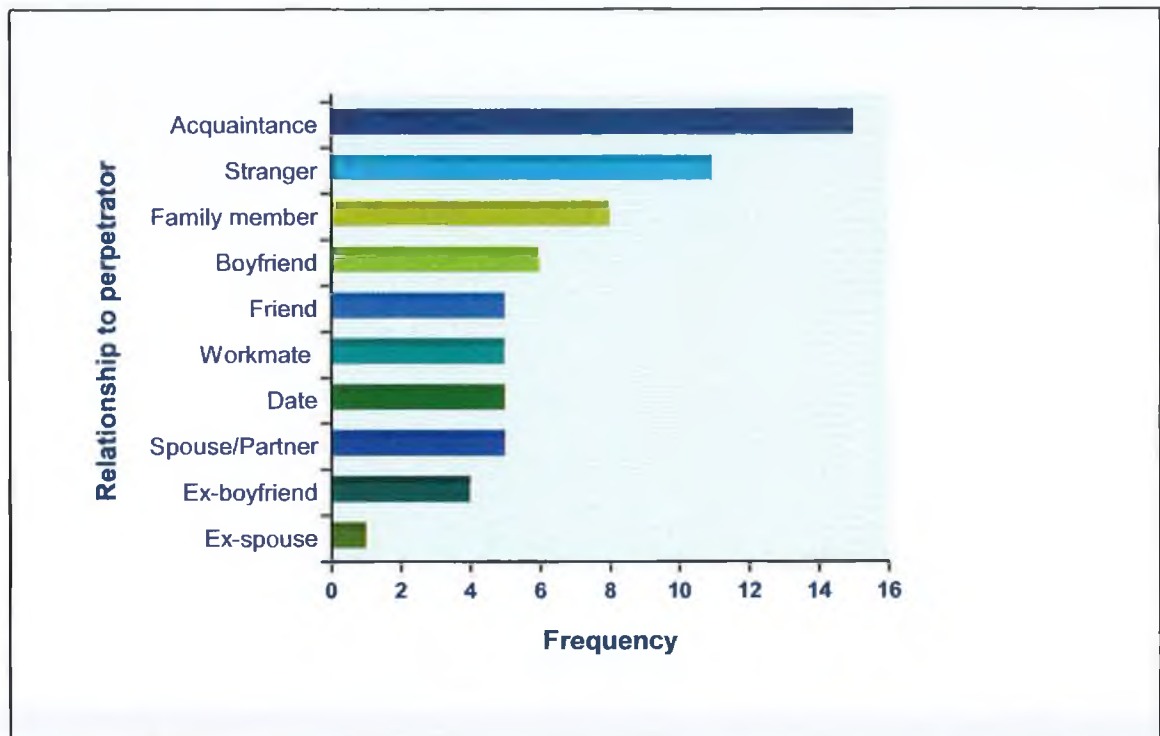


Figure 7.2: Bar chart showing the relationship between the perpetrator and the female victim of sexual violence (n = 65)

pregnancy). Two of the women in this sample also endorsed the 'Other' category and mentioned injuries such as vaginal bleeding and medical procedures which they had to undergo as a direct result of the injuries they had sustained. For example, one 45-year-old woman had to have three colonoscopies²⁵ as a result of the damage caused when she was assaulted by her partner.

7.1.5.4 Initial disclosure of experience and immediate reaction

Only two of the participants had *never* told anybody about their experience of SV. Approximately one third (32%; 21/65) had first disclosed their experience to a close

²⁵ A colonoscopy is a detailed examination of the large intestine using a fibre-optic camera.

friend whilst one in five (20%; 13/65) chose to disclose to a counsellor or therapist. Almost two in every ten women (17%; 11/65) had told a family member first (e.g. brother, sister or mother), while in more than one in ten cases (12%; 8/65), their boyfriend or partner was the first person whom they told about their experience. Both medical (e.g. doctor; psychiatric nurse) and legal (e.g. Gardaí; lawyer) personnel were equally unlikely to be the first people to whom these women would turn in order to disclose their experiences (n=3 respectively). A further four women had first disclosed their rape/sexual assault experience to an acquaintance, or someone not known to them including a manager in work and a stranger on the street.

Participants were asked to rate the immediate reaction of those to whom they first disclosed, in terms of their degree of supportiveness. Almost two-thirds (63%; 40/63) described the response as '*generally supportive*'. A further 21% (13/63) remarked that the reaction was neither supportive nor unsupportive while the remainder (16%; 10/63) indicated that the reaction they had received was distinctly unsupportive. Of this last group, six had told a close friend (n = 3) or family member (n = 3) and four had told medical (n = 2) or legal representative (n=1) or their manager (n=1). It is also worth noting that only two of the six women who disclosed for the first time to medical or legal representatives, reported that the reaction they had received was supportive overall.

7.1.6 Service utilisation

7.1.6.1 Use of health services post-assault

Participants were asked if they had used a number of services directly related to their sexual and reproductive health, in the first three months after the incident. It is commonly reported that very few women visit a GP, hospital or SATU in the immediate aftermath of a rape, or sexual assault (Resnick et al., 2000; McGee et al., 2002) and indeed, in this study, only seven women (11%; 55/62) indicated that they had attended a SATU immediately following the event. A similar proportion (11%; 7/64) attended for a cervical smear screening during the subsequent three months whilst only around one quarter (23%; 14/62) sought emergency contraception immediately afterwards. Likewise, attendance for STI screening was relatively low for the sample as a whole, with only two in every ten attending for testing in the three months after the assault.

7.1.6.2 Counselling: Type and attendance

Participants were also asked if they had ever attended counselling, either privately or through their local RCC. Many noted that they had attended for counselling on an intermittent basis over many years. Therefore, the following information provides a brief overview of the type, length and frequency of counselling in which these women engaged only since their experience of SV. The results showed that 85% (55/65) of the sample had attended for counselling, either privately or through an RCC, in the time since their rape/sexual assault. Only ten women (15%) had never received any counselling. The largest proportion of those who had received counselling (42%; 23/55) had attended private sessions while a further 31% (17/55) had availed of it through a RCC. Furthermore, a similar proportion (27%; 15/55) indicated that they had received counselling, both from a RCC counsellor *and* a private therapist/counsellor. On average, this sub-group attended counselling (i.e. privately and/or through an RCC) for two years and nine months ($n = 51$; $M = 2.9$, $SD = 4.03$) and in approximately three-quarters of cases (74%; 40/54), on a weekly (27/54) or fortnightly (13/54) basis.

7.1.6.3 Rape Crisis Centre (RCC) counselling

Given that RCCs provide a resource specifically designed to respond to the needs of women (and men) in the aftermath of SV, it was considered important to gather information on the experiences of women who had attended these services. Approximately half of the sample (49%; 32/65) had attended counselling through an RCC at some point after their experience of SV and a similar proportion (52%; 32/65) reported that they had contacted an RCC at some stage after their rape/sexual assault. Ten of this group had contacted an RCC immediately or soon after their experience, while the remainder noted that the first contact they made with an RCC occurred, on average, more than two years after the incident itself ($n = 24$; $M = 2.1$, $SD = 6.1$). In one case, it was 30 years after the event before the woman first made contact with an RCC..

Unfortunately, it is not unusual for RCCs in Ireland to have a waiting list for counselling and indeed, more than four out of ten women (41%; 14/34) in the current sample had been placed on a waiting list. The mean waiting time for counselling for this group was approximately three months ($M = 2.77$), while the longest waiting period, for one participant, was a year. Opinions were sought from this subgroup on their feelings about this waiting period and the open-ended responses were subsequently analysed for

common themes. The majority reported a mix of emotions, such as desperation, panic, trauma, frustration, anxiety, fear, annoyance and anger. One woman felt that she could not wait to see an RCC counsellor and so attended private counselling instead, while another was able to access RCC counsellors on an as-and-when-needed basis until a regular counsellor became available on a longer term basis. Another participant commented that she had found the waiting period extremely difficult, particularly after she had taken such a long time to actually make the initial contact. In fact, when her first session finally came around, she reported that she almost did not attend as she had almost “talked herself out of going”.

Most women in this sub-sample (88%; 28/32) had attended RCC counselling on either a weekly (43%; 15/32) or fortnightly (41%; 13/32) basis. Similarly, all but one woman stated that they had found the RCC counselling to be helpful (96%; 30/31); in fact, the largest proportion (61%; 19/31) reported that they found the counselling they received at the RCC to be ‘*very helpful*’. Only one woman had not found it to be helpful and expressed the view that the counsellors should listen more to the needs of their clients.

While most women had contacted an RCC after their experience, it was important to ascertain why almost half had never made such contact. Open-ended responses from 29 of these women were collated, reviewed and analysed using a brief thematic analysis (Hayes, 2000) and two major themes were identified, each of which is described briefly below.

(a) Personal reasons for never contacting a RCC

Most of the reasons why the ‘no counselling’ subgroup never made contact with an RCC were largely of an individual or personal nature, as opposed to any perceived difficulty with the service provided. Only one participant indicated that she did not know why she had never contacted a RCC. The remaining women alluded to a range of personal and emotional barriers to accessing the service. For instance, four women expressed shame (both personal and familial) and embarrassment because of what had happened whilst several other women experienced considerable post-assault fear including: fear of not being believed; fear of being forced to report the assault to the Gardaí; fear of their parents finding out; and fear of having to talk about and relive the experience, if they contacted an RCC. Five clearly stated that, at the time of the

incident, they felt that, what had happened was their fault and, as a result, they did not consider contacting an RCC for support. The most commonly reported reason appeared to reflect an attempt on the part of the women to minimise the seriousness of the assault by using such behaviours as emotional numbing, or avoiding thinking about the event for many years. The following comments illustrate well these sentiments:

'...Also I didn't really take what happened sexually very seriously. I didn't feel anything so I wouldn't have gone to the RCC.' – A 39 year old woman sexually assaulted by her cousin at 17 years of age

'At the time I didn't about it and I believed the incident was my fault and that if I sought help my family would be ashamed of me.' – A 42-year-old woman raped by her spouse/partner when she was 22 years of age.

'Fear of having to talk about the rape and when it first happened, fear that they [the RCC] would want to report it.' – A 28-year-old woman raped by her boyfriend when she was 18 years of age.

A related reason for not contacting the RCC, and something that was echoed by at least four women was the belief that they would be more effective dealing with the experience alone.

(b) Service-related issues and barriers to service provision

Service-related issues were less commonly reported than those indicated above, although 17 women mentioned these in their responses; these were categorised into two groups. One group included women who had already accessed other services and who felt, therefore, that they did not require the specific support offered by the RCC. For example, one woman did not live near a RCC and had attended a local counsellor instead. The second (and larger) group of responses were classified as directly related to RCC services with respect to information and awareness of services and other issues. For example, a number of women noted that they were either not aware of such services when they were raped/sexually assaulted, or that they did not understand the meaning of SV (i.e. that what they had experienced was SV) and therefore did not identify the RCC as a suitable source of support. For some, there was an attendant confusion as to the nature of the services offered by a RCC and, therefore, the suitability of the support provided for the kinds of problems which they were experiencing. Four mentioned the issue of anonymity/ confidentiality in relation to attending their local RCC and most of this group expressed a preference for private counselling instead. In addition, one

woman admitted that she had contacted a RCC, but was unable to make contact because the phone was constantly engaged (she never tried again), whilst another alluded to the stigma of being identified as a 'rape victim', as a barrier to attendance.

7.1.6.4 Other agencies and organisations

Participants were also asked to record the names of other organisations or individuals whom they had contacted for support, information or advice in the period since their rape/sexual assault. Responses to these open-ended questions (n=49) were again analysed for common services and themes. Five did not answer this question while another 11 (19%) indicated that they had made no such contact since their experience. Approximately one third (35%; 17/49) of the remaining women (i.e. the 'service contact group') reported that they had been contact, at some stage after their assault, with An Garda Síochána (Irish police force). The largest proportion of this group (53%; 26/49) had also contacted a GP, doctor, nurse or hospital SATU for support and/or advice and information (see Table 7.2).

7.1.7 Impact of sexual violence on key aspects of life

7.1.7.1 Education and employment

In an attempt to gauge the impact of SV on education and employment, the participants were asked to indicate whether they were in school or college, employed or unemployed at the time of their experience, as well as any time they may have taken off after the assault and the overall perceived impact of their experience on their educational and working life.

(i) Attending school or college at the time of the rape/sexual assault

More than four in every ten women (42%; 27/65) were either enrolled in secondary school (12/27) or a post-leaving certificate or college course (15/27) at the time of their experience. Most of this group (63%; 17/27) reported not taking any time off from school/college in the six months after the incident. For the ten women (37%) who did, two dropped out from their studies entirely while the remaining eight were absent for average of seven weeks (M = 35.86 days based on a five-day week) of school/college. More than half of this group (56%; 15/27) felt that their experience had not significantly affected their ability to complete their education (i.e. either 'not at all' (11%; 3/27) or 'a

little (30%; 8/27), although a substantial proportion (33%; 9/27) felt that their ability to complete their studies had been affected 'a lot'.

Table 7.2: A selection of other agencies (i.e. not a RCC) and professionals contacted by women in the SV sample (n=65)

Name of Agency/Type of professional ¹	Frequency ²
<i>GP/Doctor/Nurse/SATU</i>	26
<i>An Garda Síochána</i>	17
<i>Psychiatrist/Psychologist/Social worker</i>	17
<i>Counsellor/Therapist</i>	14
<i>Samaritans</i>	11
<i>Women's Aid/Other domestic violence support service</i>	10
<i>Priest/Pastor</i>	7
<i>One in Four</i>	3
<i>Voluntary support groups (e.g. Al-Anon, Victim Support)</i>	4
<i>Community drugs team</i>	1

Note. 1. RCC = Rape crisis centre; Gardai = National Irish police force; Samaritans = A voluntary support service for people contemplating suicide; G.P = General practitioner; Women's Aid = The national Irish domestic violence support and advocacy service; One in Four = A charity that provides support and counselling/psychotherapy for men and women who have experienced sexual abuse and/or sexual violence.

2. Some women used more than one of the above services.

(ii) Employment status at the time of the rape/sexual assault

More than one third of the total sample (37%; 24/65) was employed at the time of their rape or sexual assault. As indicated above, most of the remainder (n=27) were in full-time education, although a substantial proportion (22%, 14/65) was unemployed at the time of the incident. Fewer than half of those who were in employment (46%; 11/24) took time off from work during the six months immediately following the incident. Three women did not return to their job after their experience while a further two were absent for 10 and 12 months respectively. The remaining six women were absent from

work for an average of five weeks ($M = 26.3$ days based on a 5-day working week) during the immediate time period following their assault

The participants in this 'employed' sub-sample were also asked if they were still in the same job currently, as at the time of the incident. Whilst in many cases, a considerable length of time had elapsed since the incident, it was nonetheless, considered important to attempt to identify, insofar as possible, the impact of their experience on any changes in employment. Only one woman out of the 24 was still currently in the same job. The other women ($n=23$) were asked further for their reasons for leaving that job and their open-ended responses were collated, reviewed as a whole and subjected to a content analysis.

Unsurprisingly, several women ($n=9$) cited what would appear to be practical and logistical reasons for leaving their previous place of employment, such as: dislike for the job; moving city/abroad; a better job opportunity arising elsewhere; redundancy; or a temporary contract that subsequently ended. However, a small number of women ($n = 5$) reported that the perpetrator of the SV was employed by the same company in which they worked and that they were unable to continue working there afterwards. In a further case, the participant worked with a sister of the alleged perpetrator and as news of the incident spread, she felt targeted in the workplace and chose to leave. A further four women left their employment after the event due to a diminishing ability to cope with the demands of their job or life in general. Thus, ten women in total (42%) appeared to have left their previous employment for reasons which were related directly ($n=6$) to, or highly likely to be related to ($n=4$), their experiences. For example, one of these women indicated that it was the nature of her job (a company supervisor with responsibility for a large number of men), which she found especially difficult and in her own words, she just '*couldn't handle being with them*'. Another woman did not return to her place of employment as she felt that she was not the same person anymore, that her colleagues would notice a change in her and that she would find it difficult to answer their questions. The third participant left her job after she had completed counselling – '*a sort of letting go*' – while another left because she was unable to get time off or tell anyone with whom she worked about her experience.

(iii) Unemployed at the time of the rape/sexual assault and current employment status

Approximately one in five women (22%; 14/65) were unemployed at the time of their rape/sexual assault. As it was clearly not possible to assess the impact of their experience on their employment at the time of the incident, they were asked instead about their current employment status. Approximately three quarters (74%; 48/65) of the total sample were currently employed at the time of participating in this study. When asked how much they felt their experience of SV had impacted on their ability to perform their job on a daily basis, more than one quarter (27%, 13/48) reported that it was considerable (i.e. either 'A fair amount' (n=7) or 'A lot' (n=6)). With regard to those who were currently unemployed (26%; 17/65); over half indicated that their ability to obtain and maintain a steady job was affected to a 'fair' or large amount as a result of their experience.

7.1.7.2 Relationships

The impact of the experience of SV on participants' ability to form close friendships and relationships, was also explored. Specifically, the women were asked to rate the degree to which they felt their experience had negatively impacted on their relationships with those closest to them (e.g. mother, father, partner, children). In addition, they were asked to estimate how much they felt their experience had affected their ability to form close friendships and intimate relationships. As shown in Figure 7.3, almost half of the sample, in response to each of these questions, felt that the impact on their relationships and close friendships had been considerable (i.e. rated as 'A lot'). In sum, proportionately more women felt that their ability to form intimate relationships had been more seriously affected by their experience (60%; 39/65), when compared to their ability to sustain close relationships with family and friends (54%; 35/65) and to form close friendships (46%; 30/65).

7.1.7.3 Overall impact of sexual violence

In the final section of the BESQ, participants were asked to rate (using a scale from -3 (very negative) to +3 (very positive)) the *overall impact* of their experience of SV on key aspects of their lives. Participants indicated that the two areas of their lives most negatively affected by their experience, were their sexual relationships (91%; 59/65) and their self-esteem (91%; 59/65), followed closely by mental health (79%; 51/65) and personal relationships (82%; 53/65). For purposes of comparison, all of the areas in

which 'very negative' impact ratings were obtained, are presented in Figure 7.4. The largest proportion of women in this sample (58%; 38/65) felt that 'Personal finances' was the area in which there had been 'no impact' as a result of their experience. Importantly, everyone in the study reported that their experience had, in some way, negatively affected their life.

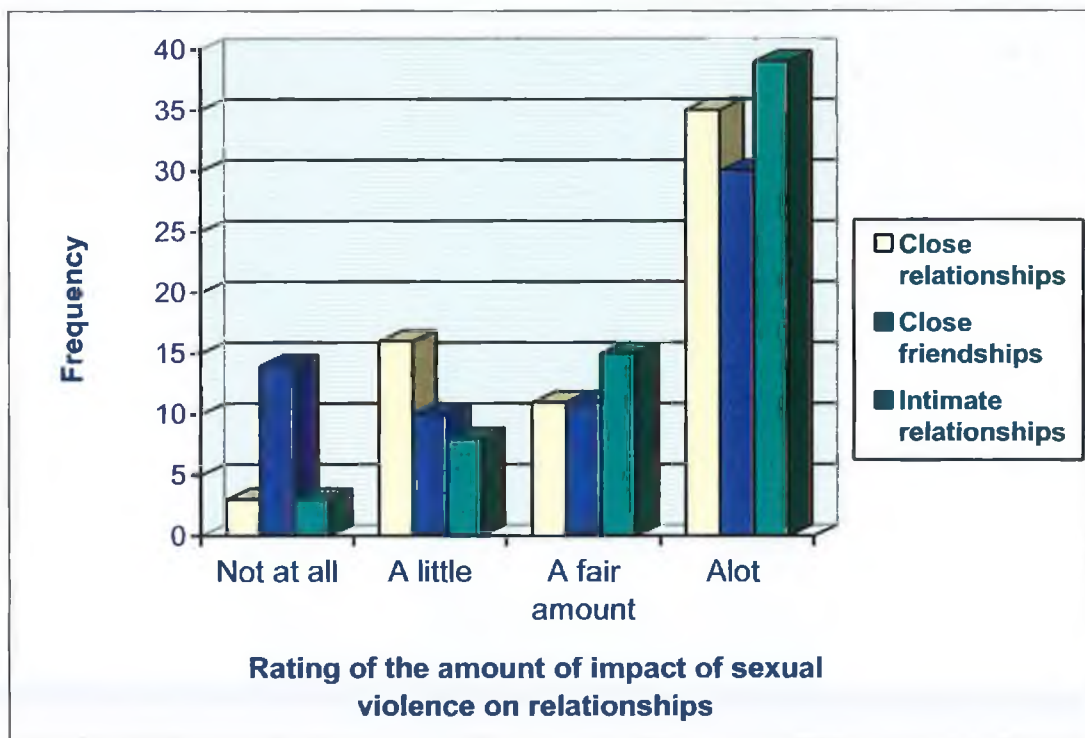


Figure 7.3: Bar chart showing the frequency of women who rated the impact of their experience of sexual violence on their close relationships, and their ability to form close friendships and intimate relationships (n=65).

In total, 28 women recorded some degree of positive impact across the nine areas (i.e. 'slightly', 'moderately' or 'very positive') as a result of their experience. For example, four women indicated that the impact of SV had been 'very positive' in terms of their education. A similar number (n = 4) felt that the incident had impacted in a 'slightly positive' way on their work life; this was the single domain that received the most positive ratings of all of the options available (n=8).

Participants were also asked to indicate the extent to which their experience had had a negative and positive impact (where applicable) on their lives overall. Figure 7.5 compares the positive and negative ratings given by participants in this respect. While

all reported some negative impact overall (e.g. 83% a considerable impact - fair to a lot), almost four in ten women in this sample reported that their experience of SV had impacted positively on their lives by 'a fair amount' to 'a lot'.

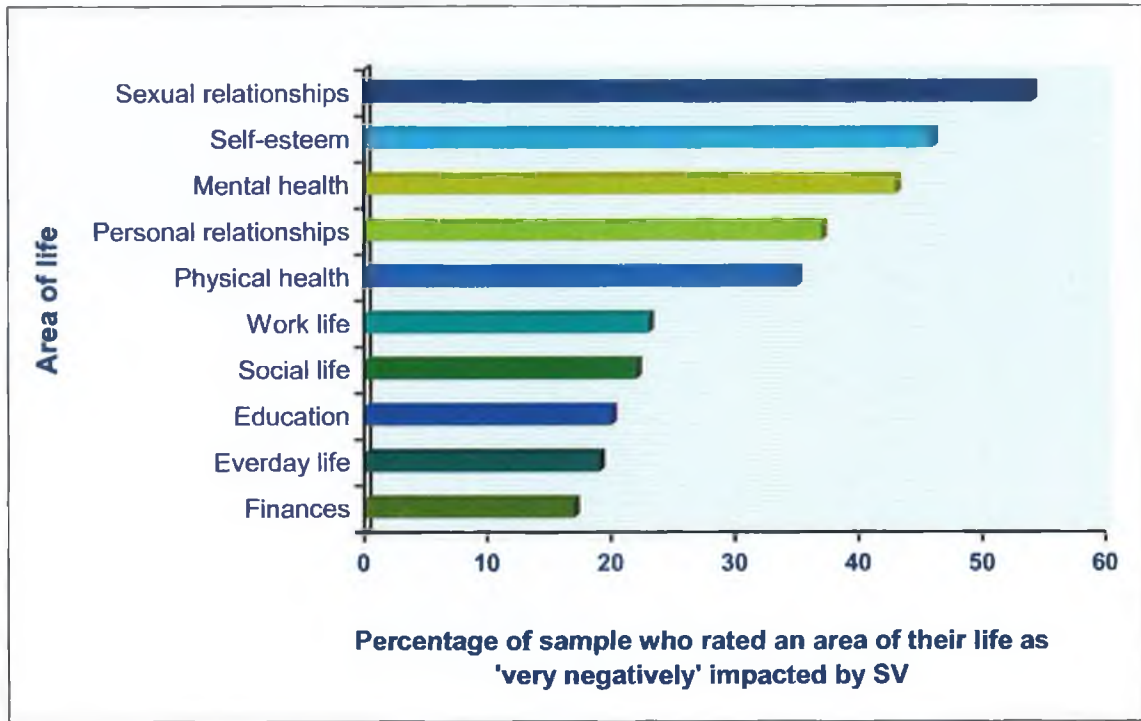


Figure 7.4: Bar chart showing the life domains very negatively impacted by the experience of sexual violence (n=65).

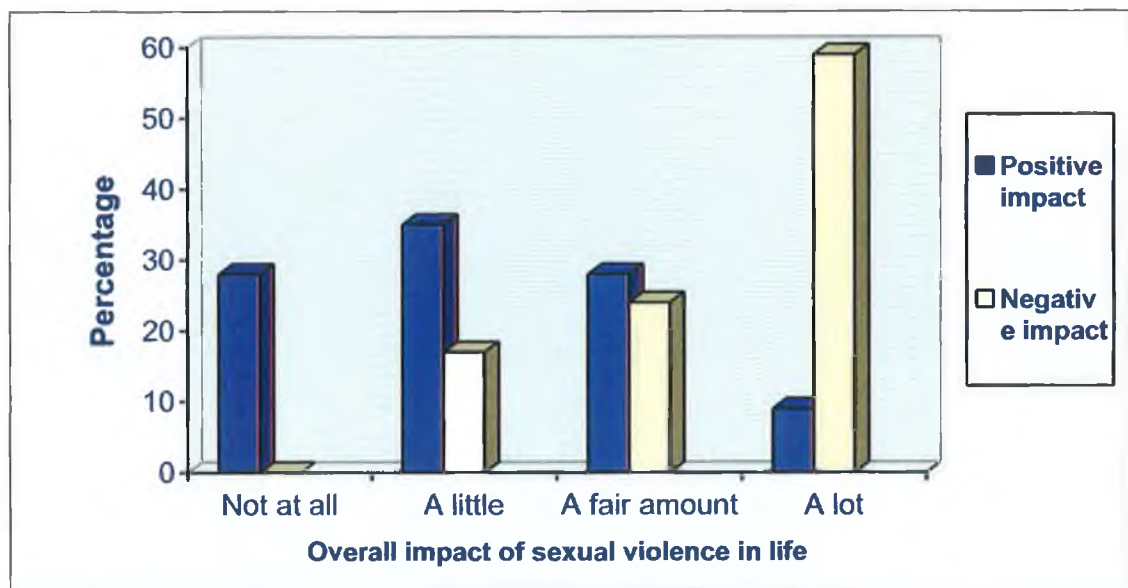


Figure 7.5: Bar chart comparing the positive and negative ratings of the overall impact of sexual violence in the lives of the participants (n=65).

7.1.8 Trauma symptoms

As indicated earlier, the 13-scale TSI was administered only to the SV sample. Initially, the three validity scales within the measure were examined and four women were excluded from any further analysis due to atypical (ATR) and inconsistent responding (INC). The findings for the remainder of the sample ($n = 61$) are detailed in Table 7.3 and are juxtaposed, for purposes of comparison, with the appropriate population norms; the symptoms that are reported pertain to the previous six months.

As illustrated in Table 7.3, the SV sample obtained significantly higher scores on each of the ten TSI scales when compared to the normative (general population) sample ($n=291$) (see Chapter Six plus Appendix 24). However, none of the scales on which they scored higher, emerged as significant when compared to the 'trauma history' normative sample of female psychiatric inpatients ($n=261$) (Briere et al., 1995; $n=136$ psychiatric inpatient and 233 psychotherapy outpatient, men and women). In fact, the current sample scored significantly lower than this norm trauma sample on the AA, D, AI, DIS and ISR scales (Please see Appendix 24 for a full report of these results). The findings from each of the broad symptom categories within the TSI are described in more detail below, followed by a brief interpretation of the trauma profile for the sample as a whole.

7.1.8.1 Dysphoric mood (AA, D and AI)

The AA subscale is related to the hyperarousal dimension of the DSM-IV-TR diagnosis of PTSD; here, three quarters of the SV sample (46/61) obtained scores higher than the first norm mean score (7.68), thereby indicating that a large number of women were presenting with frequent anxiety symptoms. High scorers on this scale reported experiencing periods of trembling or shaking, nervousness, feeling on edge, excessive worrying and fears of being physically hurt on a regular basis. Physical symptoms related to the almost constant alertness of the sympathetic nervous system, would also be common.

Table 7.3: The means and standard deviations for the SV sample (N = 61) on each of the ten clinical subscales of the TSI (appropriate population norms are also presented for purposes of comparison).

TSI Clinical Scale	SVS sample	*General population	**Trauma history sample
	M (SD)	^a M (SD)	^b M (SD)
<i>Dysphoric Mood</i>			
<i>Anxious/Arousal (AA)</i>	12.70 (5.86)	7.68 (5.22)	14.56 (5.35)
<i>Depression (D)</i>	12.77 (6.13)	7.10 (6.13)	15.36 (6.20)
<i>Anger/Irritability (AI)</i>	13.25 (6.27)	8.31 (6.24)	15.06 (6.22)
<i>Post-traumatic Stress</i>			
<i>Intrusive Experiences (IE)</i>	12.98 (6.67)	6.03 (5.55)	12.57 (6.38)
<i>Defensive Avoidance (DA)</i>	13.51 (6.48)	7.15 (6.15)	13.73 (5.98)
<i>Dissociation (DIS)</i>	10.64 (5.87)	5.46 (5.00)	13.58 (6.42)
<i>Sexual Difficulties</i>			
<i>Sexual Concerns (SC)</i>	9.39 (6.65)	4.06 (5.27)	10.57 (2.68)
<i>Dysfunctional Sexual Behaviour (DSB)</i>	5.57 (6.85)	2.29 (3.94)	4.64 (5.88)
<i>Self Dysfunction</i>			
<i>Impaired Self-Reference (ISR)</i>	12.63 (6.36)	6.46 (5.94)	15.07 (6.21)
<i>Tension Reduction Behaviour (TRB)</i>	5.75 (4.23)	2.66 (3.35)	6.50 (4.64)

Note. SV = Sexual violence; TSI = Trauma Symptom Inventory.

* Normative sample scores are taken from studies conducted by Elliott (1993) and Elliott & Brière (1994) (n = 291, adult females, aged 18 – 54 years).

** Trauma history sample (Brière et al., 1995) (n = 261, female psychiatric inpatients and outpatients).

^a = all differences were significant. ^b = significant differences found on AA, D, AI, DIS, and ISR scales.

The SV sample also scored significantly higher than the general population norm group on the *Depression* sub-scale, yet lower than the trauma history sample. High scores on this scale (46/61; 75%) would indicate feelings of unhappiness and sadness on a relatively regular basis. Likewise, three out of every four women scored at, or above, the general population norm (of 9) in terms of the frequency of angry feelings, thoughts and behaviour (i.e. '*Anger/irritability*' subscale). Therefore, the great majority of women in this sample were regularly feeling irritable, annoyed or bad tempered, and often finding that they over-reacted to minor difficulties or frustrations.

7.1.8.2 Post-traumatic stress (IE, DA, and DIS)

Turning to post-traumatic stress, the first set of symptoms - relating to intrusive experiences (IE), such as nightmares and sudden sensory flashbacks of a traumatic event - were experienced repeatedly by more than eight out of every ten women in this sample (84%; 51/61) (using population norm of ≥ 7 as cut-off point). On this particular scale, the SV group also obtained a significantly higher mean score than the general population norm group, with approximately half (54%; 33/61) scoring higher than this group overall. It is important to note that these symptoms were occurring, on average, almost 13 years after the event.

Defensive avoidance (DA) is linked with one of the hallmark signs of PTSD and high responders on this scale frequently report attempts to neutralise any negative feelings they may have arising from previous exposure to traumatic events. Three quarters of the sample (46/61) obtained higher scores than the general population norm; particularly with respect to the level of avoidant thinking and behaviours (e.g. pushing painful memories out of their mind) in which they engaged on a regular basis. Dissociation may be described as the loss of the ability by an individual '*to integrate the memory of overwhelming events*' (Herman, 2001: 34). Here, more than seven out of ten women (74%; 45/61) reported engaging in high levels of these types of behaviours and again; the overall mean score was also significantly higher than that of the general population norm group. High levels of distractibility and feelings of being out-of touch, as found in the current sample, were a commonly reported source of anxiety for the participants.

7.1.8.3 Sexual Difficulties (SC, and DSB)

Once again, 75% (46/61) of the sample obtained above-norm scores on the Sexual Concerns (SC) scale, which measures sexual distress and dysfunction. Thus, a significant proportion of the participants were experiencing, for example, negative thoughts and feelings during sex and/or sexual problems in relationships. The *Dysfunctional Sexual Behaviour* subscale was the second scale on which participants scored higher than *both* the general population and the trauma history norm groups; however, this difference only reached statistical significance with the general population norm group (see Table 7.3). According to the mean scores of the norm and trauma history groups, 54% (33/61) and 43% (26/61) respectively, of women in the current sample, had engaged in these behaviours (e.g. using sex to combat loneliness or internal distress or behaving flirtatiously for nonsexual reasons) during the previous six months.

7.1.8.4 Self Dysfunction (ISR, and TRB)

The *Impaired Self-Reference (ISR)* sub-scale assesses the frequency of a range of difficulties typical of someone with a damaged or impaired sense of self and personal identity. For example, confusion regarding one's personal identity and goals in life and/or an internal sense of emptiness. These appeared to be a problem for more than three-quarters of the sample (79%; 48/61), all of whom recorded higher scores than the general population norm group. Furthermore, the difference between this sample and the general population norm group was statistically significant.

As above, a significant majority of the participants (74%; 45/61) obtained above-norm scores on the *Tension Reduction Behaviour (TRB)* scale. The difference between the means was also significant. The most commonly reported behaviour which was endorsed by the largest proportion of participants was Item 78 (*trying to keep from being alone*). Approximately one in five (21%; 13/61) admitted to engaging in this behaviour, on a frequent basis, during the previous six months. Other commonly reported items here included: starting arguments or picking fights to get their anger out (13%; 8/61); and yelling and telling people off when they felt they should not have (11%; 7/61).

7.1.8.4 Summary of trauma symptoms/trauma profile of the SV group

The above findings suggest that the women in the current sample were typically exhibiting a range of trauma symptoms on a regular basis and in many cases, several years after their most recent experience of SV. They recorded significantly higher scores than the general population norm group on all of the scales whilst scoring significantly lower than a sample of psychiatric patients with a history of trauma on five of the scales. According to the mean scores, these women, overall, would appear to be engaging in avoidant behaviours and to be experiencing feelings of anger and irritability as well as intrusive experiences and symptoms of depression and anxiety (see Figure 7.6).

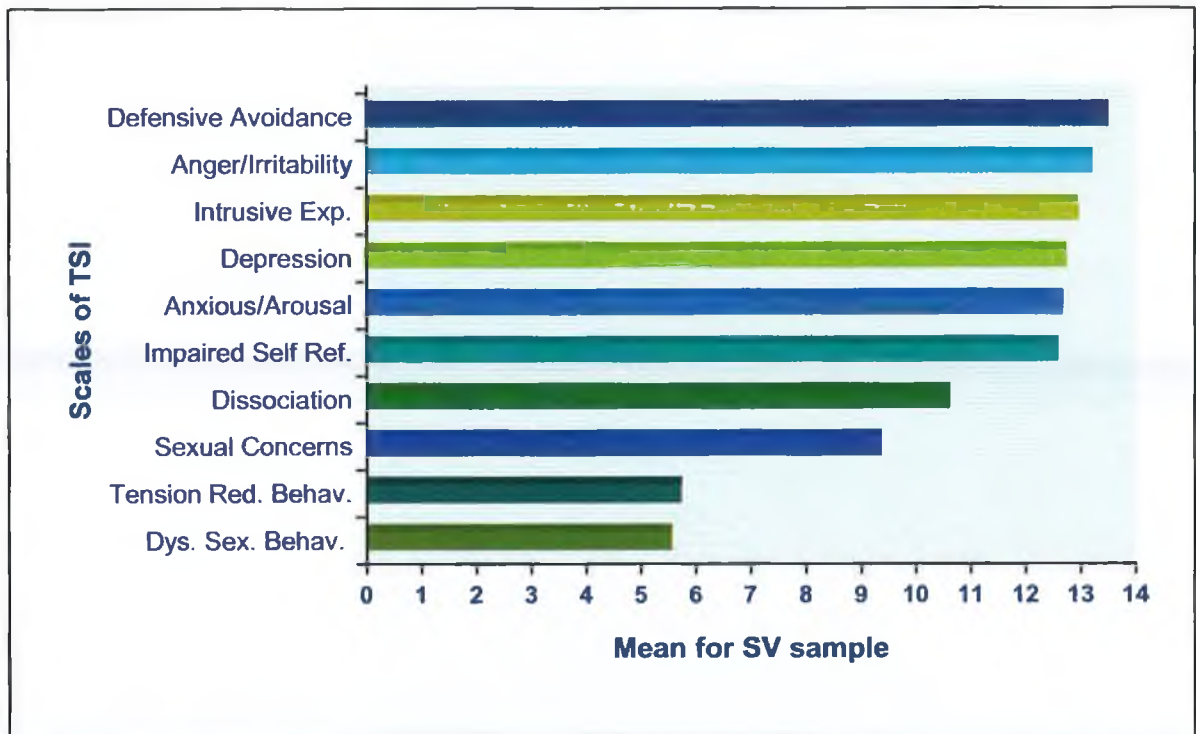


Figure 7.6: Bar chart illustrating the mean scores on each of the 10 clinical scales of the TSI

Note. TSI = Trauma Symptom Inventory; SV = Sexual violence.

Interpretation guidelines from the TSI user manual (Brière, 1995) suggest that elevated scores on both the IE and DA subscales suggest a typical post-traumatic presentation in clients. In addition, as seen in the profile of the current sample, this may be associated with elevated scores on the AI subscale (and to a lesser extent the AA scale) (Briere,

1995). Recall that the average period of time since the SV incident was approximately 13 years; thus, it is interesting to note that, according to the manual, this kind of profile would be considered typical of a '*chronic PTSD response to an event, or events farther in the past*' (Brière, 1995:15).

Brière (1995) goes on to suggest that such a chronic pattern of post traumatic responding may well indicate that these symptoms have become more or less integrated into the individual's personality. He posits that this experience of posttraumatic symptoms over an extended period of time can be extremely aversive and '*result in serious psychological disability*' (Brière, 1995:15). The next most common group of symptoms endorsed by this group, were related respectively to a damaged sense of self and habitual dissociation. Those symptoms least likely to be recorded, overall, included concerns around sexual feelings and behaviour, behaviour engaged in to reduce or avoid tension and problematic sexual behaviour.

7.2 Descriptive analyses: Comparison group (COM group)

This next section briefly presents some demographic and background information on the comparison (COM) group. A range of information was collected from the COM group (n=57) in order to facilitate like-with-like comparisons with the SV sample; this included socio-demographic variables; sexual and reproductive health; alcohol and drug use; and mental health. As indicated earlier in Chapter Six, two questions were used prior to administering any of the questionnaires in order to identify or 'screen out' anyone with a possible history of SV or sexual abuse, either as a child or adult.

7.2.1 Demographic profile

As expected, the average age of women in the COM group was similar to the SV sample (M = 35.39, SD = 14.03) and with a comparable age range (20 to 62 years). Once again, while virtually all were Caucasian and native Irish, six had been born in the UK. Approximately one third of the women (31%, 18/57) had children, most of whom had one to two children (61%; 11/18); the remainder had three to four children each (see Table 7.4).

Table 7.4: Comparison of key demographic and background information on the COM group (n=57) and SV sample (n=65)

Variable	COM group n (%)	SV sample n (%)
<i>Number of children</i>		
<i>None</i>	39 (68)	33 (51)
<i>One to two children</i>	11 (19)	24 (75)
<i>Three to five children</i>	7 (12)	6 (19)
<i>Current marital status</i>		
<i>Single</i>	12 (21)	25 (39)
<i>Steady relationship</i>	16 (28)	10 (15)
<i>Living w/partner</i>	8 (14)	10 (15)
<i>Married</i>	20 (35)	8 (12)
<i>Separated/Divorced</i>	1 (2)	9 (13)
<i>Other</i>	0 (0)	3 (6)
<i>Education level</i>		
<i>Junior Certificate</i>	5 (8)	1 (2)
<i>Leaving Certificate</i>	13 (23)	8 (12)
<i>Post Leaving Cert/RTC</i>	1 (2)	11 (17)
<i>University degree</i>	18 (32)	17 (26)
<i>Post-graduate qualification</i>	17 (30)	22 (34)
<i>Other</i>	3 (5)	6 (9)
<i>Type of medical clinic/service</i>		
<i>Early Pregnancy Unit (EPU)</i>	4 (7)	12 (19)
<i>Colposcopy clinic</i>	7 (12)	17 (26)
<i>Fertility clinic</i>	4 (7)	5 (8)
<i>Psycho-sexual counselling</i>	0 (0)	8 (12)

Note. SV = Sexual violence; COM = Comparison; RTC = Regional Technical College.

7.2.2 Physical health and mental health

7.2.2.1 Mental health status

Only five per cent of women (3/57) in the COM group had, at some stage, received a formal diagnosis of a mental health problem(s); this contrasts sharply with the 54% point prevalence rate recorded for the SV sample. Two of the three women had been

diagnosed with anxiety, and one with depression. The latter had been diagnosed approximately nine years previously and reported taking medication for a couple of months with no recurring problems since. The two participants with anxiety had been diagnosed 3 and 25 years ago respectively. The woman with the more recent diagnosis had been treated with eight months of anti-anxiety medication while the other had received three to six months of medication and approximately six weeks of counselling.

7.2.2.2 Alcohol and drug use

All but four of the COM group (93%) reported that they consumed alcohol – a figure that was marginally higher than in the SV sample (88%), as was the frequency of consumption. For example, almost three-quarters (72%; 38/53) consumed alcohol regularly (i.e. every few days (26%; 14/53) or weekly (45%; 24/53)). Only one woman reported drinking alcohol on a daily basis (SVS; n=2); whereas equal numbers (n=3), reported drinking alcohol either monthly, or only on special occasions. The remaining eight women (15%) reported that they drank alcohol on a fortnightly basis.

As in the case of the SV sample, the COM group participants reported consuming an average of four drinks per sitting ($M = 4.19$, $SD = 1.81$). None of the women were using drugs currently, although 30% (17/57) admitted to having used drugs in the past (compared to 37% in the SV sample). For purposes of comparison across both groups, more than half of the SV sample (57%; 37/65) had either used drugs in the past or were currently using them, compared with less than one third of the COM group (30%).

7.2.2.3 Sexual and reproductive health

Marginally more women in the COM group (72%; 41/57) than in the SV sample reported that they attend for regular cervical screening (68%; 44/65); however, none reported having regular STI screening (in contrast to the 20% of SV sample women). Other medical clinics and services related to sexual and reproductive health were also used less frequently by women in the COM group (please see Table 7.4).

7.3 SV versus Comparison Group: Between-group analysis on key dimensions

A number of interesting differences were found on those measures that were administered to both the SV and COM groups. Tables showing the means and standard deviations on all of these measures are presented in Appendix 25 and where available,

these are compared with appropriate population norms. The following section presents the detailed analyses performed to assess the extent to which these differences were statistically significant. Some additional sub-group analyses are also described.

7.3.1 Mental health and social support

Comparisons were also made between the SV sample and the COM group on the mental health and social support measures (see Table 7.5). Once again, the SV group reported significantly more recent psychological distress (total GHQ-12 score) and lower levels of social support (Total ISEL score) than their COM group counterparts. A more in-depth analysis of the nature of these significant differences was undertaken using Bonferonni adjusted alpha levels. With respect to the recent mental health, the SV sample was experiencing significantly higher levels of psychological distress than the COM group in the weeks before taking part in the study. For example, the SV sample reported losing significantly more sleep over worry (SV sample: $M = 0.51$, $SD = 0.50$; COM group: $M = 0.14$, $SD = 0.35$, $t(56) = 4.32$, $p < .004$) than the women in the COM group (see Appendix 26). In sum, the significantly higher levels of recent psychological distress in the SV sample appear to have affected, in particular, their sleep, and their sense of coping.

Specific dimensions of social support as measured by the ISEL, were found to be more salient than others for the SV sample when compared with the COM group (see Table 7.6). A feeling that they did not have people to whom they could talk about their intimate personal and family-related problems (*Appraisal*) was found to be particularly troublesome for the SV sample. For example, significantly more women in the SV sample felt that there was no one with whom they felt sufficiently comfortable, to talk about personal intimate problems (SV sample: $M = 1.91$, $SD = 1.06$; COM group: $M = 2.60$, $SD = 0.66$, $t(54) = 3.85$, $p < .001$). By contrast, no significant differences were found between the items in this subscale that related to advice about career plans or finances.

Table 7.5: Results comparing the SV sample and the COM group on their mean GHQ-12 and ISEL scores

Mental health/ Social support measure	SV sample M (SD)	COM group M (SD)	t (df)	p value (η^2)
GHQ-12				
<i>Total GHQ</i>	4.84 (3.78)	1.89 (2.89)	4.32 (56)	.000*** (.3)
ISEL				
<i>Appraisal</i>	19.98 (7.02)	25.49 (4.53)	4.60(54)	.000*** (.3)
<i>Tangible</i>	21.53 (6.72)	26.38 (3.86)	4.63(54)	.000*** (.3)
<i>Self-Esteem</i>	19.05 (4.92)	21.13 (4.07)	2.41(54)	.019* (.1)
<i>Belonging</i>	18.67 (6.54)	24.55 (3.75)	5.92(54)	.000*** (.4)
<i>Total ISEL</i>	79.24 (20.51)	97.55 (13.32)	5.43(54)	.000*** (.4)

Note. SV = Sexual violence; COM group = Comparison group; GHQ-12 = General Health Questionnaire (12 item); ISEL = Interpersonal Support Evaluation List.

* $p < .05$, 2-tailed. *** $p < .0005$, 2-tailed.

Overall, the women in the SV sample felt that they experienced a significant lack of perceived social support when compared to their COM group counterparts. In particular, they did not feel that they were surrounded by people to whom they could talk about personal and family problems, whilst also feeling excluded, on occasion, by their circle of friends. While they believed that most of the people they knew did not enjoy similar activities to them, they did feel that there were several people with whom they enjoyed spending some time. Overall, they also reported lower self-esteem than the COM group; this was reflected only in their perception that most of their friends were more interesting than they were. Their perceived access to material assistance was also significantly lower than that of the COM group and this was highlighted by significant findings on two items of the *Tangible* subscale, relating to help with daily chores in the event of illness and assistance in moving to a new house or apartment.

7.3.2 *Quality of life and life stress*

The SV sample participants had experienced more than twice the number of major life events than their COM group counterparts (348 versus 145 respectively). As shown in

Table 7.7: Results from a paired samples t-test between the SVS and the CG on their mean scores on the individual items of the ISEL.

ISEL subscales Items	SVS M(SD)	CG M(SD)	t (df)	p value (η)
Appraisal (Someone to talk to about things)				
<i>Item 6: Intimate personal problems</i>	1.91 (1.06)	2.60 (0.66)	3.45 (54)	.002* (.2)
<i>Item 19: Problems with family</i>	2.18 (0.86)	2.75 (0.52)	3.85 (54)	.000* (.2)
<i>Item 22: Dealing with personal problem</i>	2.05 (0.97)	2.71 (0.57)	4.44 (54)	.000* (.3)
<i>Item 36: Advice re family crisis</i>	2.00 (1.02)	2.65 (0.58)	3.93 (54)	.000* (.2)
Tangible (Practical material aid)				
<i>Item 18: Help with daily chores if sick</i>	1.89 (1.05)	2.76 (0.43)	5.25 (54)	.000* (.4)
<i>Item 39: Help moving house</i>	2.02 (0.95)	2.75 (0.52)	4.78 (54)	.000* (.3)
Self-Esteem				
<i>Item 3: My friends are more interesting than me</i>	1.71 (0.76)	2.80 (0.52)	9.12 (54)	.000* (.6)
Belonging (People to do things with)				
<i>Item 10: Excluded by circle of friends</i>	1.64 (1.03)	2.62 (0.56)	5.87 (54)	.000* (.4)
<i>Item 12: Several people to spend time with</i>	2.25 (0.82)	1.75 (0.70)	3.72 (54)	.000* (.2)
<i>Item 25: People that enjoy the same things as me</i>	1.71 (0.88)	2.29 (0.69)	3.86 (54)	.000* (.2)
<i>Item 31: Someone to have lunch with</i>	1.96 (0.82)	2.55 (0.57)	4.34 (54)	.000* (.3)

Note. Non-significant results are not reported. SVS = Sexual violence sample; CG = Comparison group; ISEL = Interpersonal Support Evaluation List.
Bonferroni adjusted alpha level: * $p < .001$, 2-tailed.

Table 7.7, the SV sample scored higher than the COM group (and the norm) on LES-N indicating that they experienced more negative life events during the previous six months than the COM group. The results of the t-test analyses revealed that the SV sample participants obtained significantly higher scores than their COM group counterparts on all scales of the LES-M, as well as the four separate domains of the WHOQOL-BREF (Table 7.7). For example, the SV group experienced significantly more negative or undesirable life events in the six months prior to the study. They also rated their satisfaction with their health and their overall QoL as significantly lower than that of the women in the COM group. Further paired sample t-tests between the individual items of each subscale obtained for both groups, were then conducted in order to identify the precise aspects of their lives most affected. Here, only the most interesting findings are reported. (Note: In order to avoid a Type 1 error, a Bonferonni adjusted alpha level was used to assess for statistical significance.)

Table 7.7: Differences between the SV sample and the COM group with regard to life stress (LES-M) and QoL measures (WHOQOL-BREF).

Life stress/QoL measure	SV sample M (SD)	COM group M (SD)	t (df)	p value (η^2)
LES-M				
<i>Negative change score</i>	6.93 (7.07)	2.54 (2.76)	4.15 (56)	.000*** (.2)
<i>Positive change score</i>	3.46 (3.67)	2.72 (3.29)	1.06 (56)	.294
<i>Total change score</i>	10.39 (8.38)	5.26 (4.63)	3.76 (56)	.000*** (.2)
WHOQOL-BREF				
<i>Rating of QoL</i>	3.61 (1.03)	4.26 (0.64)	4.48 (56)	.000*** (.3)
<i>Satisfaction with health</i>	3.00(1.10)	3.79(0.94)	4.15 (56)	.000*** (.2)
<i>Physical domain</i>	11.92(1.93)	13.34 (1.66)	4.52 (55)	.000*** (.3)
<i>Psychological domain</i>	11.98 (2.57)	14.00 (1.94)	4.71 (55)	.000*** (.3)
<i>Social domain</i>	11.38 (4.16)	15.48 (3.38)	5.80 (55)	.000*** (.3)
<i>Environment domain</i>	13.46 (2.71)	15.81 (2.40)	4.78 (55)	.000*** (.3)

Note. SV = Sexual violence; COM group = Comparison group; LES-M = Life Experiences Survey – Modified version; WHOQOL-BREF = World Health Organisation Quality of Life – Brief version; QoL = Quality of life. *** $p < .0005$, 2-tailed.

The significantly lower level of satisfaction with health amongst the SV group was supported by significant differences on almost all of the items of the *Physical* domain of the WHOQOL-BREF. For example, the SV sample, when compared to the COM group, reported experiencing significantly more physical pain that interfered with their life (SV sample: M = 2.18, SD = 1.12; COM group: M = 4.47, SD = 0.85, $t(56) = 12.74$, $p < .007$). (Table 7.8 presents all of the significant differences found between these two groups on the individual items of the WHOQOL measure).

Table 7.8: Significant differences between the SV sample and the COM group on the individual items of the QoL measure (WHOQOL-BREF).

QoL measure Domain	SV sample M (SD)	COM group M (SD)	t (df)	p value (η^2)
WHOQOL-BREF				
Physical				
Item 3: Physical pain	2.18 (1.12)	4.47 (0.85)	12.74 (56)	.01**(.8)
Item 10: Energy	3.19 (1.16)	3.72 (0.86)	2.86 (56)	.01**(.1)
Item 16: Sleep	2.68 (1.27)	3.68 (1.15)	4.61 (56)	.01**(.3)
Item 18: Work capacity	3.12 (1.23)	4.09 (0.85)	4.75 (56)	.01**(.3)
Psychological				
Item 5: Enjoys life	3.12 (0.92)	3.81 (0.85)	3.82 (56)	.01**(.2)
Item 7: Concentration	3.09 (0.89)	3.54 (0.73)	2.95(56)	.01**(.1)
Item 11: Bodily appearance	2.81 (1.16)	3.54 (1.09)	3.53(56)	.01**(.2)
Social				
Item 20: Personal relationships	2.89 (1.21)	4.07 (0.82)	6.63(56)	.02*(.4)
Item 21: Sex life	2.35 (1.32)	3.47 (1.38)	4.40(56)	.02*(.3)
Item 22: Friends support	3.30 (1.36)	3.91 (1.11)	2.60(56)	.02*(.1)
Environment				
Item 8: Daily safety	2.88 (1.05)	4.04 (0.80)	7.53(56)	.01**(.5)
Item 24: Health services access	3.21 (1.19)	3.91 (1.12)	3.12(56)	.01**(.2)

Note. SV = Sexual violence; COM group = Comparison group; WHOQOL-BREF = World Health Organisation Quality of Life – Brief version; QoL = Quality of life. * $p < .05$, 2-tailed; ** $p < .01$, 2-tailed.

A similar pattern of significant differences was found between all but one of the items on the *Psychological* domain. However, interestingly, no significant differences were found with regard to the frequency of negative feelings, such as despair, anxiety and

depression. The two groups differed significantly on all three of the items of the *Social* domain, but on only two items of the *Environment* domain. Overall, the SV sample were exhibiting a significantly lower QoL than their COM group counterparts with the majority of deficits apparent in their physical, psychological and social well being as opposed to their physical environment and surroundings. The eta squared statistic revealed moderate to large effect sizes ranging from 0.13 (*Item 10*) to 0.76 (*Item 4*). Large effect sizes (ranging from 0.14 to 0.46) were found for all of the significant items in this scale.

7.4 Within group analyses: SV sample

Further analyses were undertaken to identify, in more detail, any potentially interesting patterns within the SV sample alone. These findings are presented below.

7.4.1 Relationships between background variables

First of all, a number of chi-square tests were undertaken in order to assess the nature and extent of any relationship between key background variables. These included: age; marital status; educational background; mental health history/diagnosis; problem drinking in the last 12 months; and the experience of SV (e.g. age at the time of the incident, time elapsed since the incident; and relationship to the perpetrator). Where necessary, these variables were collapsed into dichotomous (or 3-level) categorical variables (i.e. using the SPSS function to calculate appropriate cut-off points) (See Appendix 27) and several interesting and significant relationships were found (Table 7.9). Interestingly, one variable emerged as particularly salient - the extent to which the perpetrator of the SV was known to the victim.

7.4.1.1 Level of acquaintance with the perpetrator

Three significant relationships were found between the relationship of the perpetrator to the victim and: the age of the victim at the time of the incident; their current marital status; and history of a formal mental health diagnosis (see Table 7.9). In summary, significantly more younger than older women (≤ 22 years at the time of the assault) were raped/assaulted by individuals less well known to them (e.g. a stranger, acquaintance, friend, or workmate), although the strength of this relationship was weak ($\phi=0.001$). The participants were also significantly more likely to have received a formal diagnosis of a mental health problem at some point in their lives, if the

perpetrator was better known to them, although again, the strength of this relationship was weak ($\phi=0.028$).

The final significant finding to emerge from these analyses, related to the level of acquaintance with the perpetrator and participants' current marital status. Women who were assaulted by a current or previous partner or family member (i.e. someone more well known to them) at the time of the incident, were significantly more likely to be single, separated or divorced at the time of the study, while those who were assaulted by a stranger/acquaintance/friend/workmate (i.e. someone less known to them) were significantly more likely to be in a relationship currently.

Table 7.9: Chi-square analyses on the background variables for the SV sample (n=65): level of acquaintance with the perpetrator; age of the victim at the time of the incident; current marital status; and history of a formal mental health diagnosis.

Variable/Levels	Level of acquaintance with the perpetrator		χ^2 (df) (ϕ)
	Group 1 <i>Less known</i> n (%)	Group 2 <i>Well known</i> n (%)	
Marital status			
Group 1: NIR	15 (42)	22 (76)	6.33 (1) (0.34**)
Group 2: IR	21 (58)	7 (24)	
Age at the time of the incident			
Group 1: Younger (≤ 22 years)	28 (78)	10 (36)	9.88 (1) (0.43**)
Group 2: Older (≥ 23 years)	8 (22)	18 (64)	
History of a MH diagnosis			
Group 1: No MH diagnosis	21 (58)	9 (42)	3.78 (1) (0.27*)
Group 2: MH diagnosis	15 (31)	20 (69)	

Note. SV = Sexual violence; NIR = Not in a relationship; IR = In a relationship; MH = Mental health.
* $p \leq 0.05$, ** $p \leq 0.01$.

7.4.2 Relationships between trauma symptoms and other constructs/measures

All of the subscales from each of the measures were examined to determine if there were any relationships between the various constructs assessed as part of this study. A series of Pearson product moment coefficient (r) and Spearman's Rank order (ρ) correlations were undertaken and a number of significant relationships emerged. Preliminary analyses (e.g. examination of scatterplots) were performed in the first instance, to ensure no violation of the assumptions of normality, linearity and homoscedasticity. Where any violations did occur (e.g. to normality), the non-parametric alternative (ρ) was applied. The results of all of the significant correlations are presented in Table 7.10.

7.4.2.1 Recent mental health and trauma symptoms

The relationship between recent mental health (i.e. total GHQ) and Dysfunctional Sexual Behaviour (DSB), was investigated using Spearman's ρ correlation coefficient (the *DSB* distribution was very negatively skewed thereby violating the assumption of normality). A weak negative correlation was found between the two variables [$r = -0.27$, $n = 61$, $p < 0.05$], indicating that high levels of DSB were associated with lower levels of recent psychological distress. Only 9% of the variance in participants' scores on the GHQ could be accounted for by their scores on the *DSB* subscale.

7.4.2.2 Social support (ISEL) and trauma symptoms (TSI)

The correlational analysis of all of the ISEL sub-scales and the TSI subscales revealed only one significant relationship; there was a moderate negative correlation between the *Appraisal* subscale (i.e. which measures the perceived availability of someone to talk to about one's problems), and the AI clinical scale (i.e. which assesses the frequency of self-reported anger and irritable affect in the last six months) [$r = -0.30$, $n = 61$, $p < 0.05$], suggesting that high levels of anger and irritability were associated with lower levels of perceived social support in the form of people to talk to about one's problems. The coefficient of determination suggested that, as above, only 9% of the variance in participants' scores on the *Appraisal* subscale could be explained by their scores on the AI clinical scale.

Table 7.10: Showing the significant correlations found between the subscales of the GHQ-12, TSI, LES-N, and WHOQoL-Bref (n=61).

Measure Subscale	<i>Total</i>								
	<i>GHQ</i>	<i>DSB</i>	<i>AA</i>	<i>AI</i>	<i>DA</i>	<i>LES-N</i>	<i>PHYS.</i>	<i>PSYCH.</i>	<i>ENVIR.</i>
GHQ-12 <i>Total GHQ</i>									
TSI									
<i>DSB</i>	-.272*								
<i>AA</i>	.098	.171							
<i>AI</i>	.178	.277*	.572**						
<i>DA</i>	.087	.290*	.666**	.344**					
LES-M									
<i>LES-N</i>	.065	.321*	.453**	.128	.311*				
WHOQoL-Bref									
<i>PHYS.</i>	-.593**	.517**	.046	-.120	.147	-.021			
<i>PSYCH.</i>	-.673**	.371**	.028	-.166	.204	-.016	.648**		
<i>ENVIR.</i>	-.458**	.326*	.029	-.130	.185	-.056	.556**		

Note. GHQ-12 = General Health Questionnaire-12; TSI= Trauma Symptom Inventory; LES-N = Total negative change; WHOQoL-Bref = World Health Organisation Quality of Life – Brief version; DSB = Dysfunctional Sexual Behaviour; AA = Anxious Arousal; AI = Anger/Irritability; DA = Defensive Avoidance; PHYS = Physical domain; PSYCH = Psychological domain; ENVIR.= Environment domain. *p<.05; **p<.01, 2-tailed

7.4.2.3 Recent negative life events and trauma symptoms

Significant correlations were also found between the level of recent negative life stress and two of the hallmark posttraumatic scales of the TSI. A Spearman's rho correlation found that increased levels of negative life stress (LES-N) in the recent past were significantly associated with increased levels of anxiety and hyperarousal symptoms (AA) [$r = 0.45$, $n = 61$, $p < 0.01$] and avoidant thoughts and behaviours (DA) [$r = 0.31$, $n = 61$, $p < 0.05$]. This suggests that the women in this sample were responding to increased levels of recent negative life events with high levels of anxiety, and elevated attempts to avoid thoughts and stimuli that remind them of their trauma; however, it should be noted that the strength of these associations were both moderate. Partial

correlations controlling for LES-N were also performed to rule out the confounding effect of recent negative life stress but the differences were negligible, suggesting that recent negative life stress was having little effect on the strength of the relationships between these variables.

7.4.2.4 *Quality of life and trauma symptoms*

The significant correlations found between the domains of the QoL measure (i.e. WHOQOL-BREF) and one of the TSI scales, were perhaps the most surprising findings from these analyses. Moderate to strong positive correlations were found between the DSB subscale and the *Physical* domain [$r = 0.52$, $n = 61$, $p < 0.01$], the *Psychological* domain [$r = 0.37$, $n = 61$, $p < 0.01$], and the *Environment* domain [$r = 0.33$, $n = 61$, $p < 0.05$] of the WHOQOL-BREF. Calculations of the coefficient of determination were also conducted to determine the amount of shared variance between the DSB and scales of the WHOQOL-BREF. The largest was found between the *Physical* domain and the DSB, suggesting that participants' physical well-being explained more than one quarter (i.e. 27%) of the variance in participants' scores on the DSB scale. Overall, these findings suggest that higher levels of QoL in the form of physical, psychological and environmental well-being are associated with higher levels of problematic sexual behaviour in the last six months. This finding, which is somewhat counterintuitive, is explored further, later in this section.

Another significant, positive correlation was identified between the *Psychological* domain of the QoL measure and the Impaired Self-Reference scale of the TSI [$r = 0.28$, $n = 61$, $p < 0.05$]. The ISR scale measures problems with self-identity such as confusion and may indicate a relative lack of social support, although the strength of this relationship was weak. In fact, a calculation of the coefficient of determination suggested that psychological QoL only accounted for less than one per cent (0.08) of the variance in participants' scores on the ISR scale.

7.4.2.5 *Dysfunctional Sexual Behaviour: Standard multiple regression*

As mentioned above, perhaps one of the most counter-intuitive results from these analyses, were the positive correlations found between the DSB subscale of the TSI and the scales of the WHOQOL (i.e. the increased levels of psychological, physical and environmental QoL were associated with increased levels of dysfunctional sexual

behaviour). DSB was a core dimension and as also indicated in Stage Three (and briefly in Stage One) of this study, sexual relationships/intimacy was a fundamental problem in these women's lives.

A standard multiple regression was undertaken in an attempt to disentangle some of the possible influences on DSB, including the above aspects of QoL as well as two other variables. The two additional variables were the TSI sub-scales - SC (Sexual Concerns) and ISR (Impaired Self Reference); both of these variables have been highlighted in the TSI manual as possibly being elevated along with DSB in a typical profile. An impaired sense of self (ISR) also emerged as a salient consequence of rape/sexual assault at a number of junctures throughout this study, including the one-to-one interviews conducted during Stage Three.

It is also important to note that the distribution of the DSB subscale scores was very negatively skewed and attempts to transform the data or to remove outliers were unsuccessful in addressing the problem. All other assumptions (e.g. multicollinearity etc.) were met. Due to the sample size, it was not possible to include any more than four predictor variables (IVs) in the model (Pallant, 2001). Nonetheless, it was important to try to identify those variables that were most likely to influence the scores on the DSB scale. It is important to note, however, that this violation of normality prevents any generalisation of the findings beyond the study sample.

A standard multiple regression was performed between the dysfunctional sexual behaviour (DSB) subscale as the dependent variable and the physical and psychological domains of the WHOQOL-BREF and the SC and ISR subscales of the TSI. Table 7.11 displays the correlations between the variables, the unstandardised regression coefficients (B), the standardised regression coefficients (β), R^2 , and adjusted R^2 . The model was significantly different from zero ($F(3, 61) = 5.36; p < 0.001$) and the adjusted R^2 value of 0.50 indicates that approximately half of the variability in dysfunctional sexual behaviour scores is predicted by the physical QoL of participants and their levels of SC and ISR trauma symptoms. The Physical QoL subscale makes the largest unique contribution (0.36) to explaining the scores of the DSB when the variance explained by all the other variables in the model is controlled for.

The Beta values for the SC (0.33) and ISR (0.32) subscales are broadly comparable and all three variables made a unique and statistically significant contribution to the prediction of DSB scores. The size and direction of the relationships suggest that higher levels of physical QoL, SC and ISR are found in women with higher levels of dysfunctional sexual behaviour. The *Psychological* QoL variable does not make a statistically significant contribution to the model when the other variables are included, suggesting therefore, that the relationship between this dimension and DSB is mediated by the other two variables.

Table 7.11: Standard multiple regression of two QoL domains (Physical and Psychological) and trauma symptom variables (SC and ISR) on dysfunctional sexual behaviour (DSB)

<i>Variables</i>	DSB (DV)	Physical QoL	Psych. QoL	SC	ISR	<i>B</i>	<i>β</i>
<i>Physical Qol</i>	0.47					1.266**	0.36
<i>Psych. QoL</i>	0.39	0.63				-0.007	-0.00
<i>SC</i>	0.60	0.25	0.23			0.337**	0.33
<i>ISR</i>	0.54	0.11	0.28	0.57		0.341**	0.32
<i>Means</i>	5.57	11.95	12.08	9.39	12.03		
<i>Std. Dev.</i>	6.85	1.94	2.49	6.65	6.36		
						R ² = 0.54	
						Adjusted R ² = 0.50	
						R = 0.73***	

Note. QoL = Quality of life; Psych. = Psychological domain; SC = Sexual concerns subscale; ISR = Impaired self reference subscale; DSB = Dysfunctional sexual behaviour subscale.
** p<0.01, *** p<0.001,

7.4.3 Subgroup analyses

An additional series of t-tests and one-way ANOVAs (although none of the ANOVAs were significant) were conducted using the dichotomous categorical variables created

for the correlations, to ascertain the extent to which the scores of the various sub-groups within the SV sample differed significantly on any of the psychometric measures. The t-test is a relatively robust statistic and some violation of normality is well tolerated as long as the combined sample size of the groups being compared is > 40 (Moore & McCabe, 2003).

7.4.3.1 Age at the time of the incident

The 'age at the time of the incident' variable was divided into two groups (≤ 22 years and ≥ 23 years using the SPSS cut-off function) based on the frequency distribution of age at the time of the incident. A number of significant differences were found between these two groups on several of the measures, particularly with regard to QoL. As shown in Table 7.12, the older group (i.e. Group 2) were found to be experiencing significantly lower QoL in their physical, psychological and social well being than those who were younger at the time of the incident. They were also experiencing significantly more psychological distress (i.e. 'Total GHQ'). Furthermore, it is worth noting that the younger group obtained significantly higher scores on recent problematic sexual behaviour. This suggests that the younger that the women in this sample were when they experienced SV, the more likely they are to engage in dysfunctional sexual behaviour currently (or at least in the last six months). The effect sizes ranged from moderate to large with the smallest value being found on the *Physical* domain ($\eta^2 = 0.06$) and the largest on 'Total GHQ' ($\eta^2 = 0.14$).

7.4.3.2 Current age

The variable 'current age' was split into two groups in order to create a dichotomous variable suitable for an independent samples t-test. Group 1 included women who were currently aged ≤ 36 years whilst those aged ≥ 37 years were included in Group 2. Both groups were again compared on all measures and three significant differences emerged. Firstly, younger women (i.e. ≤ 22 years) obtained significantly higher scores on the *Appraisal* subscale ($M = 21.79$, $SD = 6.13$) than their older counterparts (i.e.) ($M = 18.13$, $SD = 7.90$; $t(62) = 2.08$, $p < 0.04$). Therefore, younger women in this sample were significantly more likely than older women, to feel that they had people in their lives to whom they could talk about their problems. Secondly, the younger women ($M = 23.27$, $SD = 5.34$) also scored higher than the older women ($M = 19.19$, $SD = 7.42$; $t(62) = 2.51$, $p < 0.02$) on the *Tangible* subscale of the ISEL, indicating that they felt

they had significantly more access to material aid and practical support than their older counterparts. This pattern was repeated with regard to overall social support ('Total ISEL'), which implies that the younger women ($M = 84.21$, $SD = 18.20$) in this sample felt that they had significantly more social support resources available to them than the older women ($M = 73.45$, $SD = 22.99$; $t(62) = 2.08$, $p < 0.04$). The magnitude of all of these differences was moderate ($\eta^2 = 0.06$, 0.09 and 0.06 respectively).

Table 7.12: Significant sub-group differences with regard to age at the time of the incident.

Domain/Subscale	Group	N	M (SD)	t (df)	Sig. (η^2) (2-tailed)
<i>Physical QoL</i>	1	38	12.33 (1.96)	2.04 (62)	0.05* (.1)
	2	26	11.34 (1.81)		
<i>Psychological QoL</i>	1	38	12.65 (2.11)	2.23 (62)	0.03* (.1)
	2	26	11.21 (2.80)		
<i>Social QoL</i>	1	38	12.21 (3.87)	2.14 (62)	0.04* (.1)
	2	26	10.05 (4.12)		
<i>Total GHQ</i>	1	38	3.74 (3.41)	3.16 (62)	0.00**(.1)
	2	26	6.65 (3.92)		
<i>DSB</i>	1	37	7.22 (7.96)	2.83 (58)	0.01* (.1)
	2	23	2.96 (3.56)		

Note. Group 1 = Younger at the time of the rape/assault (≤ 22 years); Group 2 = Older at the time of the rape/assault (≥ 23 years); QoL = Quality of life; GHQ = General Health Questionnaire; DSB = Dysfunctional Sexual Behaviour.

* $p \leq 0.05$, ** $p \leq 0.005$.

Lastly, the older women reported significantly more symptoms of depression during the previous six months (*Depression* subscale of the TSI) ($M = 14.48$, $SD = 6.85$) than those in the younger age group ($M = 11.22$, $SD = 5.43$; $t(59) = 2.07$, $p < 0.04$; $\eta^2 = 0.07$). In sum, the older women in this sample, when compared to their younger counterparts, were experiencing significantly lower levels of social support (specifically in their access to material aid and people they feel they can talk to about their problems), and significantly higher levels of depression during the previous six months.

7.4.3.3 *Current marital status*

With regard to marital status, a significant difference was found between those women who were currently in a relationship (IR) and those were not (NIR), on just one of the scales administered in the study. The former obtained significantly higher scores ($M = 12.76$, $SD = 4.38$) on the *Social* domain of the WHOQOL-BREF measure than those not currently in a relationship ($M = 10.20$, $SD = 3.46$; $t(63) = 2.64$, $p = 0.01$) (The eta-squared statistic (0.10) indicated that the magnitude of the differences in the means was moderate). This finding suggests that women who were single or separated/divorced at the time of the study, were significantly less satisfied with their personal relationships, their sex life and the support they received from friends, although the likelihood of this finding could not be ruled out in single/divorced women irrespective of their experiences of SV.

7.4.3.4 *Mental health history*

The largest number of significant sub-group differences were found when comparing those women with (Group 1) and without (Group 2) a formal mental health diagnosis (see Table 7.13). As shown in Table 7.13, those women who had, at some stage, been formally diagnosed with a mental health problem, were experiencing significantly lower QoL, particularly with regard to the psychological, social and environmental aspects of their lives. This group was also experiencing a significantly lower sense of social support across all four aspects of this measure (i.e. Appraisal, Tangible, Belonging, Self-Esteem). Conversely however, those without a formal mental health diagnosis (i.e. Group 1) appeared to be experiencing significantly more trauma symptoms on seven of the ten clinical scales of the TSI. The magnitude of the differences in the means for all of these findings was moderate to large and ranged from 0.06 on the *Social* domain to 0.16 on the *Anxious Arousal* (AA) subscale. No significant differences between the two groups emerged with respect to level of education; problem drinking in the last 12 months; time since the incident; or the victim's level of acquaintance with the perpetrator.

Table 7.13: Table showing significant differences between those with (n=29) and without (n=35) a mental health history.

Measure Subscale	Group	M (SD)	t (df)	Sig. (η^2) (2-tailed)
WHOQOL-BREF				
<i>Psychological</i>	1	12.78 (2.59)		
	2	11.58 (2.28)	1.97 (62)	0.05*(.1)
<i>Social</i>	1	12.41 (4.45)		
	2	10.44 (3.56)	1.97 (62)	0.05*(.1)
<i>Environmental</i>	1	14.40 (2.39)		
	2	12.94 (2.78)	2.22 (62)	0.03*(.1)
ISEL				
<i>Appraisal</i>	1	22.39 (8.16)		
	2	18.37 (5.83)	2.20 (61)	0.03*(.1)
<i>Tangible</i>	1	23.75 (6.04)		
	2	19.57 (6.66)	2.58 (61)	0.01*(.1)
<i>Self-Esteem</i>	1	20.54 (5.34)		
	2	17.91 (4.24)	2.17 (61)	0.03*(.1)
<i>Belonging</i>	1	20.79 (7.70)		
	2	17.43 (4.73)	2.02 (61)	0.05*(.1)
TSI				
<i>AA</i>	1	15.27 (5.62)		
	2	10.50 (5.12)	3.43 (58)	0.00**(2)
<i>IE</i>	1	14.88 (5.68)		
	2	11.21 (6.82)	2.22 (58)	0.03*(.1)
<i>DA</i>	1	16.27 (5.63)		
	2	11.18 (6.25)	3.27 (58)	0.00**(2)
<i>DIS</i>	1	12.88 (5.70)		
	2	8.53 (4.91)	3.18 (58)	0.00**(1)
<i>DSB</i>	1	8.23 (8.52)		
	2	3.71 (4.50)	2.46 (58)	0.02*(.1)
<i>ISR</i>	1	14.15 (5.68)		
	2	10.18 (6.33)	2.52 (58)	0.01*(.1)
<i>TRB</i>	1	6.96 (4.54)		
	2	4.79 (3.85)	1.99 (58)	0.05*(.1)

Note. Group 1 = No mental health diagnosis; Group 2 = History of mental health diagnosis; WHOQOL-BREF = World Health Organisation Quality of Life questionnaire – Brief version; ISEL = Interpersonal Support Evaluation List; TSI = Trauma Symptom Inventory; AA = Anxious Arousal; IE = Intrusive Experiences; DA = Defensive Avoidance; DIS = Dissociation; DSB = Dysfunctional Sexual Behaviour; ISR = Impaired Self-Reference; TRB = Tension Reduction Behaviour.

* $p \leq 0.05$, ** $p \leq 0.005$.

7.5 Summary of the key findings

A summary of the main findings is presented below and includes: (1) the main descriptive results for both of the groups in the sample (SV sample and COM group); (2) the significant differences between the two groups on the measures administered; and (3) selected significant results from the detailed within-group inferential analyses of the data.

7.5.1 Participant background profile

- Women in the SV sample had a mean age of 37 years and fewer than half were currently in a relationship. Six out of ten women had been educated to degree or postgraduate level and this was similar to the educational profile of the COM group. The COM group also had a mean age of 36 years, although more than three quarters were currently in a relationship.
- Fifty-four per cent of the SV sample had been formally diagnosed with a mental health problem at some point in the past, compared with just five per cent of the COM group.
- The average age of the women in the SV sample when they were raped or sexually assaulted was 23 years and it had been approximately 13 years, on average, since their most recent experience. Approximately one third had also experienced sexual abuse or SV before the age of 16.

7.5.2 Experience of SV

- Eight out of ten women in this sample were forced to have sexual intercourse without their consent. The vast majority were assaulted/raped by someone they knew (to a greater or lesser degree). In almost one third of cases, this was perpetrated by a current or ex-partner/spouse/boyfriend. More than three quarters reported minor or no physical injuries/consequences as a result of their assault.
- The majority of the SV sample had not attended a SATU in the three months after their experience, although virtually all had disclosed to somebody about what had happened to them.
- Nine out of ten women had attended counselling as a result of their experience, either privately or through an RCC and all but one rated they help they had received through the RCC, as helpful.

- Almost half of the SV sample had never contacted a RCC due mainly to personal (e.g. fear of not being believed) or service-related (e.g. no RCC in the area) issues.
- Participants stated that with regard to relationships in general, their ability to form intimate relationships was most affected by their experience. Sexual relationships were also rated as the area of their life that had been most negatively affected by their experience; however, some positive effects were noted with regard to aspects of their work life.

7.5.3 *Impact of SV*

- The SV sample had experienced significantly more negative life stress in the months leading up to the study and rated their overall QoL and satisfaction with their health as significantly lower than the COM group. They also reported experiencing significantly lower QoL than the COM group in the physical, psychological, social and environmental aspects of their lives.
- The women in the SV sample were also characterised by significantly higher rates of psychological distress in the weeks prior to the study and significantly lower levels of perceived availability of social support, including people to whom they could talk about their problems, access to material aid, and people with whom they enjoyed doing things. They also exhibited a significantly lower sense of self-esteem than their COM group counterparts.
- With respect to the experience of trauma symptoms in the recent past, the SV sample obtained above-norm scores on all 10 clinical scales of the TSI. These differences were found to be statistically significant when compared with a general population norm group. The women in the SV sample also obtained significantly lower scores on some of the scales when compared to the trauma history normative sample.
- Within group analyses of the SV sample found that those women who were more closely acquainted with the perpetrator, were significantly more likely to be older at the time of the rape/assault, were currently single or separated/divorced and had a mental health history.
- A series of correlations also found a number of significant relationships. Low social support in the form of someone to talk to about problems was found to be significantly associated with increased levels of anger and irritability.

- Significant positive associations were found also between levels of Dysfunctional Sexual Behaviour and physical, psychological and environmental well-being; in addition, lower levels of recent psychological distress as measured by the GHQ-12, were found in the high DSB group. Poorer psychological functioning, as measured on the WHOQOL, was also found to be associated with higher levels of confusion with self-identity (Impaired Self Reference).
- Recent negative life stress was significantly associated with increased levels of anxiety and hyperarousal symptoms, and avoidant cognitions and behaviours designed to reduce contact with distressing or painful stimuli. These findings were largely stable when recent negative life stress was controlled for.
- Those women, who were older at the time of the rape/assault, were experiencing significantly lower levels of physical, psychological and social QoL and higher levels of psychological distress, than those who were younger, although the latter were significantly more likely to be engaging in problematic sexual behaviours.
- Women in the SV sample, who were not currently in a relationship, had less satisfying personal relationships, sex life and support from friends, when compared to those who were in a relationship.
- The older women in this sample reported significantly more depression than the younger women and significantly lower levels of social support (e.g. practical and material support and people in their lives with whom they felt they could discuss their problems).
- Women in the SV sample with a mental health history obtained significantly lower scores than those without, with respect to psychological, social and environmental QoL and all aspects of social support. However, those without a psychiatric history obtained scores that were significantly higher on a range of trauma symptoms including: anxiety and hyperarousal; intrusive experiences; avoidant cognitions and behaviours; dissociation; dysfunctional sexual behaviour; impaired self-identity and confusion and tension reduction behaviours.

SECTION B: TWO ILLUSTRATIVE CASE STUDIES (SV SAMPLE)

This final section reports two case studies, both of which were selected at random from a pool of 'high' and 'low' scorers on the TSI. Scores at, or above *T65* on all of the TSI clinical scales, are considered to be clinically significant. Therefore, participants were allocated to one of two groups based on their TSI profile of scores. Those in the 'high scorer' pool (n=7) had TSI scores *at, or above T65*, on at least eight of the ten clinical scales whilst those in the 'low scorer' pool (n=28) had TSI scores *below T65* on eight or more of the clinical scales (Note: 26 participants failed to reach either of these criteria and thus were excluded from selection. One woman was then selected, at random, from each of the pools; their complete profiles are now presented in an attempt to illustrate the typical impact of SV in the lives of these women. Fictitious names are used in both cases to preserve confidentiality. (High TSI scorer - 'Audrey'; Low TSI scorer - 'Joanne'.) Interesting comparisons between the results of each on the main psychometric measures will follow, with a brief summary at the end.

7.6 Background information

Audrey (high TSI scorer) was a 44-year-old married woman with no children. She completed her education at Leaving Certificate level and at the time of the study, was working in administration. She reported consuming alcohol (an average of 7-8 glasses) only on special occasions and had never taken non-prescription drugs. However, her *RAPS-4* score indicated a high level of problem drinking in the last 12 months.

Audrey was 39 years old when a family friend raped her. She reported no history of sexual abuse, or sexual violence before the age of 16. Her assault resulted in severe injuries, including being knocked unconscious, broken bones and internal injuries. The first person she told about the incident was a close friend whose reaction she described as 'generally supportive'. She had contacted an RCC approximately one week after the assault and went on to attend weekly counselling there for up to three years. Overall, she found the counselling offered by her RCC '*very helpful*'. She also reported contacting Victim Support²⁶ and her GP for information, support and/or advice as a result of her experience. Furthermore, she attended for STI screening within three

²⁶ Victim Support provide emotional and practical support to all victims of crime.

months of the incident, but does not attend regularly and while she did not avail of emergency contraception, or the local SATU service post-assault, she did have a cervical smear, and currently attends for screening on a regular basis. She has never attended a colposcopy clinic, fertility clinic, Early Pregnancy Unit (EPU) or received psychosexual counselling.

Audrey was unemployed at the time of the incident and was not working either at the time of the interview. She felt that her experience of SV had impacted negatively (a 'fair amount') on her ability to secure and maintain employment, particularly in relation to her health. She also felt that her experience had had a considerable negative impact on her relationships with her parents, and siblings, and on her ability to form close friendships, and intimate relationships. Audrey reported no positive impact of her experience of SV in any area of her life and rated several areas of her life as having been very negatively affected. These include (in no particular order): her physical health (including sexual health); her self-esteem/self-confidence; her personal relationships; her sexual relationships; and her social life. Other areas which she described as having been moderately affected (negatively) included: personal finances; occupation/work life; mental health and everyday life. Overall, she reported that her experience of SV had a considerable negative impact on her life, but went on to state that she had achieved some positive benefits from the counselling which she had received. Audrey reported experiencing a number of positive and negative events during the six months preceding the study. She reported more negative events (9) than positive ones (4) including: loss of a job; major personal injury or illness; and major change in family living circumstances. The positive events included: a major change in the closeness of her family members and a major change in the usual type and/or amount of recreation or social activities. Audrey rated her overall QoL as 'good', but stated that she was very dissatisfied her current levels of health.

Joanne (Low TSI scorer) is a 33-year-old single woman with no children. She completed her education at degree level and is currently a student. She consumes alcohol (an average of 2 glasses) on a weekly basis and has never taken non-prescription drugs. In contrast to Audrey, her *RAPS-4* score suggested no problem drinking during the previous 12 months.

Joanne was 16 years old when the man for whom she was babysitting, sexually assaulted her (i.e. by putting his fingers in her vagina without her consent). She reported no history of sexual abuse or sexual violence prior to the age of 16, nor did she have any physical injuries or consequences as a result of her assault. The first person whom she told about the incident was a counsellor and she describes his/her reaction as generally supportive. She also went on to contact a RCC two to three years after the incident and received counselling there on a monthly basis, although she did not disclose for how long. Overall, she found the counselling she had received to be '*very helpful*'. She identified no other agencies (e.g. the Samaritans) that she had contacted for advice or support during the previous 17 years. Due to the nature of the assault, Joanne did not avail of emergency contraception nor did she attend the local SATU service, or attend for either an STI screening, or a smear test post assault; however, she reported that she currently attends for a regular cervical smear and STI testing. Similar to Audrey, she had never used any other sexual health services.

Joanne was attending secondary school at the time of her assault and while she did not take any time off from school in the six months after the assault, she reported that her ability to complete her education was slightly affected (i.e. 'a little') by her experience. As previously stated she is currently a student and not working and she did not feel that her experience had impacted on her ability to secure and maintain employment in any way. However, she did indicate that her experience has had some negative impact on her close relationships with her parents, and siblings, and also on her ability to form close friendships, and intimate relationships. She did not provide any information with respect to the overall impact of her experience of SV on various areas of her life and while she stated that her life has been negatively impacted to a small extent, the positive impact was greater. Joanne stated that she did not experience any events that had had a positive, or negative impact on her life during the previous six months. She rated her overall QoL as '*good*' but, in contrast to Audrey; she stated that she was very satisfied with her current levels of health.

7.7 Mental health and trauma symptoms

While Audrey indicated that she was formally diagnosed with a mental health problem at some point in the past, she did not provide any further details (e.g. type of diagnosis or treatment received). In relation to her recent mental health, she scored above the cut-

off point on the GHQ-12 (total GHQ score = 8) and was considered, therefore, to be in need of formal mental health intervention. For instance, she reported that she had been losing more sleep than normal over worry that she felt under constant strain rather more than usual and had been less able to enjoy her normal day-to-day activities. By comparison, Joanne had never been diagnosed with a mental health problem and negatively endorsed all of the items of the GHQ-12 (Total GHQ = 0). This indicates that she was not experiencing any psychological distress during the weeks preceding the study.

Based on the selection criteria described earlier, Audrey scored substantially higher than Joanne on every scale of the TSI; however, for illustrative and comparative purposes, this section focuses on the five scales with the largest differences. A profile of these scores is generated below and reported using interpretative guidelines from the TSI user manual (Brière, 1995). These guidelines indicate that, all but one (i.e. the *Depression* (D) subscale) of Audrey's scores, were above the point for clinical significance ($T \geq 65$). This means that she was reporting a level of trauma symptoms and exhibiting a degree of self-dysfunctional behaviours comparable with individuals who had received professional clinical treatment. Based on her transformed raw scores, she was experiencing clinically significant levels of dissociation (DIS), dysfunctional sexual behaviour (DSB) and impaired self-reference (ISR). According to Briere (1995), this particular profile (i.e. elevated levels of DIS in conjunction with elevated levels of ISR) is a fairly typical two-point elevation commonly seen in clinical groups. This pattern of responding is indicative of an individual with a reduced or altered sense of connection with her external environment, accompanied by an unstable self-identity. For example, she may present as someone unable to adequately express, or describe her feelings (or other internal events) and may appear to have a limited understanding of her own reactions or behaviours in certain situations (e.g. when she is under stress).

Audrey's stressor (i.e. the rape six years ago) was relatively recent which may account for this trauma profile which Brière states '*may indicate an individual who feels overwhelmed by trauma*' (1995:15). This supposition is supported by another multi-point elevation on Audrey's profile. Clinically significant scores are also present on the DSB and TRB subscales of the TSI. Brière (1995) suggests that, elevations on DSB (Dysfunctional Sexual Behaviour) indicate that an individual is attempting to reduce

contact with the posttraumatic distress. Furthermore, when elevations on TRB (Tension Reduction Behaviour) and DIS (Dissociation) occur in the same profile, that individual is attempting to externalize the distress. It is also possible that the typical behaviours of the DSB and TRB subscales are occurring in a dissociated state. For example, sexual behaviour may have a repetitive or automatic quality, or be too shame-inducing or socially inappropriate that it can only take place if Audrey is dissociated from the activity to some degree.

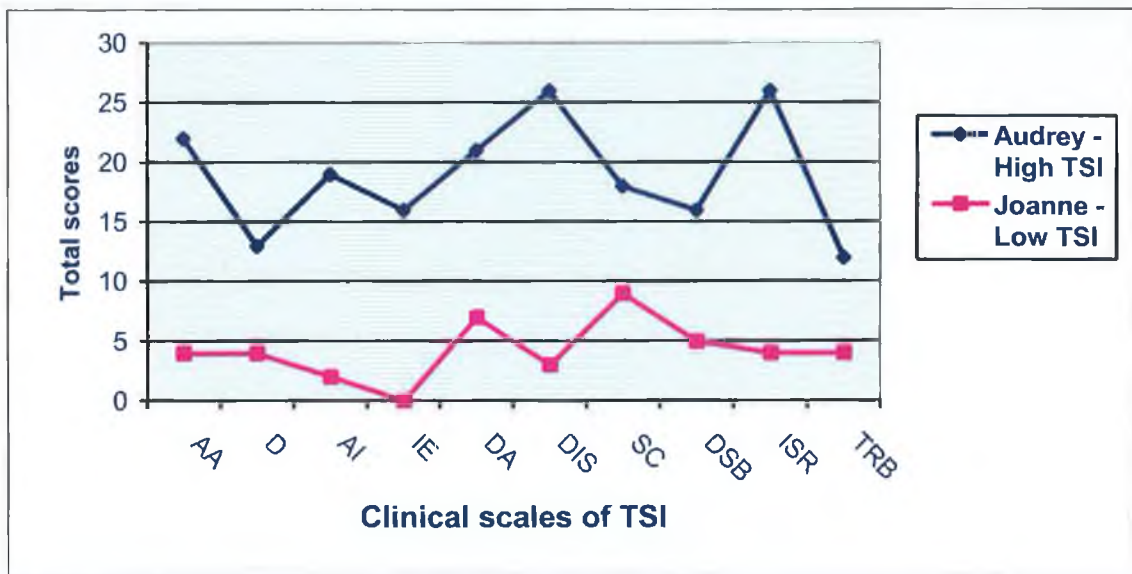


Figure 7.7: Line graph comparing the total scores from 'Audrey' and 'Joanne' on the ten clinical scales of the trauma symptom measure.

Note. TSI = Trauma Symptom Inventory; AA = Anxious Arousal; D = Depression; AI = Anger/Irritability; IE = Intrusive Experiences; DA = Defensive Avoidance; DIS = Dissociation; SC = Sexual Concerns; DSB = Dysfunctional Sexual Behaviour; ISR = Impaired Self-Reference; TRB = Tension Reduction Behaviour.

Joanne's trauma symptoms are much less severe than Audrey's, which may be a reflection of the less serious nature of her experience of SV (although this might be considered subjective), or the time that has passed since the incident. In fact, none of Joanne's scores, once transformed, reached clinical significance. However, it is worth noting that the highest scores recorded for Joanne were on the SC (Sexual Concerns), DSB (Dysfunctional Sexual Behaviour), and DA (Defensive Avoidance) subscales. This means, for example, that more than any other symptoms on the TSI, Joanne was engaging relatively frequently in avoidance responses, such as pushing painful thoughts from her mind, as a way of managing her posttraumatic distress. While not reaching

clinical significance, the two-point SC/DSB elevation present in her profile, is also quite typical in clinical practice (Briere, 1995).

While Joanne was experiencing sexual distress and engaging in problematic sexual behaviour to a considerably less degree than would be seen in a clinical population, these seem to be her most current and pressing issues, even 17 years after the event. This combination of symptoms might reflect an individual reporting little or no sexual enjoyment or satisfaction, while simultaneously engaging in considerable sexual behaviour. Conversely, Joanne may indeed derive enjoyment from her sexual activity, but may also experience substantial shame or conflict with respect to the dysfunctional aspects of her behaviour (Brière, 1995). Brière (1995) also suggests that individuals, such as Joanne, may be using sexual behaviour, or activity as a way of gaining attention, validation or distraction from internal distress.

7.8 Quality of life and social support

Joanne obtained higher scores on the WHOQOL-BREF than Audrey within all of the domains (see Figure 7.8). For instance, within the *Physical* domain, Joanne reported good levels of energy, and sleep as well as satisfaction with her ability to work and to perform her daily living activities. By contrast, Audrey appeared to have particular difficulties with her physical health (i.e. *Physical* domain) including a high level of dissatisfaction with: her sleep; her ability to perform daily living activities; and her level of energy for everyday life. In addition, she reported requiring an extreme amount of medical treatment to function in her daily life.

As shown in Figure 7.8, Audrey also appeared to be experiencing a lower QoL than Joanne with regard to her psychological health (*Psychological* domain), including an inability to concentrate and a lack of feeling 'satisfied with herself'. She only felt that she was moderately enjoying her life, or that it was meaningful and she also reported experiencing negative feelings (e.g. despair, anxiety, depression) 'quite often'. Joanne appeared to have good psychological functioning as she reported that she was enjoying her life very much and felt that it was meaningful. She had no difficulties with her concentration and was happy to a large extent with her bodily appearance. Overall, she

felt satisfied with herself and seldom experienced negative feelings such as despair, depression or anxiety.

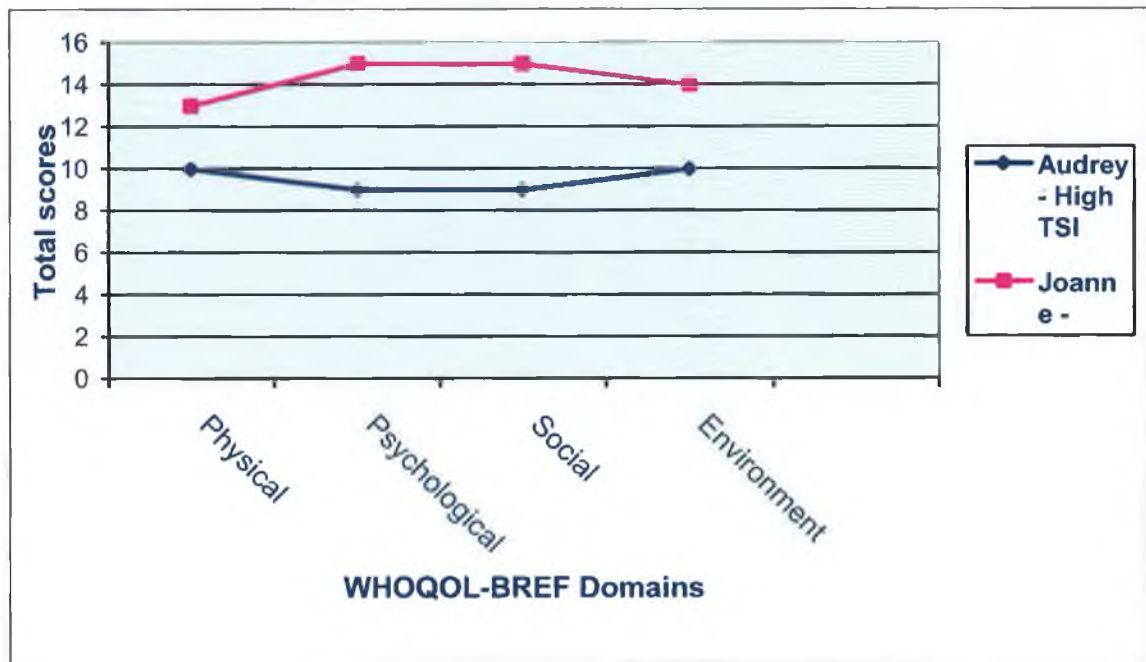


Figure 7.8: Line graph comparing the four WHOQOL-BREF domain scores of 'Audrey' (high TSI scorer) and 'Joanne' (low TSI scorer) Note. TSI = Trauma Symptom Inventory; LES-N = Negative life change; LES-P = Positive life change; WHOQOL-BREF = World Health Organisation Quality of Life questionnaire – Brief version.

A similar pattern was evident in the *Social* aspects of Joanne's life (*Social* domain), where she reported feeling very satisfied with her personal relationships and the support that she had received from her friends. However, she reported feeling some ambivalence with respect to her level of satisfaction with her sex life. By contrast, Audrey indicated that she was '*neither satisfied nor dissatisfied*' with the support she was receiving from her friends or her personal relationships. She also stated that she was very dissatisfied with her sex life. On the final *Environment* domain of the WHOQOL-BREF, Joanne's higher level of QoL is reflected in the increased sense of safety she was experiencing in her daily life and her healthy physical environment. Unlike Audrey, she is moderately satisfied with her access to money and health services and with her living accommodation.

With regard to social support - as measured by the ISEL, Audrey's scores on two of the four subscales were lower than those obtained by Joanne. While Audrey was experiencing lower social support in terms of self-esteem and people to whom she could talk about her problems, Joanne was experiencing particular difficulties related to the perceived availability of material aid (e.g. having someone that could drop you to the airport for an early morning flight) and people with whom she could do things.

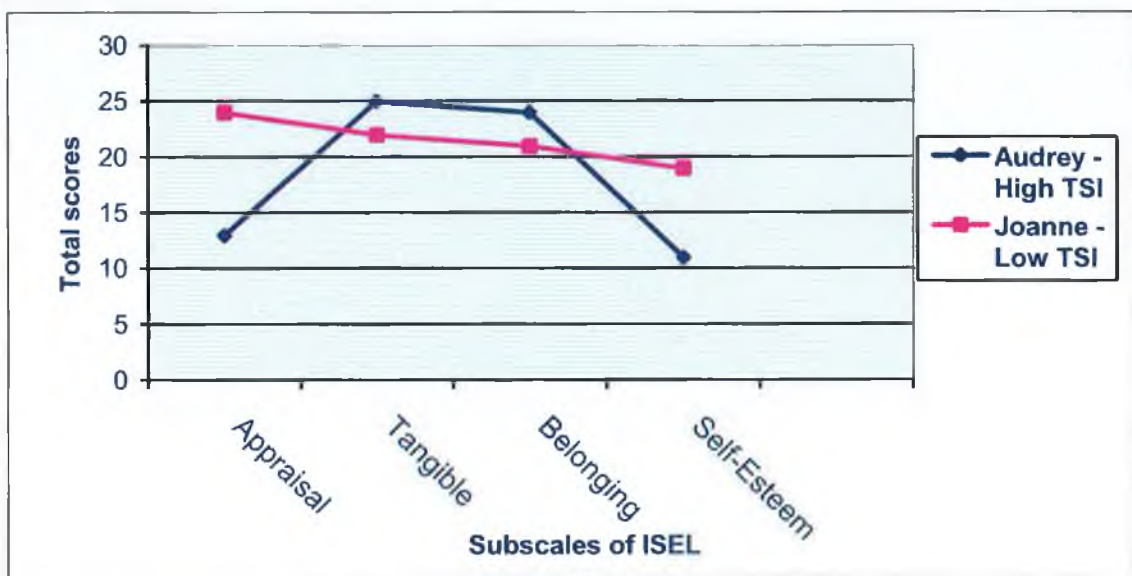


Figure 7.9: Line graph comparing the total scores of 'Audrey' and 'Joanne' on the four subscales of the ISEL.

Note. TSI = Trauma Symptom Inventory; ISEL = Interpersonal Support Evaluation List.

Particular difficulties highlighted within the *Appraisal* subscale, revealed that Audrey did not feel that there was someone to whom she could turn, for advice about her career, or finances. She described how she did not feel sufficiently comfortable with anybody to discuss intimate personal problems, nor was there anyone in her life currently; whom she felt could give her an objective view of how she was handling her problems. Joanne's scores here were almost twice those of Audrey (see Figure 7.9) and this was reflected in her strong sense that she had people to whom she can turn in a personal or family crisis. Unlike Audrey, Joanne had someone with whom she felt comfortable in discussing her intimate personal problems and someone from whom she could seek career or job advice.

Audrey also had lower levels of self-esteem than Joanne and felt that there was nobody in her life who took pride in her accomplishments and that most of her friends were “more interesting” than her. There was a marginal difference between the two participants on the *Belonging* and *Tangible* subscales of this measure. Nonetheless, according to Audrey’s responses and in contrast to Joanne, she felt there were more people in her life with whom she could do things. For example, Audrey was confident that she was included by her circle of friends and that she was often invited to do things with others whereas Joanne was unsure that this was the case in her life.

In sum, Audrey, in comparison to Joanne, reported experiencing lower levels of social support in terms of the availability of someone to whom she could talk about her problems (*Appraisal*) whilst she also did not feel positive about herself in comparison to others. Joanne appeared to have access to substantially more people from whom she could seek advice and support, particularly with regard to her personal problems. She also showed a greater sense of self-esteem in terms of how she saw herself when compared to others. Thus, the social support deficits for Joanne seem to manifest in the availability of material assistance and people with whom she can share activities and interests.

7.9 Summary

In sum, Audrey showed some level of problem drinking during the previous 12 months and appeared to be experiencing a substantial level of psychological distress in the weeks prior to the study. This is reflected also in a high incidence of negative events experienced by her during the previous six months. By contrast, Joanne reported no problem drinking, positive or negative life events, or severe psychological distress in the recent past.

Both women felt that their experiences of SV had negatively impacted on their relationships with their family, and their ability, to a greater or lesser degree, to form close and intimate relationships/new friendships. While both felt their overall QoL was good, Audrey reported feeling very dissatisfied with her general health and was experiencing a lower QoL across all aspects of her life including her physical, psychological, social, and environmental well-being. Interestingly, in contrast to Joanne, Audrey perceived a greater availability of social support resources although her

scores were substantially lower than Joanne with regard to her levels of self-esteem and people to whom she felt she could talk about her problems.

The trauma profiles of both women are interesting in that, irrespective of (or perhaps as a result of) the type of incident, or time elapsed since the incident, both women were experiencing trauma symptoms to a greater or lesser extent. For example, Audrey's TSI scores were clinically significant across all subscales whilst Joanne appeared to be experiencing particular difficulty in relation to the sexual aspects of her life. She recorded symptoms and behaviours (albeit at low levels) suggestive of someone who was engaging in problematic sexual activity with little or no associated pleasure or satisfaction. In contrast, Audrey's pattern of trauma symptoms reveal someone who is feeling possibly overwhelmed by the effects of her rape and who subsequently dissociates as a means to reduce and/or avoid upsetting and distressing internal states. Her sense of identity and perception of self also appeared to be significantly affected, a fact which is likely reflected in her lowered self-esteem score from the social support measure. While some of Audrey's trauma symptoms may be exacerbated by her recent levels of psychological distress, ill-health, and her experience of a range of other negative life events (e.g. losing her job), her trauma profile is distinctly similar to a typical clinical presentation. Furthermore, while Joanne reports no recent negative life changes or psychological ill-health, she was still exhibiting pervasive and measurable levels of sexual dysfunction almost two decades after the event.

All of these findings will be discussed in Chapter Ten, in conjunction with findings from the other stages of this study.

Chapter Eight

Method III: Stage III

CHAPTER EIGHT

Method III: Stage Three

8.1 Stage Three: An overview

As outlined earlier, the third and final stage of this study involved a series of in-depth qualitative interviews with a reduced sub-sample of participants (who had agreed to be interviewed) in order to explore in detail their experience of sexual violence and its impact on their lives. Their need for, and views of, service provision were also elicited, as well as any stigmatising experiences to which they may have been exposed. As in all qualitative research, the aim of recruitment was to reflect as far as possible, the experiences, attitudes and views of all participants and, therefore, to facilitate adequate conceptual generalisations. Recruitment was carried out as part of Stage Two, during which 'consent to be contacted again' was obtained from participants.

8.2 Participants and settings

Sixty-one of the 69 participants who returned, or completed questionnaires in Stage Two, provided contact details and their consent-to-be-contacted using Follow-up Interview cards (see below and Appendix 20). All of these Follow-up Interview Cards (see on) were then assembled and a list including contact details, addresses, email, and phone number(s) of all interested participants (n=61) was compiled. Information regarding their mode of participation (postal or face-to-face) and their preferred mode of contact (as indicated by previous contact) was also noted. Finally, two lists of eligible participants (one postal (P), one face-to-face (FF)) were compiled using participants' unique code number only. The three control variables used to frequency match the comparison group in Stage Two (i.e. *age*, *marital status* and *education*) were also employed here. Each was collapsed to create a dichotomous variable (e.g. Marital status was collapsed into those in a relationship (IR) and those not in a relationship (NIR)) to yield a total of eight possible combinations/groups (see table in Appendix 28). The numbers from both lists were then allocated to one of these eight groups according to the various combinations of variables.

Once each participant had been allocated to one of the eight groups, they were further divided according to their mode of participation during Stage Two (i.e. those who had

participated on a face-to-face or postal basis). This was undertaken to control for any response bias and to ensure, therefore, that there was no differences between those who had/had not previously met with the researcher. Once the sampling list was complete, one *FF* and one *P* participant from each of the eight groups was then selected at random. The researcher then returned to the original list of participant contact details in order to initiate contact with each eligible participant.

It was thought appropriate to select two people (at random) from each of the eight groups in order to generate a sub-group of interviewees that could be considered sufficiently representative of the sample as a whole and yet not so large that the chosen analytical approach - Interpretative Phenomenological Analysis (IPA) (see on) - would no longer be appropriate (personal communication with Dr Jonathan Smith, developer of IPA; June, 2008). By the time the fifteenth interview had taken place, the researcher was confident that information saturation had been reached and so no further interviews were conducted

All of the 16 participants (eight *P*, and eight *FF*) who were initially contacted agreed to take part in an interview, although only 13 were available to complete the interviews due to time constraints, prior commitments and unexpected life events (e.g. one participant broke her wrist). Consequently, a further three women were selected at random from the list and contacted, two of whom agreed to complete the interview; the third did not respond. This resulted in a final sample of 15, with at least one participant representing each of the groups outlined previously

8.3 Materials and measures

A *Participant Interview Schedule* (PINS) (Appendix 29) was devised following a review of the literature and also on the basis of information gathered during Stage Two. The design of this schedule was also influenced by the proposed analysis technique (IPA) (e.g. Smith, 1996; Smith, Flowers & Osborn, 1997). Further details on this are provided below. A range of questions was devised and put in the most logical order. While sensitive questions are normally not asked at the beginning of an interview, it was most logical in this instance, to ask participants about their experience of SV first, before exploring its impact on their lives. Furthermore, on advice of the developer of

IPA, Dr Jonathan Smith (personal communication), it was felt that this was appropriate as participants were well aware in advance of the nature and purpose of the interview.

The questions were grouped under four main headings – *Experience of sexual violence; Impact of the experience of sexual violence; Experience of disclosure and services; and Research feedback*. All of the questions were open-ended and prompts and probes were also noted where needed. The schedule included questions on: interviewees' experience of SV; their immediate feelings and experiences; their contact with formal services/agencies (e.g. Gardaí, medical personnel, RCCs etc.); to whom they disclosed and their reactions; their coping strategies; their experiences of counselling (if any); the perceived impact of SV on different areas of their lives; the most difficult aspect of their experience; and their services they wish had been in place for them at the time of the incident. Feedback on their participation in the research process was also sought in order to: gauge participants' motivation for engaging in the research; assess their experiences of the research process; and probe their hopes as to how the research findings might be used. Modified versions of the Information Sheet and Consent Forms used in Stage Two were also used here.

A digital voice recorder (Olympus Digital Voice Recorder VN-2100PC) was used to record all of the interviews (with consent), after which the audio files were immediately transferred onto a laptop (with restricted password-protected access). The transcription of all interviews was facilitated by a voice recognition software programme called *Dragon Naturally Speaking (Version 9.5)*. This can be used to transcribe aural material by the researcher speaking into a microphone. This programme then produces the spoken words in text form on the computer.

8.4 Procedure

After completing the questionnaires in Stage Two, all participants were asked if they would be interested in taking part in the next stage of the study. Follow-up Interview Cards were designed and printed on a firm A4-size card in a different colour from the rest of the questionnaires. This made them readily identifiable so that they could be stored separately from the rest of the participants' data. The information included on the card provided reassurances that the women were simply agreeing to be contacted in the future about the next stage of the study and that they were under no obligation to

participate. If they agreed, they were instructed to provide as little, or as much detail with which they were comfortable, in order that they could be subsequently contacted by the researcher.

Each participant was then contacted by phone/email/text. This reminded them of their previous participation and of their consent to be contacted. They were also told that they were not obliged to take part if they did not wish to do so. They were then invited to participate in a one-to-one interview at a convenient time and location. This contact process was staggered over a number of weeks to ensure that the researcher would be able to respond adequately and within a reasonable time to potential participants. Interviews took place either in the participants' homes, or an alternative quiet, location generally chosen by the participant (e.g. hotel lobby). The researcher travelled to the location of the participant in all but one case (this participant, at her own request, met the researcher at the university campus). Interviews typically lasted one to two hours.

Each interview began with some 'lead in' questions, after which participants were asked to read an Information Sheet and provide their written informed consent (including their permission for the interview to be recorded) before recording began. Prior to the interview, the participants were given a list of questions to be covered. It was thought that this would be a useful visual tool to keep the interview 'on track' when required, whilst also ensuring that participants felt as comfortable as possible in advance. A significant amount of time was allowed for each of these interviews due to the sensitive nature of the subject matter (All relevant participant and researcher ethical issues are discussed in detail in the ethics section of Chapter Four). As in the case of Stage Two, the researcher 'closed' the interview appropriately and referrals to support services were made, if deemed necessary (e.g. if a participant commented on, or it was obvious that the interview had raised a lot of, issues or distressing emotions). Participants were then thanked and a follow up phone call was arranged for the following day.

All but one of the interviews were transcribed verbatim by the researcher (using *Dragon Naturally Speaking Version 9.5* – voice recognition software) and prepared for analysis (this process is described in the next section). A single interview, which was conducted in a public place (i.e. in the bar of a hotel early morning), had to be excluded from the analysis due to the poor quality of the recording.

8.5 Data analysis: *Interpretative Phenomenological Analysis (IPA)*

The data consisted of typed transcripts of audio-recorded interviews with participants (n=14), all of which were edited for purposes of clarity and subsequently analysed using Interpretative Phenomenological Analysis (IPA; Smith, 1996; Smith et al., 1997). The data were ideally suited to this form of analysis for a number of reasons. Firstly, one of the main aims of the research was to expand our traditional notions of the impact of trauma above and beyond the, arguably limited, parameters of the DSM-IV-TR PTSD diagnosis. While the DSM diagnosis is undoubtedly useful, there may be a substantial loss of meaning and associated understanding, by solely adhering to this model. Thus, IPA aims to explore the experience of the participants from their own individual perspective (Willig, 2001). It involves a systematic analytical process designed to probe, in detail, the ways in which participants strive to make sense of their own experiences (Brocki & Wearden, 2006). However, it recognises that an exploration of these experiences must necessarily implicate the researcher's own view of the world, as well as the nature of the interaction between researcher and participant (Willig, 2001: 53). Therefore, the results of the analysis will always represent an interpretation of what the participant has experienced (Willig, 2001).

IPA is strongly idiographic, meaning that the analysis process begins with the detailed and complete examination of one case before moving onto the next one (Smith, 2004). It is also inherently inductive in that it is a flexible technique that allows unanticipated themes to emerge during analysis (Smith, 2004). Smith also states that one of the central tenets of IPA is '*to make a contribution to psychology through interrogating or illuminating existing research*' (Smith, 2004:43). Although it differs, to a large extent, from mainstream psychology (e.g. in its epistemological assumptions or methodological practices), it still shares constructs and concepts that allow and even facilitate an active and constructive dialogue with this field (Smith, 2004).

As recommended by the authors, the data were collected using a semi-structured interview schedule containing mostly open-ended questions and utilising a non-directive interview style (Brocki & Wearden, 2006). The purpose of this is to allow participants to share their experiences with the researcher about the topic under investigation and '*specific questions should be used to encourage participants to elaborate rather than to*

check whether they agree or disagree with particular claims or statements' (Willig, 2001:54). Smith (2004) posits that a detailed nuanced analysis using IPA, is only possible with small samples and comments that many studies report sample sizes of between five and ten. This type of analysis is better suited to a relatively small sample size, as other researchers purport that the analysis of large data sets with this method, could lead to the loss of 'potentially subtle inflections of meaning' (Collins & Nicolson, 2002:626)

Transcripts were initially analysed individually and notes made in the margins of each. This type of detailed reading is undertaken in order to obtain a holistic perspective of the participant's account of the impact of SV, thereby ensuring that later interpretation remains as close to this account as possible. Initial themes were then identified from these notes, organised into clusters and checked against the data. These were largely guided by the questions of the Interview Schedule and the psychological concepts and abstractions underpinning them. The next stage involved the refining and condensing of these themes and a close examination of any connections between them. As recommended by the authors, these were then used to produce '*a narrative account of the interplay between the interpretative activity of the researcher and the participant's account of her experience in her own words*' (Smith & Eatough, in Creswell, 2005: 333). Once this process had been repeated for each of the 14 transcripts, a table of themes was devised and each compared for convergence and divergence. This facilitates a higher level of analysis of the data leading to a richer and more enhanced account of the participants' experiences. Once the final themes were identified, suitable comments were selected from the data to illustrate the relevant themes.

8.6 Researcher reflexivity and IPA

Reflexivity is concerned with the interaction between the researcher, the research and the research participants (Holloway, 2005). At the core of this concept, is the implication that researchers exercise '*self-awareness, critical evaluation and self-consciousness of their own role*' at every stage of the research process (Holloway, 2005:279). In qualitative research, the researcher is the main research instrument and, as such, they have a central role in the inferences and conclusions drawn from the data (Holloway, 2005). While appropriate training can enhance researcher reliability by promoting fidelity to the analysis technique (e.g. this researcher completed introductory

and advanced workshops in IPA in the summer of 2008), an articulation of the researchers' position with respect to the topic being studied, their experiences, and any assumptions and values they might have that may influence data collection and analysis, is critical in order to allow the reader to discern how they arrived at a particular interpretation of the data (Merriam, 2002).

The method of IPA inherently acknowledges the role, and potential influence, of the researcher in the interpretation of the raw data (Smith, 1996). The IPA process is both '*phenomenological* (that is, it aims to represent the participants' view of the world) and *interpretative* (that is, it is dependent upon the researcher's own conceptions and standpoint)' (Willig, 2001:67). Whilst IPA demands a reflexive attitude from the researcher, guidance on how to demonstrate this in reporting results has not been made explicit (Willig, 2001). For purposes of enhancing the reliability and validity of the findings reported here, a statement of the researcher's perspective is provided below.

8.6.1 Researcher's perspective

The researcher (CK) had previously been involved in a voluntary programme designed to respond to the needs of victims and their families in the event of an airline incident. This prompted a growing interest in trauma and its effects. While conducting a preliminary literature review in the field of PTSD, prior to designing the research proposal (and as part of her undergraduate degree), the researcher discovered that the highest incidence of PTSD occurred in women who had experienced SV. At the time, SV research in Ireland was virtually non-existent and a natural field of inquiry presented itself. CK's readings and awareness of SV and related issues was supplemented by involvement with a support service for victims of SV and a personal desire to understand and represent the true impact of this crime. In order to control for the impact of the researcher's preconceived ideas and assumptions (e.g. that all the effects that women experience after SV, are negative), a series of 'checks and balances' (such as those described in section B of Chapter Four) were incorporated into the relevant stages of the research.

The following chapter presents the results of the Stage Three qualitative interviews.

Chapter Nine

Results III: Stage III

CHAPTER NINE

Results III: Stage Three

This chapter presents the findings from a series of one-to-one in-depth interviews conducted with a reduced sub-sample of women (n=14); all had experienced SV and had agreed to take part further in the study. The objectives of this part of the study were to explore in detail, participants' experiences of SV and their subjective views on its impact on their physical and mental health, relationships, quality of life and overall well-being, as well as their views and experiences of post-assault services. Extensive background information on the sub-sample is presented first (Section A) including information on their most recent experience of SV, their relationship to the perpetrator and their experience of disclosure (as in Chapter 7). This information is also compared, where appropriate, with the larger sample as a whole, in order to provide some insight into the extent to which those who took part in this final stage of the study, were broadly representative of those who participated in the research as a whole. The results from the qualitative analyses are then presented in Section B. A range of key themes and sub-themes was identified from the data, all of which are accompanied by illustrative quotes.

SECTION A: SAMPLE DESCRIPTION

9.1 Participant profile

The women in this sub-sample were typically aged in their late thirties (M=39; SD=8.1; range 29-53 years) and were not currently in a relationship (n=4). Eight women had children, six of whom had one child; the remainder had two and three children respectively. Further demographic information is presented in Table 9.1. This information is juxtaposed, for purposes of comparison, with that for the larger SV sample (i.e. excluding the 14 participants here) (n=51).

9.2 Physical and mental health

9.2.1 Mental health status

While more than half of the larger sample had been diagnosed with a mental health problem at some point, more than two-thirds of this sub-sample (n=10) reported that they had received a formal mental health diagnosis. The average time that had elapsed

since their diagnosis was approximately five and a half years ($M = 68.43$ months, $SD = 70.32$ months); that is, more than two years longer than the mean for the sample as a whole ($M = 31.31$ months, $SD = 61.69$ months). Their diagnoses included depression and/or anxiety ($n=8$), work-related stress ($n=1$) and PTSD ($n=1$). Two of the women

Table 9.1: Demographic information on the sub-sample ($n=14$) and the SV sample ($n=51$)

Variable	Stage 3 Sub-sample n (%)	SV sample n (%)
<i>Women with children</i>	8 (57)	25 (49)
<i>Current marital status</i>		
<i>Single</i>	7 (50)	18 (35)
<i>Steady relationship</i>	1 (8)	8 (16)
<i>Living w/partner</i>	2 (14)	8 (16)
<i>Married</i>	1 (8)	7 (13)
<i>Separated/Divorced</i>	3 (20)	7 (13)
<i>Other</i>	---	3 (7)
<i>Education level</i>		
<i>Junior Cert.</i>	---	1 (2)
<i>Leaving Cert.</i>	---	7 (14)
<i>Post Leaving Cert/RTC</i>	2 (14)	9 (18)
<i>University degree</i>	3 (22)	14 (28)
<i>Post-graduate qualification</i>	7 (50)	16 (31)
<i>Other</i>	2 (14)	4 (7)

Note. SVS = Sexual violence sample

reported multiple diagnoses of depression and anorexia and depression and 'nervous disability' (participant's own words). All of the women with a mental health history had been prescribed anti-depressants (or some other unspecified medication), four of whom had received no other form of treatment. For the remainder, medication was accompanied by counselling, therapy and/or alternative therapies, such as meditation and yoga.

9.2.2 Alcohol and drug use

All but one of the women, who took part in this stage of the research, reported that they consumed alcohol (n=13). In most cases, this was either every few days (n=4) or on a weekly basis (n=5) while a smaller minority indicated that they drank alcohol either fortnightly (n=2) or monthly, or only on special occasions (n=1 respectively). No one reported consuming alcohol on a daily basis. The average consumption of alcoholic drinks per sitting/occasion was just over three drinks (M = 3.14, SD = 2.07) which was slightly less than the mean for the sample (n=51) as a whole (M = 4.51, SD = 4.38).

Four women reported currently using drugs and typically on a daily basis (n=3). The fourth participant currently using drugs indicated that this was not on a regular basis. Furthermore, six of the women indicated that they had used drugs at some point while the same number again, stated that they had never used non-prescription drugs. Marijuana was the drug of choice for two of the women in this sub-sample while another reported using sleeping tablets and pain killers and the other, over-the-counter pain medication (i.e. *Neurofen Plus*).

9.2.3 Sexual and reproductive health

With respect to their sexual and reproductive health, most of the women in this sub-sample were attending for regular cervical screening (n=11) whereas very few (n=3) (and substantially less than those in the main sample (n=10)) reported getting checked for STIs on a regular basis. They had also attended a range of sexual and reproductive clinical health services in the time since their most recent experience of SV. For example, equal numbers of the sample had attended an Early Pregnancy Unit (EPU) and for psycho-sexual counselling (n=2 respectively). One participant reported attending an eating disorder clinic and a psychiatric outpatient clinic (on two occasions). Another had attended a fertility clinic whilst the largest single proportion had attended a colposcopy clinic at some point in the past (n=5).

9.3 Experience of sexual violence

The average age of participants at the time of their most recent experience of SV was 23 years (M = 23.00, SD = 6.62) (as in the larger sample). The youngest participant, at the time of their rape/sexual assault, was 16 years; the oldest was 35 years old. All but one of the women had been forced to have vaginal intercourse, and in some cases alongside

another type of sexual assault, whilst half had sustained some form of physical injury as a result of the incident. Further information is provided in Table 9.2 and again, juxtaposed with information on the larger sample. As can be seen from the table, similar proportions from the main sample and the sub sample were raped/assaulted by a stranger, as opposed to someone with whom they were acquainted. In addition, substantially more women in this sub sample (than the main sample) obtained emergency contraception and/or attended for STI screening post-assault.

The mean time elapsed since the incident of SV for the women in this sub-sample was just over 15.5 years ($M = 189.57$ months, $SD = 137.42$ months) compared to approximately 12.5 years for the sample as a whole ($M = 152.84$ months, $SD = 120.28$ months). The most recent assault had occurred in the last 12 months, while the longest period of time since the incident was 38 years. Most of the women indicated that they had not had an experience of SV before the age of 16 years, nor had they experienced any childhood sexual abuse ($n=11$ respectively).

9.3.1 Experience of disclosure

Two of the women in this sub-sample (and the only two in the entire sample) had never told anyone about their experience prior to taking part in this study. Typically, the most likely person to whom the women had disclosed was a friend ($n=6$), or a family member (e.g. sister or mother) ($n=4$). Only two participants had disclosed to professionals (i.e. a RCC counsellor and a doctor). In nine cases, the women in this sub-sample reported the initial reaction to their disclosure as '*generally supportive*'; the remainder were either ambivalent ($n=4$) or negative about the reaction they had received.

9.4 Service utilisation: Counselling and follow-up support

All but four of the women had attended for private and/or RCC counselling, which took place typically on a weekly basis and lasted, on average, for just over two years ($M=27.79$ months, $SD=33.70$) (Table 9.3). Further specific information was obtained on the women's experiences of RCC counselling due to the central role of these centres in helping women (and men) who have experienced SV. As previously indicated, six of the nine women who had received counselling in the past had been in contact with an RCC counsellor. While one woman reported contacting her local RCC immediately after the incident, the remainder had waited between five months and 36 years to make

Table 9.2: Table presenting background information for both the Stage 3 sub-sample (n=14) and the larger SVS sample (n=51)

Variable	^a Stage 3 sub-sample n (%)	^a SV sample n (%)
<i>Type of incident</i>		
<i>Forced vaginal intercourse</i>	13 (93)	44 (86)
<i>Forced oral sex</i>	3 (21)	13 (26)
<i>Forced anal sex</i>	1 (7)	17 (33)
<i>Fingers in vagina</i>	4 (29)	20 (39)
<i>Object in vagina</i>	1 (7)	10 (20)
<i>Relationship to perpetrator</i>		
<i>Stranger</i>	2 (14)	8 (16)
<i>Acquaintance</i>	2 (14)	9 (18)
<i>Friend</i>	---	4 (7)
<i>Workmate/Colleague</i>	---	3 (6)
<i>Someone you were/had been on a date with</i>	3 (21)	2 (4)
<i>Boyfriend</i>	3 (21)	4 (7)
<i>Spouse/Partner</i>	---	5 (10)
<i>Ex-boyfriend</i>	1 (7)	3 (6)
<i>Ex-spouse/partner</i>	1 (7)	---
<i>Other</i>	2 (14)	13 (26)
<i>Physical injuries/consequences</i>		
<i>None</i>	7 (50)	21 (41)
<i>Minor (e.g. bruises)</i>	3 (22)	19 (37)
<i>Severe (e.g. internal injuries)</i>	2 (14)	5 (10)
<i>Sexually transmitted infections</i>	1 (7)	1 (2)
<i>Pregnancy</i>	1 (7)	2 (4)
<i>Other</i>	---	---
<i>Medical services post-assault</i>		
<i>Emergency contraception</i>	10 (71)	11 (22)
<i>SATU</i>	0 (0)	7 (14)
<i>Cervical screening</i>	2 (14)	5 (10)
<i>STI Clinic</i>	4 (29)	9 (18)
<i>Other</i>	---	4 (8)

Note. SV = Sexual Violence sample; SATU = Sexual assault treatment unit; STI = Sexually transmitted infections. ^a = All of these variables allowed participants to endorse more than one item; therefore the figures in both of these columns take account of those women who endorsed more than one item (e.g. forced vaginal intercourse and forced anal sex).

contact. In all but one case, there was a waiting list for counselling with an average waiting time of almost two months ($M = 1.86$ months, $SD = 3.61$) (comparable to 3 months for the larger sample). The overwhelming response to this waiting period was one of desperation and frustration. For example, one participant, who reported one of the shortest waiting periods, commented that it had taken her such a long time to reach out and ask for help, that when she did, she had reached her breaking point and needed help immediately, rather than having to wait a further four weeks.

Table 9.3: Table presenting information for both the Stage 3 sub-sample (n=14) and the SVS sample (n=51) on the number of women who attended counselling, and the nature of this counselling (i.e. private or through a RCC).

Variable	Stage 3 sub-sample n (%)	SV sample n (%)
<i>Attended counselling</i>		
Yes	10 (71)	46 (90)
No	4 (29)	5 (10)
<i>Type of counselling</i>		
Private	4 (40)	19 (41)
RCC	3 (30)	14 (30)
Both	3 (30)	13 (29)

Note. SVS = Sexual violence sample; RCC = Rape Crisis Centre.

Most of the participants indicated that they had found the counselling offered by the RCC 'very helpful' (n=4) whilst only one woman reported that it had not been helpful at all. This was the only one woman in the entire sample to endorse this response and her reasons for doing so were reported earlier in Chapter Seven. The most commonly cited reasons (n=7) for *not* attending RCC counselling, were largely personal in nature, such as feeling to blame for the incident, feeling ashamed or embarrassed, fear of not being believed, or a belief that the assault was not sufficiently important to warrant counselling. Only two women referred specifically to a lack of information around the availability and appropriateness of services.

Nine women reported that they had contacted other agencies and organisations for information, advice and support following their experience (Table 9.4). Almost equal proportions of this group had sought support from professionals (e.g. GP) and voluntary support agencies (e.g. The Samaritans) while two had gone to friends and/or a work colleague for support and advice.

9.5 Impact of SV

The impact of participants' experience of SV on their lives was also assessed by examining their responses to a series of closed- and open-ended questions. The responses from these were collated into categories relating to education and employment, relationships and overall impact. The findings for this sub sample were found to mirror the pattern observed in the larger sample; therefore, the tables presenting this information are provided in Appendix 30.

Table 9.4: A selection of the other agencies and professionals contacted for information and support as a direct result of the experience of SV (n=14)

Name of Agency/Type of professional	Frequency¹
<i>An Garda Síochána</i>	3
<i>Mental health professional</i>	4
<i>Samaritans</i>	3
<i>G.P.</i>	3
<i>Women's Aid/Other domestic violence support service</i>	3
<i>Private counselling service</i>	1
<i>Community drugs team</i>	1
<i>Social worker</i>	1

Note. Gardai = National Irish police force; Samaritans = A voluntary support service for people contemplating suicide; G.P = General practitioner/Doctor; Women's Aid = The national Irish domestic violence support and advocacy service.

1. Respondents may cite more than one type of service

9.5.1 Results from psychometric measures

In order to avoid repetition, a brief summary of some of the key findings on the psychometric measures for this group will now be presented. An assessment of recent alcohol and drug use indicated that three quarters of those who consumed alcohol (75%; 9/12) had engaged in problem drinking in the last 12 months while all three participants who reported using drugs currently scored positive for problematic drug use in the last 12 months. This sub-sample appears to have experienced slightly lower rates of desirable and undesirable events in the recent past when compared to the overall sample and similar to the main sample, they rated their overall QoL higher than their satisfaction with their health. They exhibited an identical profile to the overall sample with respect to their levels of QoL across all domains whilst they also appeared to be experiencing similar levels of perceived social support in terms of material resources and people in whom they can confide when they have a problem. However, in contrast to the main sample, they appear to be experiencing a slightly lower level of personal self-esteem and a marginally higher level of social support with respect to people with whom they can enjoy activities and interests.

Fewer women in the sub-sample scored at, or above the cut-off point for recent psychological distress, suggesting that less women in this group were experiencing elevated levels of recent psychological distress when compared to the main sample. The level of trauma symptoms in this sub-group was broadly similar to that of the overall sample, although this group seemed to be experiencing marginally higher levels of anxiety and anger-related symptoms as well as more intrusive experiences, such as flashbacks or nightmares. They also appeared to be experiencing slightly fewer sexual difficulties and distress than the main sample, and fractionally less instances of dysfunctional sexual behaviour.

9.6 Summary

- The women who participated in the Stage Three interviews (n = 14) were typically in their late 30s and most were not currently in a relationship; almost two-thirds had pursued their education to degree or postgraduate level.

- Almost all consumed alcohol on a regular basis while a small minority reported habitual current drug use. In virtually all of these cases, instances of problem drinking and problematic drug use were reported during the last 12 months.
- Approximately two thirds had been diagnosed with a mental health problem in the past; this figure was marginally higher than that obtained for the overall sample (54%).
- At the time of their experience, the mean age of the women in this sub sample was 23 years with an average of 15 years having passed since the incident, while only a small minority had any history of SV prior to the age of 16 years.
- Most of the women in this sample had been forced to have sexual intercourse and in almost all cases, the perpetrator was known to them. While half of the sample reported no physical injuries or consequences as a result of being raped or assaulted, none had attended a SATU unit post-assault.
- While all but two had told someone about what had happened to them, almost two thirds had attended counselling either privately, or at a RCC, on mostly a weekly basis for an average of two years. In most cases, there was a waiting list for counselling at the RCCs, which the majority of participants found very difficult and distressing.
- Participants felt that their intimate relationships had been more negatively impacted by their experience than their close relationships with their family and friends or their ability to form close friendships.
- Overall, and in line with findings for the larger sample, they felt that their sexual relationships and mental health were the areas of their lives that had been most negatively affected, followed closely by their self-esteem and physical health.
- All of the women felt that there had been some negative impact in their lives, overall, as a result of their experience, although a substantial number also felt there had been some degree of positive impact.
- For the most part, the pattern of scores on the psychometric measures was broadly similar to the overall sample.

SECTION B: THE IMPACT AND EXPERIENCE OF SEXUAL VIOLENCE

Qualitative findings

Several key themes and sub-themes were identified from the data, each of which is described and illustrated here using selected quotes. These findings support and amplify the quantitative results reported earlier. As expected, the interviews were necessarily long and very wide-ranging and it was beyond the scope of this part of the study to present an exhaustive analysis of the large amount of rich data collected here. Instead, the analysis was guided, in the first instance, by the central aim of this stage of the research, which was to assess the experience and impact of SV in the lives of Irish women. Secondly, a number of anticipated and emergent themes/sub-themes were explored in an attempt to expand and challenge, at least in part, the application of the traditional post-traumatic model as an explanation of women's response to SV.

Another important aim of this study was to yield findings that could be potentially used to inform policy and practice in this area and enhance our understanding of the impact of SV in women's lives. The results presented here, strongly reflect the inherently inductive nature of the analysis technique employed (IPA) (Smith, 1996). Six superordinate themes were identified, in total, virtually all of which comprised more than one sub-theme; these sub-themes were all closely inter-related, thereby reflecting the complexity of women's reactions to their experience. (See Table 9.5).

9.7 Theme 1: Reactions to the experience of sexual violence

The first theme focused on the psychological and emotional reactions of the women in the immediate aftermath of their experience. Clear patterns emerged in relation to the types of cognitive and behavioural strategies used to cope with the emotional and psychological turmoil experienced in the days, weeks, months and, sometimes years, following their experience. The interviewees clearly identified many of the expected reactions (e.g. PTSD-related symptoms) to their experiences, such as shock, disbelief, dissociation, fear and anger (Please see Appendix 31 for a selection of illustrative quotes). However, the analysis reported here, focused deliberately on the kinds of, coping strategies employed by these women to cope with the impact of their experience. This is important because it shows how the lack of appropriate coping strategies can

Table 9.5: Table showing the six superordinate themes and associated sub-themes that emerged from the one-to-one interviews (n=14)

SUPERORDINATE THEMES	SUB-THEMES	DESCRIPTION
<i>1. Reactions to the experience of SV</i>	(i) Ineffective coping strategies employed by participants	Participants used avoidance and distraction techniques to cope with their experience of SV (e.g. alcohol/drugs, preserving normality, risk-taking behaviours etc.)
<i>2. Impact of the experience of SV</i>	(i) Psychological and emotional consequences (ii) Problems with intimacy and sexual relationships	The impact of the experience on participants mental health (e.g. depression, PTSD), and their sense of self-worth, self-esteem etc. The impact of the experience on achieving and maintaining loving and sexually intimate relationships
<i>3. Service utilisation</i>	(i) Experiences of medico-legal services (ii) RCC counselling and other counselling experiences	Participants' experiences of medical and judicial services Participants' experiences of RCC and private counselling services
<i>4. Disclosure</i>	(i) Barriers to disclosure (ii) Encouraging disclosure	Obstacles identified by participants that prevented or discouraged them from disclosing their experience (e.g. stigma, fear, societal reactions) Factors and issues that participants felt would encourage them to disclose their experience (e.g. non judgemental approach, normalising their experience)
<i>5. Recovery and healing</i>	(i) Use of internal and external resources (ii) Advice for possible future victims of SV	Internal and external resources that participants felt had helped them in their recovery The most important information any future victims of SV should have
<i>6. Experiences of participating in research</i>	(i) Reasons for participation (ii) Experiences of the research process (iii) Suggestions for improvement	Participants' motivation for taking part in the research Participants' experiences of the research process, and feedback on the materials and techniques used Participants comments on and suggestions for, research methods

often compound the negative impact of an experience of SV. This sub-theme is described below and is accompanied, where applicable, by illustrative (anonymised) quotes.

9.7.1 Ineffective coping strategies employed by participants

The most common immediate reaction to the experience of SV was very often one of confusion, followed quickly by disbelief and denial (Please Appendix 32 for a selection of quotes in relation to this). Participants spoke about the shock they felt immediately after the incident and this was, in some cases, more acute when the perpetrator was personally known to them. Invariably, there was considerable confusion, to the extent that participants were often unable to name their experience as ‘rape/sexual assault’ for some time afterwards. This corroborates the findings from Stage One in which the stakeholder participants alluded to the reluctance - or perhaps more accurately, an inability on the part of victims to name their experience as rape - as a significant barrier to accessing appropriate services. Interviewees regularly talked about blaming themselves for what had happened and operating almost on ‘automatic pilot’ in the immediate aftermath (and sometimes longer term). This denial and self-blame was a core response to the incident for many of the women and the following comments provide an indication as to how this was articulated:

‘I went around afterwards like as if nothing happened...and I was, like, nothing happened...no nothing happened. It was, like, I was in denial or something.’ (A 38-year-old woman, raped by her boyfriend when aged 24)

‘...instead I just wrote it off as nothing and carried on as though it never happened.’ (A 32-year-old woman raped by someone with whom she was on a date when aged 18)

‘I didn’t want to talk about it. I didn’t want to think about it myself. I was so busy clamming up, pretending like it didn’t happen...trying to convince myself...trying to block it out.’ (A 40-year-old woman raped by a family friend when aged 18)

‘It was complete and utter denial of everything around it up until like 10 years later...[this] is the first time I actually ever thought about it and thought about the effects.’ (A 29-year-old woman raped by an acquaintance when aged 20)

When emerging from their experience, many women described carrying on their lives as if nothing had happened, both immediately, and in some cases for years, afterwards. They described their efforts in terms of preserving a sense of normality. The goal of this appeared to be two-fold. Firstly, if they could pretend that everything was normal and convince those around them that everything was normal, then they themselves could be 'normal', in spite of what had happened. Secondly, if they could prevent other people from finding out what had happened, they could avoid having to face up to it and also avoid being judged negatively by others. The fear of being seen as a 'victim' was palpable in many of these interviews and the stigma associated with being a rape victim, is discussed later in the context of the *Barriers to disclosure* sub-theme (Section 9.10.1). The efforts made by these women in order to maintain this façade were exhaustive and, in some cases, involved changing jobs, travelling to avoid coming home and throwing themselves into their work. This projected perception of normality appeared to be a critical coping mechanism for several of these women, as illustrated by some of the following comments:

'It's like this inward screaming in your head...outside you're carrying on a normal life but you're living in this kind of bubble and nobody has an idea...you feel like you're putting up such a charade...like you're presenting one side to normal everyday life and then inside [it's a different story] ...' (A 40-year-old woman raped by a family friend when aged 18)

'I think I went to mass the next morning and I went back...I was in nursing school and I went back that night...but I just covered it up as best I could...' (A 53-year-old woman raped by someone with whom she was on a date when aged 17)

'I couldn't come home because I thought everybody would know...I thought everybody would see it straight away when I came home so...I kept travelling, I kept moving...I just couldn't face it at that stage.' (A 42-year-old woman raped by a stranger when aged 22) (This participant travelled for 9 months before coming home after being raped abroad)

'You become a kind of super normal...looking back it was probably a bit super normal...if everything is normal around me then it didn't happen...yes, if everything is perfect then everything will be fine, [and] then it didn't happen.' (A 36-year-old woman raped by her ex-boyfriend when aged 33)

'Certainly in the day after it...it was like that happened but it didn't happen and I just wanted to be back in love the way I was before this morning...' (A 36-year-old woman raped by her boyfriend when aged 35)

Another relatively common coping mechanism used by the women to avoid, or distract themselves from the emotional upheaval of their experience, involved the use of excessive amounts of alcohol and/or drugs and, perhaps counter-intuitively, in a number of cases, engaging in sexual risk-taking behaviours. While not all women engaged in alcohol and drug use as a coping strategy, those who did, remarked that this was their way of escaping, even just for while. The following remarks sum up some of these experiences:

'That [the rape] was the starting point of destructive behaviour for me...certainly I drank too much and I never ever touched drugs...but yeah, I definitely drank too much and I was always sort of thrill-seeking...' (A 32-year-old woman raped by someone with whom she was on a date when aged 18)

'I was using cocaine, I was smoking like weed all the time...I was taking drugs all the time...during the day, all day. I used to go out and I'd be like just off my face constantly...' (A 30-year-old woman raped by a stranger when aged 24)

'I was an alcoholic at the time as well. A lot of drugs...drugs was the main thing...it still is...I still need a smoke and If I don't have it, then I'll be suicidal...it's the only thing that makes it go away.' (A 30-year-old woman raped by an acquaintance when aged 22)

'I went to college and I threw myself into drugs and booze...I took anything that was going.' (A 36-year-old woman raped by someone at a party she was attending when aged 18)

As stated earlier, the reasoning behind many of these reactions was multi-faceted. While alcohol and drugs appeared, albeit temporarily, to act as effective numbing agents to the overwhelming feelings of participants, the increased level of sexual risk-taking behaviours (e.g. having sex with multiple partners) seemed to arise for different reasons. Some women described their sexual activity post-assault as a reflection of their low-self esteem and self worth where they no longer cared about themselves and putting themselves in risky situations, therefore, was inconsequential. One or two of the women also described an overwhelming sense of guilt or regret about their behaviour during this time. The following extracts illustrate some of these points:

'I'd no intention of sleeping with a man...[but] I went and got the pill and that started me on a cycle of finding men and going home with them and having sex on that first night...even I started doing a line, I would have sex very early...usually the first night in the relationship...I didn't know you were supposed to hold back.' (A 53-year-old woman raped by someone with whom she was on a date with when aged 17)

'I ended up sleeping on the beach which seems so crazy but it just shows...I didn't care what happened to me at that stage...I didn't care at all. I did more dangerous things than I probably did in my life because I was just... 'what difference does it make?'' (A 42-year-old woman raped by a stranger when aged 22)

'I slept with anybody that was willing...and even put myself in lots of really dangerous situations...down the canal with a bottle of vodka going 'Come and get me!'...I don't care what happens. I continued for another couple of years just boozing and sleeping around.' (A 36-year-old woman raped by someone at a party she was attending when aged 18)

'It still bothers me that I would have been sexually callous...that bothers me...that will probably always bother me.' (A 32-year-old woman raped by someone with whom she was on a date when aged 18)

While the reactions of women to their experience and the manner in which they coped in the aftermath, were unique to each interviewee, there were undoubtedly some commonalities. The above analysis shows that, very often, the strategies employed, while effective in the short-term, have the potential for negative long term sequelae for women, which only serve to compound and exacerbate the initial devastating impact of a sexually violent act. For example, Allsworth, Anad, Reding and Piepert (2009) found that the incidence of STIs was significantly associated with a higher number of sexual partners during the previous month in a sample of women (N=542) with, and without, a history of physical and sexual violence. While this is, in no way, intended to attribute blame or responsibility to participants for their actions, it does underline the importance of effective support systems for these women following the assault, as well as the development of appropriate education and awareness raising around the impact of SV in contemporary society.

9.8 Theme 2: Impact of the experience

A second superordinate theme - and one related to the above and also a central aim of the study - focused on the impact of the experience of SV on the lives of these women. The interviewees were very clear and expansive with regard to those areas of their lives which had been most affected by their experiences. Throughout the interviews, they alluded to the negative effects on their: mental health; physical health; emotional well-being; self-esteem and self-confidence; family relationships and friendships; and sexuality and sexual intimacy. While many of these could be easily subsumed within the context of a 'PTSD' explanation or framework for women's 'typical' reactions to SV, some of them are often, if not omitted, glossed over. Therefore, while the main

effects recounted by these women (e.g. depression, mental health problems, insomnia, panic attacks etc.) are included here (and illustrated with quotes), the two broad sub-themes highlighted for purposes of this analysis, include the effects on psychological and emotional well being (i.e. providing support for the trauma response model) and issues related to personal and sexual relationships (i.e. expanding the trauma response model).

9.8.1 Psychological and emotional consequences

Most participants mentioned that they had experienced, or were currently experiencing mental health problems, such as depression, anxiety, PTSD, and addiction problems. This supports the quantitative findings reported earlier which showed that 54% had been formally diagnosed with a mental health problem. This finding is also consistent with the literature on PTSD and its relatively high co-morbidity with other psychiatric disorders (e.g. Kessler et al., 1995; Kessler et al, 2005). Anxiety was common, as were panic attacks and flashbacks and nightmares - often considered to be a PTSD hallmark symptom (Davison et al., 2004). These symptoms were, in some cases, accompanied by sleep disturbance, whilst episodes of depression were reported consistently across the sample. In addition, a smaller number of women mentioned that, at times after the assault, they had experienced auditory and visual hallucinations and feared that they were “*going insane*”. Appendix 33 presents a representative selection of comments detailing some of the effects on mental health.

Another commonly reported problem amongst most of the women in this sub-sample was suicidal ideation and, for a smaller number, parasuicide (See Appendix 34). While only one participant described the actual attempts that she had made to take her own life, most reported an almost passive, but pervasive wish to die, some for many years after the assault. Some remarked that while this desire was quite strong at times, it was rooted in an overwhelming need for their pain and suffering to cease. However, perhaps the most insidious and devastating impact in terms of their psychological well-being (and the main focus of this sub-theme), was the impact on their self-identity and self-esteem. Participants described the negative effects of their experience on their sense of self, in terms of: (a) how they identified themselves as a woman, or even as a worthwhile human being; (b) their body image and the associated impact on how they dressed; and (c) their self-confidence and how they failed to pursue their life or work goals. Two

participants, in particular, mentioned the impact on their body image, with one of them explaining how her choice of clothes is influenced by her desire to avoid any male attention:

'For me it was such a gradual thing...chipping away the person that you were...you just wake up one morning and you don't know who you are...you just get to the point where nothing matters...nothing about me matters...you don't even like your body image...you don't like anything about yourself...' (A 46-year-old woman raped by her ex-spouse when aged 35)

'You know the kind of normal stuff where you notice men looking at ya? In terms of my build, I should be wearing something lower cut rather than here [indicates her neck]...but very low cut things...no...I can't...so I think it has impacted on my body image...definitely...' (A 47-year-old woman sexually assaulted by someone with whom she was on a date when aged 20)

Other women found that their confidence in their abilities to conduct their everyday lives was negatively affected. For some, the detrimental impact on their self-confidence meant that, irrespective of their success in their professional lives, they never quite believed in their own ability. For instance, one woman felt that she would have made wholly different choices in her career, had her self-belief not been so damaged. The following selection of comments clearly illustrate some of these points:

'Well I lost a lot of confidence certainly since that happened...in my abilities to do anything...I would have felt totally incapable of doing anything other than just the day-to-day basics...that took a huge knock...confidence-wise...' (A 36-year-old woman raped by her boyfriend when aged 35)

'Even to this day, I still see my background as being that story [the rape]...I can not describe who I am now without being honest and open about all of that. Even professionally like...I still had this belief that I was nothing and worth nothing...' (A 36-year-old woman raped by someone at a party she was attending when aged 18)

'I could have possibly made a lot of very different decisions in my life...I wouldn't have been afraid to go for stuff...I wouldn't have held back as much as I do...deep down I think 'I'm not worthy'... it [the rape] stunted my personal growth and my development and it was like it compounded everything I'd always believed [in]...' (A 40-year-old woman raped by a family friend when aged 18)

'I had to totally go and re-discover myself...I was just broken. I call them the lost years...I didn't know how to do anything for myself...like I didn't develop as a person.' (A 46-year-old woman raped by her ex-spouse when aged 35)

While intuitively, it might be expected that a woman's sense of self-esteem would be negatively affected by such a traumatic experience, this cause-and-effect relationship would appear to be infinitely more complex than at first expected. For example, as one participant remarked, if a woman's first sexual experience is rape or sexual assault, then the development of her sexual identity and sense of boundaries are irrevocably altered. According to some of the responses of the interviewees, being mistreated and made to feel worthless in a sexual context, can sometimes initiate a pattern of sexual behaviour that only causes the woman even more distress and damage in the longer term. For instance, some of the interviewees in this study alluded to a pattern of behaviour whereby they had multiple sexual partners, and a cycle of abusive relationships. Two women, one who was a virgin when she was raped and the other who experienced SV both as a child and as an adult, described the kind of effects this had on their later sexual experiences and their ability to be sexually assertive:

'I was kind of forced into a maturity that wasn't there when this guy violated me...I didn't know anything about boundaries...I thought that what this guy did was normal. I mean whatever self-esteem I had leaving home as a virgin...I fell down into this pit of sex...and I think my promiscuity became almost the norm for me...' (A 53-year-old woman raped by someone with whom she was on a date when aged 17)

'I would have been getting myself into situations where I became sexual with people and kind of saying [to herself]... 'How did this happen...how did I get here?'...so no clear sense of boundaries about... 'I'm ok with this, I'm not ok with that'... or even knowing that I could say no...' (A 47-year-old woman sexually assaulted by someone with whom she was on a date when aged 20)

The sense of worthlessness felt by these women was profound and several noted that who they were, as a person, was virtually determined by that one single act. Some of the participants reported experiencing the impact of this rape/sexual assault at the very depth of their person and, based on their comments this impact on their sense of self is perhaps the one that was most salient overall. The selection of representative quotes below eloquently captures these sentiments:

'My self-esteem was completely and utterly robbed...it was on the ground and it's probably something I never really picked back up. Trusted friends of mine would say to me... 'God you've no idea how much you have going for you' ...I don't see it.' (A 40-year-old woman raped by a family friend when aged 18)

'I feel like I don't really exist...it's cost me the basis of myself as a person...[and] the loss of your dignity and self-respect and self-esteem...I doubt my own ability to do things because of things that have happened.' (A 30-year-old woman raped by an acquaintance when aged 22)

'It broke my world...I feel I have a fault line in me as a person and it happened that night and I've no doubt about that...there's definitely a flaw in your psyche, in your soul, in your body...' (A 42-year-old woman raped by a stranger when aged 22)

'I felt this had such a huge impact on my life in an ongoing sense...it's not the most important thing...it's part of what happened but it's not all of who I am...[but it] certainly contributed to making the person that I am.' (A 47-year-old woman sexually assaulted by someone with whom she was on a date when aged 20)

One particularly striking comment by a 30-year-old woman who had been abused as a child (by a neighbour) and subsequently raped on more than one occasion as an adult succinctly captures the impact of these experiences on her life:

'I know life is confusing for everyone but it seems to be a lot more confusing [for me]...it [SV] destroys a part of you that is supposed to work and everyone takes it for granted...it's like the connection between your brain and your heart and your soul...when you get raped or assaulted, it's just gone...it's like something snaps and it's gone.' (A 30-year-old woman raped by an acquaintance when aged 22)

Many of the effects described here by women, in terms of their mental health and other psychological consequence, provide additional support for the PTSD framework in understanding women's responses to SV. However, the most devastating impact appears to have been on their self-identity and self-esteem. Whilst a disturbance in self-esteem often lies at the core of mental ill health, participants were very clear that this had led to a significant additional burden in their lives following the assault. Clearly, the impact of their experience had led to a pervasive and enduring ripple effect in their lives that contributed cumulatively to the negative effects of their original experience.

9.8.2 Problems with intimacy and sexual relationships

The interviewees also reported negative effects on relationships with family members, children and close friendships (Please see Appendix 35 for a selection of quotes related to these). However, perhaps not unexpectedly, the relationships most affected were those with the opposite sex; here, the interviewees reported multiple problems in their relationships with men and with sexual intimacy. Likewise, the findings in Chapter

Seven for the entire sample showed that respondents ranked their sexual relationships as the most negatively affected area of their life. Thus, this second sub-theme is concerned with the impact that SV has had on participants' ability to secure and maintain successful and contented intimate relationships (in all cases this refers here to heterosexual relationships, although some degree of transferability might be expected with same-sex couples).

Interestingly, when interviewees were asked what had been most difficult for them in dealing with the trauma of their experience, five of them mentioned relationships and related issues (e.g. intimacy, trust etc.). Participants reported that the most painful and enduring negative effects on their lives - over and above the impact on their mental and physical health - had been the effect on their ability to have normal, healthy, relationships. Although perhaps not exclusive to this group, trust, and sexual/ emotional intimacy were very often issues with which they struggled when embarking on a new relationship post-assault. Furthermore, these were often compounded by their fear, or distorted views, of men, their overwhelming fear of emotional intimacy and of beginning a sexual relationship as well as decisions about whether or not they should disclose their experience of SV. The reality for many of these women was that they often had to re-visit these issues at the beginning of every new relationship thereby causing the pain and distress to be resurrected each time – as illustrated by the following comments:

'I suppose initially the intimacy issue...you know when I would meet somebody new...it was something I would always worry about...it's like you relive it and you have to keep explaining yourself and trying to be understood and wondering if you're going to be believed.' (A 40-year-old woman raped by a family friend when aged 18)

'I think the hardest now is relationships...I still can't...I've never been able to get into one...I want to be able to have a relationship but I can't.' (A 30-year-old woman raped by a stranger when aged 24)

It should be noted, though, that several of the women were clear that not all of their experiences with men (pre- and post-assault), either as friends or as partners, were negative and many had happy and rewarding relationships. Additionally, while a small number of women reported experiencing a fear of men after their experience, this was by no means the case for all women in this sample. Nonetheless, for those women that

did experience this overwhelming negativity, they found certain everyday interactions to be extremely difficult, as illustrated by the following comments:

'I was so afraid of men after that...say I'm walking down the road and I see man coming up in the distance I'd actually cross the road...I couldn't even walk past a man. And if I caught somebody looking at me...to me that means I'm going to be attacked.' (38-year-old woman, raped by her boyfriend when aged 24)

'I think the most difficult part for me was that it left me fearful of all men...seeing all men as a potential threat...' (A 47-year-old woman sexually assaulted by someone with whom she was on a date when aged 20)

Women typically recounted avoiding men's company for various periods of time (i.e. from months to years) after the assault and attempting to avoid attracting their attention (e.g. not dressing in a revealing manner). As indicated earlier, some of the sexual encounters, which these women were having after the incident, were not always desirable and perhaps not conducive to developing trusting and respectful relationships with men. Another pattern seen with some of the women in this sub-sample, was a tendency to end up in abusive relationships that further compounded their poor impression of men and their low opinion of themselves. For example, four women in this sample had married men (or were already married to them at the time of the rape) who had abused them physically and/or sexually and they describe, in the following comments, the impact of this on their future relationships:

'It's left me very distrustful...I've only had one relationship since [she separated from her abusive husband]...I nearly became a recluse...it's something [relationships] I always have to really work and take time with...' (A 46-year-old woman raped by her ex-spouse when aged 35)

'My chances of succeeding in marriage were pretty poor because of the way I began my sexual history [she was a virgin when she was raped]. I always went for men who were a challenge...if they weren't hurting me verbally, they were hurting me physically...' (A 53-year-old woman raped by someone with whom she was on a date when aged 17)

'I've probably gone to the other extreme with men...I would be hugely intolerant, over controlling, very dominant. I couldn't make a relationship last to save my life...I have convinced myself of that.' (A 36-year-old woman raped by her boyfriend when aged 35)

'I don't know what a healthy relationship is like, where I haven't been threatened...as I said, I'm 55 and this has been going on since I was 15...I was just turned 16 when that [the rape] happened to me...I don't know if I would ever be able to have what I would

call a proper long-lasting emotional relationship.’ (A 53-year-old woman raped by her boyfriend when aged 16)

Another significant source of regret and sadness for some of these women was the way in which they had treated some of the ‘good’ men they had encountered over the years and the likelihood that they may have missed opportunities and rewarding relationships because of their fear and distrust of men. Their understandably distorted interpretation of social interactions with men, accompanied by an overwhelming desire to avoid being hurt again, meant that, on many occasions, they either kept men at arms length and never progressed a relationship beyond a certain point, or else they made it virtually impossible for any man to get close to them in the first place. The following illustrative quotes succinctly highlight some of these points:

‘I’d always be very wary, very standoffish...you put up the shutters and they only come down if somebody earns that trust. I may have missed out on meeting some very nice guys by having this shutter up...’ (A 40-year-old woman raped by a family friend when aged 18)

‘I would certainly have rejected them on an emotional level or, if they got too close or pushed me or challenged me...that was the end for them... so I feel ashamed for not... because I hurt a few really decent men. I’m also sorry for myself... for my life... what might have been... you know, I often wonder about that...’ (A 32-year-old woman raped by someone with whom she was on a date when aged 18)

‘There would come a point in the relationship where I would just like ‘freak out’...there would definitely be no sex and that would be the end of it...I probably just got very strange and I would just tell them to get lost...’ (A 29-year-old woman raped by an acquaintance when aged 20)

‘When it comes to the whole kind of relationship...I’m thinking it’s ok now but what about in 2 months time...the relationship is going to have to move on and you won’t be able to...there’s no point so you may as well not do it at all...’ (A 30-year-old woman raped by a stranger when aged 24)

In spite of all of these experiences and emotions, most of these women had some, kind of relationship and sexual intimacy with men (albeit brief in many cases) following their assault. However, as indicated in some of the comments above, this was essentially only the beginning of their problems. Once some of the women began relationships, the issue of sex would inevitably arise and this seemed to be a significant and sometimes persistent problem for these participants. For some, the natural development of sexual intimacy over time, in a relationship, posed a significant barrier from the outset as shown by the following comment:

'It's like your psychological sexual development happens through that [a normally progressing relationship] while you're getting ready...you're only it as you're feeling ready...but that doesn't happen to you when you're sexually abused...you go from being psychologically and physically a virgin to being physically not a virgin but still psychologically a virgin...' (38 year old woman, raped by her boyfriend when aged 24)

Interviewees commonly reported having to negotiate this issue repeatedly in relationships and often felt that, unlike many other women, they were bringing an added undesirable dimension to relationships. For instance, one 40-year-old woman spoke poignantly about her envy for her sisters and friends in this respect:

'You know in intimate relationships, or if she met somebody [her sister]...sex is never going to be an issue...I envy that...I envy her and I envied my friends for that...I'd love to be like that and not have to try and carry this big monkey around...' (A 40-year-old woman raped by a family friend when aged 18)

Furthermore, she reported, with some surprise, that this did not become any easier with the passage of time:

'Once I got over the initial hurdle, I would have enjoyed sex as much as the next person...but then the next time you go into it [i.e. another relationship], you're starting all over again and you have to go through the same hurdles...it didn't get any easier...that's one thing that I would have expected to be different...it didn't actually get any easier as time went on...' (A 40-year-old woman raped by a family friend when aged 18)

Apart from the act of sexual intercourse itself, even casual yet intimate contact with a partner, may elicit strong adverse reactions:

'One time he [her boyfriend] came over and he was kissing me and I was pushing him...like... 'What are you doing?...and he was like... 'What is your problem?' So it wasn't even just like the act of intercourse, or like penetration or anything, it was even all the intimacy stuff before that...just normal relaxed chilled out...' (A 30-year-old woman raped by a stranger when aged 24)

Another participant felt so far removed from normal sexual experiences that she almost started to believe that she had no sex drive at all:

'I've always almost considered myself nearly asexual because it used to be so unimportant...the sexual [side of] relationships were desperate...I always let them have sex with me and that was the end of that like...' (A 36-year-old woman raped by someone at a party she was attending when aged 18)

Overall, most participants highlighted a range of interesting, but regrettable effects on their sexuality, sexual intimacy and personal relationships which, in many cases persisted for years after their rape/sexual assault. It was clear from talking to the women that the relationship between these factors was a complex one and that their experience of SV had a lingering impact in these (and other) areas of their lives which had led, in turn, to a seriously compromised quality of life.

9.9 Theme 3: Experience of medico-legal and support services

This third superordinate theme was related to the participants' post-assault experiences and contact with (i) judicial and medical services and (ii) support services in general. It should be noted that only three of the interviewees had any formal contact with the Gardaí in relation to their experience(s) of SV¹ and none proceeded with a criminal case against the perpetrator. While this is a small number, it is nonetheless important to examine their experiences. The remainder of the sample (n=11) cited a variety of reasons for not reporting the incident to the Gardaí, but these are explored in more detail later (under the *Barriers to disclosure* sub-theme (Section 9.10.1)).

Participants also offered their views on how the findings on service provision could be most effectively translated into practice and suggestions for improvement are also included here where appropriate. Participants also had contact with other support services and, in particular, the RCCs. Whilst they were not asked specific questions about these or other counselling services they may have received, references to their experiences with these services (as might be expected) were common throughout the interviews.

9.9.1 Experience of medico-legal services

With regard to the three women who had contacted the Gardaí, one of this group had been subjected to SV as part of a domestic abuse situation and while she had contacted the police on a number of occasions, she had never mentioned the SV, as she did not know whom to trust. Furthermore, even when she attended court in relation to the divorce of her husband (the perpetrator of the SV), she still did not highlight the extent

¹ Just 17 women in the entire sample indicated they had had dealings with the Gardaí but as this was not the focus of the study, information on prosecutions, successful or otherwise, was not collected.

and nature of the abuse that he had inflicted on her. She recalled the day that her solicitor grasped the extent of what she had endured:

'I remember bringing in a baton [to court] that he used to keep beside the bed...you know that he told me was for burglars but it wasn't, he used it on me...my solicitor, I remember him nearly crying because he said like... 'You never told us enough, you never told us it was as bad as it was' ...you know...they thought it was just [physical abuse]...' (A 46-year-old woman raped by her ex-spouse when aged 35)

Another 42-year-old woman, who was brutally assaulted almost 20 years ago, while holidaying in a foreign country, was unable to access medical treatment without making a formal statement to the local police. She found the entire process and attitudes toward her almost as much of an ordeal as what she had experienced the previous night:

'I think what happened the next day was just as bad...they couldn't see me until I reported it to the police. The police interview was horrible...there was cleaners walking in and out...it was like a freak show...you were like the novelty act for the day...' (A 42-year-old woman raped by a stranger when aged 22)

The third woman reported being raped on two separate occasions as an adult as well as being sexually abused as a child), but her experience of rape only emerged when she was reporting her childhood abuse to the Child Protection Agency. Unfortunately, the perpetrator was informed of this allegation and her identity was not protected. The woman indicated that the thought of going to court 'terrified her' (participant's own words) so much that she did not pursue this charge at the time. While she did eventually return to the police some year's later, she felt that the Gardaí with whom she dealt were 'putting words in her mouth' (participant's own words again) and she never made a formal statement thereafter. In spite of this, she describes her dealings with the Gardaí in very positive terms:

'I thought they were pretty fair...apart from that [her experience of trying to make a statement]...yer one [the female Garda] was nice...I didn't feel under that much pressure.' (A 30-year-old woman raped by an acquaintance when aged 22)

Whilst any contact with the judicial system was relatively limited in this sub-sample, many of the interviewees suggested that the findings generated by this research should be used to inform how SV survivors might best be treated within the Irish judicial system in the future. For example, several suggested improvements to the court and

trial/sentencing process in sexual crime cases, were highlighted and it was clear that most women felt that they could not contact the Gardai (see Section 9.10.1 for more information on barriers to service provision). For example, the following woman felt that serious change was needed in how the legal system treats victims of SV and the procedures required in order to bring a case:

'I would like to see things changing for women legally...[so] they don't have to go through so much in order for the case to be made...I think giving a statement is probably okay but if it got to the stage where you have to stand up in court, I think that's just horrific.' (A 32-year-old woman raped by someone with whom she was on a date when aged 18)

Another woman who did have some direct experience of reporting to the police, felt very strongly that the whole trial system had failed victims of SV and that victims were less likely to subject themselves to the ordeal of the trial process due to lenient sentencing:

'The whole trial system is a joke I think...the sentencing...I mean that puts people off...that put me off...like you would go through 10 years of torture if they got put away for 10 years but they won't...[they] might not even get 10 days even if it was proved...' (A 30-year-old woman raped by an acquaintance when aged 22)

'Sentencing I think...I wish they would take that more seriously...and that the laws would be harder...if there was a more stronger sentence [for rape and other sexual offences] and if it was in the law, considered to be a serious crime then people might think twice...' (A 38-year-old woman raped by her boyfriend when aged 24)

Some of the women also spoke about a range of other experiences they had when contacting with doctors or other medical personnel. For example, they described a mix of positive and negative reactions in response to their disclosure of SV. One woman was very pleasantly surprised by the reaction of her GP:

'I suppose my doctor...[was the] least likely person really that I would have thought would have any real impact apart from giving me a few anti-depressants...[but] he was very knowledgeable about sexual violence and he was like 'You've got PTSD' and he made me feel 80% better by saying that...' (A 36-year-old woman raped by her boyfriend when aged 35)

The woman, who talked about her unpleasant experience of the police investigation process in a foreign jurisdiction, spoke very positively about the kindness of the doctor who had examined her during her ordeal:

'...[the] doctor practising...he was just so nice...he was the first person in the whole day that had any care...he was very nice during it [the examination]...but I just remember just crying through the whole thing...I really just found the whole thing just cruel...' (A 42-year-old woman raped by a stranger when aged 22)

While many women did not have contact with medical personnel as a direct result of being raped or sexually assaulted, their encounters with these services in subsequent years, alerted them to specific issues and difficulties, which they now had to overcome because of their experiences. For instance, some women felt that doctors and nurses (and even dentists) needed to be more aware of the prevalence of SV in Ireland and the likelihood that they may come into contact with a woman who has had this experience. One woman, in particular, felt that health services should be attached to the RCCs and be staffed by personnel with suitable training and sensitivity around the issues of SV, thereby addressing some of the difficulties in accessing appropriate medical care post-assault:

'... the RCC should have someone, a nurse or a doctor...somebody that you can go to as part of the centre, like, that knows...because I mean, if I went to a nurse, I'd find it very hard to tell them... "Listen, I don't, know what way I'm going to react here."' (A 30-year-old woman raped by a stranger when aged 24)

In summary, there was a clear suggestion from the responses of most of the women, that their understanding and perception of the judicial system had prevented them from formally reporting their experience of SV. Furthermore, their contact with medical personnel (for problems both related and unrelated to their experience of SV) had caused them to contemplate the nature and appropriateness of current services for women with a history of sexual violence. While the data presented here are based on only a small sample of women, they do nonetheless, hint at some of the underlying issues with regard to service provision, that will be further illuminated in later themes and discussed in more detail in the subsequent chapter.

9.9.2 RCC counselling and other counselling experiences

As mentioned earlier in Section A, six of the women in this sub-sample had received counselling through an RCC following their assault, while three more had attended counselling or psychotherapy privately. Interviewees reported varying levels of awareness about the existence of, and the services offered by, RCCs, both at the time of the incident and thereafter. While many of them took a considerable length of time to contact the RCC directly, most had quite positive experiences, which they often felt were critical to their recovery (the issue of recovery is dealt with in more detail under Theme Five further on). By contrast, others felt too intimidated to engage with a service that dealt specifically with rape and instead felt that private therapy/counselling was a more appropriate route to the support they needed. As two women commented:

'I didn't go to the RCC because I didn't even want to say that my problems were because of rape...I felt I should look at general counselling and all sorts of other issues...' (A 42-year-old woman raped by a stranger when aged 22)

'Everything I was reading was saying this is the only way [counselling]...I didn't want to go the RCC because it was the RCC...so I got the phone book and there was nothing, kind of for counsellors but not...like I didn't want a rape counsellor...' (A 30-year-old woman raped by a stranger when aged 24)

Nonetheless, for many of these women, counselling provided them with a safe 'space' where they felt believed and understood, and were given time to process their most difficult emotions. Although this process was, in many respects, painful for them most commented on the compassion and support they had received throughout this process. This is illustrated by the selection of comments presented next.

'I think maybe something in my head I said that these are the people [RCCs] that can help me...and as I was telling her [the RCC counsellor], her face softened and I knew she got me...she really helped me...' (A 38-year-old woman raped by her boyfriend when aged 24)

'And it's not the most pleasant...going in and out to the RCC but you know I always felt better after a session...I wouldn't look forward to them but I felt better after them and certainly it was so good to be somewhere where someone understood me...' (A 36-year-old woman raped by her boyfriend when aged 35)

'I got this one girl and she was brilliant and she said 'You know you should come in and give it a try [RCC counselling]...'...and I ended up making an appointment and then I went in... She's [her current RCC counsellor] just absolutely brilliant...with this and everything in my life...she's been just an absolute rock.' (A 30-year-old woman raped by a stranger when aged 24)

'The counselling psychologist I saw...she helped me to push it away and change the patterns [of destructive behaviour] and stuff...she every much listened to me around what happened and stuff...' (A 36-year-old woman raped by someone at a party she was attending when aged 18)

However, for a small minority, counselling (and sometimes the people whom they encountered through counselling) had not provided the answers and direction they had sought and expected. On occasion, this was related to the negative response they had received from the service provider whereas, at other times, it appeared to be the non-directional nature of counselling that had prompted their frustration. The following women remarked:

'I finally went to the RCC and I was given this therapist and she was useless...I sometimes wonder had she ever been through anything like that herself because like she didn't understand the most simplest things about me...' (A 38-year-old woman raped by her boyfriend when aged 24)

'I went to one...she was a psychotherapist...I went to her once or twice and while I talked I got absolutely no benefit out of it...I got no answers...I suppose I went looking for answers but I certainly didn't find them...' (A 40-year-old woman raped by a family friend when aged 18)

'It's just counselling...I don't find it that helpful...I'm not knocking this place [the RCC]...this place is great like but there's no feedback...' (A 30-year-old woman raped by an acquaintance when aged 22)

Participants reported a range of experiences - through the counselling and support that they had received - that were for the most part quite positive. There appeared to be a relatively good awareness around the value of counselling and the services offered to women with an experience of SV. However, access to these services was sometimes thwarted by the stigma attached to attending a service such as this. Additionally, RCC counselling, while undoubtedly valuable, may not be sufficient as a 'stand-alone' solution to this problem in view of the differing needs and requirements of these women.

9.10 Theme 4: Disclosure

A fourth theme that was explored during the interviews, related to the nature, extent and experience of disclosure and the reactions and responses received as a result. Two key sub-themes were identified here, relating to (i) barriers to disclosure and (ii) perceptions and views as to how to respond most appropriately to disclosure. All of the women in this sub-sample had disclosed their experience to one or more people since the incident

happened, but in the majority of cases, this was not immediately after the event and in some cases, it had occurred several years later. The women described a range of reactions that either made them feel believed and listened to (positive), or that discouraged them from any further disclosure (negative).

9.10.1 Barriers to disclosure

Interviewees described a variety of reasons for not disclosing their experience until much later after the event, and many of these were related to some of their own immediate reactions to the incident (described in Theme One) such as confusion, fear, self-blame, shame and guilt. These cognitions and perceptions prevented them from telling others as they very often felt that they would be blamed and judged negatively, thereby enforcing their own negative inner thoughts and feelings. For example, for those women who felt that they were, in some way, to blame for what had happened, the risks of having this possibly confirmed by someone's reaction outweighed the potential benefit of receiving a more positive reaction and perhaps support. Several of the women felt ashamed and were adamant that they would not be believed, or that they would be judged negatively by those closest to them, regardless of the circumstances. Another woman felt that society's preconceived ideas of what constituted rape in the context of an intimate relationship, would mean that she would not be believed and seen as a genuine victim of rape. The following comments illustrate more clearly the women's thoughts and feelings in this respect:

'I thought there's no way on earth I can go home and tell them [her parents] that this happened...they would also blame me. I just felt so ashamed, I just felt so dirty, I just felt who on earth would possibly believe...that I wasn't just 'crying wolf' or "you must have been asking for it" ...' (A 40-year-old woman raped by a family friend when aged 18)

'I blamed myself at the time because I did such a good job of wearing that mask that people just couldn't get their heads around that we weren't that happy couple...maybe if people did hear the hardness of it all, they just couldn't take it in or didn't want to think that that could have been happening.' (A 46-year-old woman raped by her ex-spouse when aged 35)

'I was ashamed. They [her parents] probably would have believed me but they probably would have given out to me for bringing shame on them.' (A 53-year-old woman raped by someone with whom she was on a date when aged 17)

'I never ever felt that I was believed, listened to you know...nobody wanted to know because you brought that trouble you know...' (A 53-year-old woman raped by her boyfriend when aged 16)

'A huge part of me not telling either was the disbelief factor...it's like 'You're going out with someone, what are you talking about?' People don't understand what rape basically is and that's really hard because if it was a stranger that jumped out of a bush people would be around you going 'Are you ok?' (A 36-year-old woman raped by her boyfriend when aged 35)

'I felt so ashamed...I felt so horrible that I just thought if I tell him [her partner at the time] that's it...he was definitely...he won't stay around.' (A 30-year-old woman raped by a stranger when aged 24)

While the reasons for not disclosing, were rooted in the women's own sense of shame and self-blame a recurrent theme throughout the interviews, was an overwhelming desire, on the part of interviewees, not to be seen as a 'victim' by friends and family and society at large. Many of them were very resistant to this notion and avoided telling people about their experience in order to preserve what they felt were people's positive opinion of them. Some were afraid that they would be viewed negatively by others if they became aware of the rape/sexual assault and that those around them would forever see them through this 'victim' lens. Several of the women explicitly mentioned this in their interviews and a selection of these comments are presented below:

'I didn't not tell some of my friends because I didn't trust them...but because I thought what will they think of me...I was like, I was tainted...I suppose I didn't want to be the victim, but I also didn't want people's opinion of me to drop...and I thought well this is not what I want to be known for here.' (A 40-year-old woman raped by a family friend when aged 18)

'Like my best friend ever in the whole world...I never told her about this nor would I ever...I still don't like her to know that I am a victim.' (A 32-year-old woman raped by someone with whom she was on a date when aged 18)

'So my two sisters knew...[but] I was in such terror of people knowing that I made them swear that they wouldn't even tell their partners...I didn't want to be the one in the family that was tainted with this...it's nearly like 'Oh you're not the person I thought you were'...' (A 42-year-old woman raped by a stranger when aged 22)

These women often went on to suggest ways of improving society's response to victims of SV. The issue of public education and awareness, in particular, was highlighted, as was the hope that societal attitudes would begin to change as a result. As shown by the comments below, some of the women felt that the general public failed to understand the extent and pervasiveness of the impact of SV in a woman's life and that this needed to be urgently addressed:

'What I would also like is for people to really get it...this stays with you for such a long time...it's still a part of ya...it's like a shadow there...it's a lifelong journey through it.' (38 year old woman, raped by her boyfriend when aged 24)

'This needs to be dealt with...because then the person is confronted with the impact on the person and the women who are trying to cope...[and] live their lives where they're working and they're rearing children...my hope for this [the study] is that it will be another step towards better understanding.' (A 47-year-old woman sexually assaulted by someone with whom she was on a date when aged 20)

'I hope it just changes people's attitude. If people knew that it's not just...it doesn't just go away after a couple of months like...it's ongoing, it's not going to go away...' (A 30-year-old woman raped by a stranger when aged 24)

Another participant felt that, without public education around the many common myths and stereotypes, society was effectively condoning SV. She advocated a complete change in the way society even talks about SV and men and women:

'It's all the myths...he was a very good-looking guy...good looking men don't rape. I really do want to change the conversation...it has nothing to do with women protecting themselves...there's absolutely no conversation about why men shouldn't [rape]...' (A 29-year-old woman raped by an acquaintance when aged 20)

It is important to identify these barriers to disclosure in order to help raise awareness within the wider public domain and to inform service providers (i.e. not only those that respond specifically to women with an experience of SV) how to respond sensitively and effectively in these circumstances. It appears that the bulk of women's fears are associated with the perception that they will be judged negatively and blamed, or thought less of, as a result of the incident. Further themes discussed below and in later sections of this chapter (e.g. *Encouraging disclosure* and *Advice for possible future victims*) will examine in more detail how these barriers might be overcome. However, it seems clear that the stereotypes and impressions that society holds about rape and rape victims, are playing a crucial negative role in maintaining the shame, stigma and silence that surrounds this crime. A final comment from one participant perhaps sums this up:

'It's ridiculous - the stigma attached to the victim of a crime...specifically this one...any other crime in the world, it'd be fine...people would believe ya, there's no questions about it...this one though...you have to fight just to say 'No, it actually happened' ...are you kidding me?' (A 29-year-old woman raped by an acquaintance when aged 20)

9.10.2 Encouraging disclosure

While participants identified a range of barriers to disclosure, they also recounted more encouraging experiences where they felt listened to, believed and perhaps most importantly, not judged. These experiences, along with the advice and support that they had received, were critical turning points for some of these women. It allowed them to acknowledge and, in some cases, accept that perhaps they were not to blame for what had happened, either at the time of the incident, or in the intervening years since. This current sub-theme highlights some of these key experiences and turning points, which should help other women who find themselves in a similar situation.

As mentioned earlier, participants often had a mix of both positive and negative reactions to their disclosure during the time since their rape/sexual assault. With regard to feeling 'listened to' and validated, they recalled, and recommended, a compassionate and non-judgemental approach. In fact, some of the key moments they described, involved talking to people who offered little more than a 'listening ear'. A selection of comments made by women in relation to the more positive and encouraging reactions they received, is provided below:

'...she [a counsellor] turned around and she goes... "I'm so sorry that happened to you" '...and that broke my heart...nobody had ever said that to me you know?' ' (A 38 year old woman, raped by her boyfriend when aged 35)

'I remember one particular boyfriend, he was fantastic...he was very understanding, very caring, very kind and I felt that he didn't judge me...he just seemed to manage it better and I never felt that I was burdening him.' (A 40-year-old woman raped by a family friend when aged 18)

'...you know to have someone who didn't really know me or didn't really know my story but believed me...it was a real turning point for me...to be believed...to sit there and listen, not judge but not kind of ram advice down my throat...' (A 46-year-old woman raped by her ex-spouse when aged 35)

' [her ideal reaction]...if they had explained what had happened and if they had told me that this was wrong [i.e. the rape] and don't be hard on yourself and I'll look after you...just to know that someone was on my side.' (A 53-year-old woman raped by someone with whom she was on a date when aged 17)

' [after taking part in a theatre workshop on repression]...I remember at that moment just thinking how there was actually nothing that I could do in that circumstance...there was nothing I could do only what I did...and I remember just something lifting when I actually really acknowledged that to myself.' (A 42-year-old woman raped by a stranger when aged 22)

'I think the people who listened and who didn't question what I was doing...or supported what I was doing...and just supported it in a quiet way...the people who trusted me and trusted the people that I was working with to find the best way forward.' (A 47-year-old woman sexually assaulted by someone with whom she was on a date when aged 20)

'The person I'm closest to...hers would have been the most kind of non-judgemental reaction and she's always been really supportive...' (A 36-year-old woman raped by someone at a party she was attending when aged 18)

In comparison to the responses that many of the women cited as being particularly encouraging and supportive, a smaller number of women also referred to the helpfulness of having their experiences and reactions normalised by a professional. For example, one woman described how helpful she had found her GP's awareness of PTSD and the labelling of her reactions and emotions:

'Certainly putting name on it [PTSD]...without a doubt...my doctor talking about it...obviously helped.' (A 36-year-old woman raped by her boyfriend when aged 35)

Another woman who had been attending counselling at her local RCC for several years, found the normalising of her reactions and behaviours to be invaluable and this had given her hope for a future beyond her experience:

'Definitely the best support obviously was the RCC...just knowing that like everything I was feeling was normal. I might say to her [the counsellor] this happened this weekend and you know she'd have an explanation for it...she'd say to me 'I've seen so many people that have went through this and they've come out the other side'... and it gives me hope...' (A 30-year-old woman raped by a stranger when aged 24)

In line with these experiences, one woman suggested that it would be helpful to devise and distribute a pamphlet or information booklet that could be given to rape victims/survivors to help them understand better their post-assault thoughts and feelings and to encourage them to access support sooner rather than later. As she pointed out:

'I think they [the research findings] could be used to help women to understand...when they feel a [certain] way, that it's probably natural for them to feel that way. If it was used in a booklet form or something like that then you're sort of saying... 'Oh well I'm not weird...you know it's a normal reaction'...its another thing to help somebody to get help earlier...' (A 53-year-old woman raped by her boyfriend when aged 16)

The types of validating reactions and advice described above had helped the women to accept their normal reactions and responses to an essentially abnormal experience. These kinds of non-judgemental and supportive responses seem to be at the core of what these women need when they choose to disclose but, unfortunately, these appear to be the exception rather than the rule. Arguably, unless society reaches a level of comfort with talking about the (realistic) prevalence and impact of SV, then responses like these will continue to be relatively rare. While this may be a challenge in itself, it pales in comparison to the daily experiences of victims of SV. Clearly, most of these vulnerable women require appropriate forms of intervention and support, but attempting to create a society that is informed, compassionate and understanding about the issues and misconceptions surrounding this complex issue, would be a crucial step forward in helping us to respond collectively in a sensitive and appropriate manner to this crime and its many victims.

9.11 Theme 5: Recovery and healing

The penultimate theme to be addressed within this chapter encompasses the recovery and healing that these women have experienced (to a greater or lesser degree) since their experience of SV. In fact, one of the difficulties of conducting this type of research is that many of the potential target group, may feel unable to come forward to participate in research. Therefore, it may well be the case that the women, who took part in this study, had already achieved some sense of distance from, and perspective on, the trauma of their experience, when compared with their responses and reactions immediately after the assault.

The nature and level of healing varied from one woman to the next, as did the resources on which they relied for recovery. However, some interesting patterns emerged in participants' responses and the first sub-theme described here, highlights some of the key resources that these women had used. In addition, the perspective gained from the passage of time and personal development, allowed the women to safely re-visit their experience and identify the most useful information for other women who find themselves in a similar situation. These commonalities and differences are reported in the second sub-theme described here.

9.11.1 Use of internal and external resources

Participants described a variety of resources that had helped them through the low points in the recovery process and which had ultimately helped them on the way to recovery. Some women identified internal beliefs and strengths on which they had relied through the worst of times and which had helped them to 'hold on' until their situation had improved. For example, in the case of one woman, the person who had abused her as a child was someone from outside of her family, which meant that she could hold on to certain positive beliefs about her family. As she puts it:

'...because I always felt like it had only happened to me and it wasn't a member of my family...my family, I just feel, are really good people so I suppose that kept me going...that I wasn't born to be like this, to feel like that...I was born with hope and loads of prospects and opportunity...my Da worked hard to give us all a chance...so I suppose that kept me going til I could get back to being a normal person.' (A 30-year-old woman raped by an acquaintance when aged 22)

A number of others had relied on medication (e.g. anti-depressants) at different times, and with varying degrees of success, although most viewed this as a short-term solution to their problems. Many of the women who were mothers, indicated that their children were a crucial resource in their recovery, particularly if they were contemplating suicide. Even one woman, who did not have any children of her own, felt that the presence of her niece in her life and her desire to see her grow up, was what kept her alive. Several comments below illustrate participants' feelings on this subject:

'I think having my daughter forced me to hold onto some sort of normality...I would have been 20 and I thought if I have a baby then, I'll have to stay alive for that baby's sake and then I won't be able to kill myself because I can't leave that baby on her own...' (A 38-year-old woman raped by her boyfriend when aged 24)

'I say that I'm here today because of my kids - because they were the only thing that kept me going...but there were days when I woke up and I thought oh God no...not another day.' (A 46-year-old woman raped by her ex-spouse when aged 35)

'The parenting wouldn't ever be a bother...I mean I just find through all of this my daughter was such a comfort...I would have found great refuge in my role as a parent and just getting on with that.' (A 36-year-old woman raped by her boyfriend when aged 35)

It was anticipated that education would be another area of participants' lives that would be negatively affected by their experience of SV and indeed, this was the case for some of the interviewees. Surprisingly however, several of the women found that their

educational pursuits served as a valuable resource and an effective means of escape from their trauma. A substantial proportion of this sub-sample (n=9) was educated to degree level or higher and some indicated that they found that their studies had helped to distract from the impact of their trauma, while others felt even more determined to complete their courses because of their experience. As some women remarked:

' [in the year post assault]...I finished college just...well I nearly dropped out and then I didn't...I just got on with it.' (A 29-year-old woman raped by an acquaintance when aged 20)

'I completed my education...I think that in the process of therapy what was very grounding for me...cos it was horrific...it was very good to me to have that day in college and to have that study time...I could put it [the work she was doing in therapy] down and study...' (A 47-year-old woman sexually assaulted by someone with whom she had a date when aged 20)

'Well I finished college...I made sure I 'stuck out' college and got my exams...I just stuck with it...I just made it the only thing in my mind.' (A 30-year-old woman raped by an acquaintance when aged 22)

As mentioned earlier, most of the sample (n=9) had attended for counselling, either privately or through their local RCC. Many reported that the help and support they had received were invaluable and that they would not have progressed as well without it. While their progress in many cases was frustratingly slow, the women were generally very complimentary about the 'healing' they had received through their contact with various counsellors/therapists and, as indicated below, they were very clear that the changes brought about by their experiences, would not have happened without this kind of help:

'It's only now that I'm a few months into counselling that I see the side of me that I buried for these years...it's time for that to come out but as a different me...a healed me...a self-forgiven me. I'm going to the RCC and it's so hard for me to believe that I deserve this, but it's creeping in and I have complete faith that it will all come out and I will be healed.' (A 53-year-old woman raped by someone with whom she was on a date when aged 17)

'...and I think what helped as well...xx [her counsellor] said to me one time... 'D'you know people who were abused...they're not the only people with problems with sexual intimacy, we all have that.'...and that was really helpful because it normalised the struggles that I would have...' (A 47-year-old woman sexually assaulted by someone with whom she was on a date with when aged 20)

'...and I sit there for an hour and not even speak and she wouldn't even speak either...there's no kind of pressure...and I can feel myself getting stronger and stronger and I think it's because...it's 100% because of them [her RCC]...' (A 30-year-old woman raped by a stranger when aged 24)

'I finally met a woman...she was a counselling psychologist...she really focussed on getting me moving and getting, you know, positive relationships in my life...I had nothing...except for work...and my family I guess and friends...but my relationships were desperate...' (A 36-year-old woman raped by someone at a party she was attending when aged 18)

While the participants identified a number of resources, which they felt had been crucial both in terms of their initial reaction and later in their healing and recovery, it was clear from the findings that no single resource was effective for each individual woman. Undoubtedly, the traditional 'talking therapy' practised by most RCCs, is an appropriate and effective response to an obvious need within this population and appears to actively promote a sense of healing and tangible progress. Additionally, the identification of other family members and children, in particular, as a valuable resource, reflects again the importance of social support as a factor in recovery. The fact that education served as a refuge for some of these women is also encouraging, a point that is clearly reflected in the high educational achievement of the sample as a whole. While not negating the negative impact of this experience on education, it is clear that for the majority of participants, a high level of educational attainment became a desirable goal following their assault.

9.11.2 Advice for possible future victims

Participants were also given the opportunity to offer their opinions and views on the most important information which they thought other women in their situation should have. This allowed them to reflect on their progress since their experience of SV and to identify the most crucial piece of knowledge they had gleaned or, in some cases, wish they had been told, during the period since their assault. Here, more than half of the interviewees were adamant and clear that women who find themselves the victims of rape or sexual assault should know, unequivocally, that it was not, under any circumstances, their fault. This was highlighted again and again throughout the interviews and is demonstrated well by the following selection of comments:

'I'd have to let her know that it wasn't her fault...that she did nothing wrong...that it was all completely the rapist's fault...that's what I would want somebody to know.' (A 38-year-old woman raped by her boyfriend when aged 24)

'Well I suppose the most important thing shes needs to know is that it's not her fault...I kind of took it all on myself...it's not your fault...it does happen and it doesn't have to be your fault...' (A 40-year-old woman raped by a family friend when aged 18)

'Any woman needs to be told that the fault is with them [the perpetrator]...it wasn't her fault...don't waste your time and your energy wondering whether it was what you wore or what you said or how many drinks you had...it doesn't matter...it's ultimately their decision...' (A 42-year-old woman raped by a stranger when aged 22)

'...the most important thing...somehow not believe that it's your fault...cos it's never your fault...it doesn't even matter if it's your husband...nobody's allowed [to] violate you in any way.' (A 36-year-old woman raped by someone at a party she was attending when aged 18)

Several of the participants also felt that it would be important for a woman to trust someone and tell them what happened and in so doing, gain access to necessary support sooner rather than later. They emphasised the need, during this difficult and often terrifying time, for the kinds of resources that were described above, whether they be internal or external. Some also felt that it was important to report the crime either through the Gardai or a local hospital. They felt quite strongly that accessing appropriate support as soon as possible, and/or as soon as the woman felt able to, was crucial and an essential preventative measure in helping to minimise some of the 'fallout' from their experience. The following provide a snapshot of the many comments made on this point:

'Deal with it because otherwise you're just bottling it up...but have a safe place where you can go and have somebody there to help you...' (A 38-year-old woman raped by her boyfriend when aged 24)

'...she's going to be carrying it around for a long time...she needs to trust somebody somewhere...speak to someone who can tell you before it gets a hold of you...all the bad stuff that it was your fault and you brought it on yourself...' (A 40-year-old woman raped by a family friend when aged 18)

'...she needs to seek help...she needs to go quickly...so talk to people...let people know.' (A 53-year-old woman raped by someone with whom she was on a date when aged 17)

'I'd say yes, this could have a huge impact on your life if you allow it to and if you don't look after yourself and you don't start talking about it and you don't start looking at your self-esteem...unless you look at all of that you're going to be one or two years dealing with it like and it's going to ruin your life...' (A 36-year-old woman raped by someone at a party she was attending when aged 18)

'I could imagine it would be quite hard for someone to go to the Gards straight away but I would strongly suggest it. She needs to know that the RCC is there for her, that the

Gards are there...all the practical things, plus she's going to be alright you know?' (A 36-year-old woman raped by her boyfriend when aged 35)

'...whatever decision she makes, let it be her decision and not others' decision...and whatever help there, is there for her...good solid support so as that she's not carrying this huge burden of guilt...the burden of guilt you're made feel when the truth won't be heard...' (A 53-year-old woman raped by her boyfriend when aged 16)

'I'd try and get her to go to a hospital because I think for three months afterwards I didn't get my period...so I thought I was pregnant and that was like absolute torture...' (A 30-year-old woman raped by a stranger when aged 24)

As indicated by the illustrative comments below, participants felt that it would be more important to give other women a degree of hope and reassurance that they would successfully overcome the trauma of their experience, rather than tell them about the difficult 'journey' that may lie ahead. Some reiterated that this would only be possible if they dealt with what had happened, rather than ignoring it and trying to pretend that it never happened (as some of them had done).

'...it would break my heart to tell her what it was like...you're going to have 12 years of horror...how do you say that to somebody? I wouldn't say that to them...I'd have to tell them it'll be alright...that you won't think it will now, but it will be...' (A 30-year-old woman raped by an acquaintance when aged 22)

'That it will get better...[and] find what it is, that creates a strength...so whatever it is they can identify in themselves internally or externally in their lives and to really hang onto them.' (A 38-year-old woman raped by her boyfriend when aged 24)

'...if you have a bereavement it's not a great time to say to someone...well you're not going to get over it...you're just going to somehow learn to live with it...it's not really going to get any better...I wouldn't want to tell anyone about what it's going to be like.' (A 29-year-old woman raped by an acquaintance when aged 20)

Thus, participants were quite clear on the key messages that they would like to convey to future victims of SV. The importance of their message – that 'the victim is not at fault' and that disclosure to someone trustworthy should be encouraged - stands in stark contrast to their collective experiences, where more often than not, they engaged in self-blame, and in some cases, told no one of their ordeal. It is reassuring to note that this is consistent with the widespread messages from support agencies that also categorically absolve victims of blame and advocate disclosure. However, the challenge remains to

create a society where support agencies are not the only place to which these women can turn.

9.12 Theme 6: Experience of participating in the research

The final theme emerging from this analysis relates to the involvement of the women in this research project. This examined their motivations for taking part, their experience of the research process through each stage, and their suggestions for improvement. These sub-themes are briefly detailed below.

9.12.1 Reasons for participation

Many of these women had never taken part in anything like this before, much less spoken to a complete stranger about their experience. While several of the women spoke about their desire 'to have their voice heard', this was enhanced by the added benefit of the complete anonymity and confidentiality offered by the nature of the research process. In turn, they felt that the research provided an opportunity to raise awareness of the issue of SV, but more importantly, to potentially help others who have had similar experiences. In fact, helping others to cope with their experience appeared to be the single most motivating factor as illustrated by the following selection of quotes:

'I wanted to do this [the research]... I really wanted to do it... because I feel hurt for women who are in the throes of it... who don't see any light at the end of the tunnel and don't think things can be any better... and if you have that little bit of time... you think yeah, things can be good again.' (A 46-years-old woman raped by her ex-spouse when aged 35)

'I didn't do anything about it at the time...you know there's a greater awareness of it out there now and if...by some minute chance I can possibly help somebody else...not go through what I went through well then...yeah I want to do it...' (A 40-year-old woman raped by a family friend when aged 18)

'I need to do something because even though like...I'm only a number in it...it's still my opinion, and my experiences and factual evidence and stuff...and that hopefully that will have repercussions...in the positive sense for anyone else.' (A 32-year-old woman raped by someone with whom she was on a date when aged 18)

'The reason I took part in the research in the very first place was that I felt...I felt often over the years that there were...there were certain things that I would never be able to say to my family and things like that but they're things that might help somebody else without actually coming out and saying to somebody else...its me...you know that with the finger pointing at me...' (A 53-year-old woman raped by her boyfriend when aged 16)

Several participants also had a strong academic background, or experience conducting research and therefore were motivated by their belief in the value of research and their appreciation of the difficulties inherent in conducting it. A combination of these factors prompted some of these women to take part in this research as the following two quotes show:

'Having been and still am a student... I know what it's like when you're trying to do research and you're trying do interviews, and I'll always help somebody doing research... because I know how many people are just trying to get people and running around with questionnaires.' (A 36-year-old woman raped by her ex-boyfriend when aged 33)

'Having been in college myself and doing research myself and knowing just how...kind of difficult it is to get the right people and...and even to get the research done correctly and to get it em...so that it actually means something.' (A 36-year-old woman raped by someone at a party she was attending when aged 18)

For some of the interviewees, a desire to understand themselves better and to gain a better awareness of how they had reacted to, and processed their experience, over the years was a genuine incentive to participate in this research. Some felt they owed it to themselves to explore their experience through the medium of this project in greater detail than they had in the past. The following extracts provide an indication of this particular motivating factor for two of the women interviewed:

'As I said I just thought maybe it will...help me understand more of why I've...maybe felt the way I have or gone through the decisions I have...you know how my life evolved after that [the rape].' (A 40-year-old woman raped by a family friend when aged 18)

'There was a part of me that felt I owed it to myself because I never...I never did do much exploration of it or much acknowledgement of it to myself...like it took me years to acknowledge that something had happened.' (A 36-year-old woman raped by someone at a party she was attending when aged 18)

While for many women, their motivation for taking part was due to a combination of some or all of the reasons mentioned above, there seemed to be an overwhelming and deep-rooted sense of responsibility across the sample, towards other women who find themselves in a similar situation. It seemed that while the experience for these women was difficult and painful, at least it might, in some way, be transformed into something positive if it were to help another victim/survivor. It was also clear that for some of

these women, this research provided an opportunity to be listened to, while simultaneously having their identity and privacy protected.

9.12.2 Experience of the research process

The participants' experience of the research process explored their initial concerns and reservations about taking part, as well as their comments on the approach used by the researcher and the research methods and materials used. These are described and illustrated briefly below. While many expressed a strong desire to engage in this project (and in the interview stage of the study), it was not without some initial reservations and concerns on their part as illustrated by the following comments:

'I suppose I read it a few times before I actually did it [the questionnaires]...and at no stage did I feel I can't back out. There was always I suppose comfort in that...well I don't really have to go through with it if I don't want to.' (A 46-year-old woman raped by her ex-spouse when aged 35)

'I thought about it...because when you do something like this it's not nothing...it's not at no cost to you as a person.' (A 47-year-old woman sexually assaulted by someone with whom she was on a date when aged 20)

Another woman, who had initially made contact almost changed her mind at the thought of disclosing personal contact details:

'I nearly pulled out of it at that stage cos it was like...I don't want to give my address out like cos...you never really know who you get talking to and you never know who know who...' (A 30-year-old woman raped by a stranger when aged 24)

In addition, their expectation of what the interview would involve and how much detail they would be expected to provide, was a little disconcerting for another woman:

'I mean as you were saying earlier...the word interview you're thinking...oh God when I sit here...how graphic is this going to be and how many details do I have to get into?' (A 40-year-old woman raped by a family friend when aged 18)

Fortunately, the experience and feedback from all of the participants who took part in this stage of the research was very positive and all felt that their initial concerns had been assuaged by both their contact with the researcher (through phone calls and emails) and the manner in which the information on the study was presented and advertised. For

example, several of the participants remarked that their contact with the researcher had made the process a lot easier and in fact encouraged them to participate. The extensive relationship and trust building that took place in the planning and arranging of interviews appeared to be a critical factor in their decision making process as highlighted by the following selection of comments:

'It's just your approach...it's just...you made it personal, it was easy...there was a rapport straight away you know.' (A 53-year-old woman raped by someone she was on a date with when aged 17)

'Contacting you on the phone was good...you contacted very quickly [and] you were very clear about what would happen. You came across very well on the phone.' (A 47-year-old woman sexually assaulted by someone she was on a date with when aged 20)

'I mean your approach was very gentle...and there was lots of space...' (A 36-year-old woman raped by her boyfriend when aged 35)

'When I sent you the email and then you came back to me...just even in the way you kinda dealt with the queries that I had...it just felt really professional and it felt like...you know what these guys know that this is not an easy thing to do...' (A 30-year-old woman raped by a stranger when aged 24)

This type of information and feedback is important and reassuring to hear. Not only does it provide validation for the methods and approach used in this research it also provides an evidence-base (albeit small) for the design and planning of future research in this area.

9.12.3 Suggestions for improvement

Participants also commented on the materials and media used to promote the research and the methods used in the study (i.e. questionnaires and face-to-face interviews). It appears that previously mentioned a number of the concerns around anonymity and confidentiality were alleviated by the manner in which the study was advertised. For example, one participant saw this study on the DRCC website and was reassured by this:

'...when I first sent the email it was kinda like I'll test the water to see...I didn't know how legit it was...[but] because it was on the RCC's website that obviously...you know they wouldn't have put it up there unless it was legit.' (A 30-year-old woman raped by a stranger when aged 24)

Others mentioned the appropriateness of the design and wording of the leaflets and posters used to promote the study. It seems, at least for some of the women in this sample, that they (i.e. the posters and leaflets) were successful firstly in prompting these women to identify with, and consider taking part in, the research and secondly, at addressing any concerns they may have had via the information contained within. One participant in particular commented on the wording and the picture used in the leaflet/poster:

'It was not one thing. It was the flowers...what was it... 'How does it feel? ...cos that just made some much sense...you feel like...you feel like you're so different to everyone around ya.' (A 30-year-old woman raped by an acquaintance when aged 22)

Other participants also offered their opinions on the methods used (postal questionnaires/face-to-face interviews). It should be noted that approximately half of this sub- sample had met the researcher previous to meeting to complete the face-to-face interview. Therefore, seven of the women were meeting the researcher face-to-face for the first time in Stage Three. While all of the participants were happy with the research process, as they had experienced it, they had mixed views about alternative method such as email or a web-based participation. Some would have preferred to take part in the study purely through email:

'I was hoping the questions could be emailed to me and that I could answer them and email them back...it would be easier like...cos I find it easy to write about what happened but I don't find it easy to talk about it.' (A 30-year-old woman raped by a stranger when aged 24)

The majority however, were very happy with the face-to-face element of the study and for a range of reasons. The following remarks succinctly illustrate this point:

'On the web I could have just...no, it wouldn't have made it any easier because I would feel as if I was answering this anonymous person and I wouldn't know who this anonymous person would be...I might feel threatened...' (A 53-year-old woman raped by her boyfriend when aged 16)

'[I preferred it]...just the way it was...in person...it's just the way I am I think. I'm not really an emailer and I think it's easier for me to talk about it than to write it out.' (A 30-year-old woman raped by an acquaintance when aged 22)

'I actually preferred today [the interview]...I felt after the first one [the face-to-face meeting to complete the questionnaires]...there's still a hell of a lot I would have liked to have added in or said. I think today I'm actually very appreciative of the chance to give a bigger picture.' (A 42-year-old woman raped by a stranger when aged 22)

'...it perfectly suited me...I'd no problems with it at all. In fact it was easily done because we could communicate without having to meet up face-to-face first and I could read about it...so it fully suited me.' (A 36-year-old woman raped by someone at a party she was attending when aged 18)

Moreover, others felt that if the research had been solely web-based they would not have even heard of it, much less taken part. Another participant went so far as to comment that even though the idea of a web-based study appealed to her, this might result in the automatic exclusion of a cohort of women without internet know-how: She remarked:

'I'm not sure if it is possible to do it another way. You might capture more nuances if you were to do it on the web...then you will also miss an age bracket. I think there are probably women in their 60s and 70s who might be less comfortable with the email stuff.' (A 47-year-old woman sexually assaulted by someone she was on a date with when aged 24)

These sub-themes provide crucial information and feedback on important issues related to the participant's experience of taking part in this research and in some way provide validation and support for the careful planning stages of the research and for the ethical safeguards that were put in place. While not presuming that the methods used here would appeal to every women it was nonetheless extremely reassuring to be able to document such positive responses.

9.13 Conclusion

This stage of the research has allowed this carefully selected sub-sample to 'tell their own story' and to contribute invaluable information on their 'real-life' experiences that would not otherwise have been accessed by quantitative means alone. While the quantitative stage of this study provided important and interesting information on the nature and extent of the impact of SV in women's lives, the findings reported here, help to bring the quantitative data 'alive' by elucidating the impact of SV as re-told by these women in their own words. These findings and their implications are discussed in more detail in the final chapter, both in the context of the literature and also with reference to the results reported earlier in this thesis.

Chapter Ten

Discussion

CHAPTER TEN

Discussion

The overarching aim of the research reported here, was to examine and document the psychosocial impact and experience of sexual violence (SV) in the lives of Irish women. This is an important area that has, hitherto, received very little research attention in Ireland, whilst research conducted elsewhere, especially in the UK and Europe, has focused broadly on attrition and/or prevalence rates and medico-legal and policy responses to SV (e.g. Hagemann-White, 2001; Kelly & Regan, 2002, 2003; Lovett & Kelly, 2009; Lovett, Regan & Kelly, 2004). An additional theoretical and broader aim of this study was to contribute toward expanding and developing our traditional understanding of the impact of trauma and women's typical responses to SV.

The study was conducted in three discrete, but inter-related stages involving: (1) interviews with a sample of stakeholders who were providing services and support to women with an experience of SV (Stage One); a detailed quantitative assessment of a sample of women with an experience of SV and a matched comparison group (without a history of SV) (Stage Two); and a series of in-depth interviews with a reduced sub-sample of women (Stage Three) recruited from Stage Two. Some of the key findings from Stage One have already been reported elsewhere (Kelleher & McGilloway, 2008; Kelleher & McGilloway, 2009) (See Appendix 36 and 37). The current chapter discusses the collective findings from all three stages of the study and their implications for policy and practice. An alternative framework for understanding the true impact of SV is then explored and discussed.

The key findings from this study - with particular relevance to the research questions indicated in Chapter One - are summarised below.

- The women with a history of SV who took part in this study in their mid-thirties, well educated and likely to be currently single or separated/divorced.
- Approximately one third of the sample (24/65) had experienced SV prior to the age of 16 and more than half had been formally diagnosed with a mental health problem in the past.

- Approximately 13 years had passed since the most recent experience of SV; the average age, at the time of the assault, was 23 years.
- The great majority were acquainted with their perpetrator to some degree and while very few had attended a SATU post-assault, virtually all had disclosed their experience to someone, most typically a close friend or family member. Notably, service providers identified the availability of current SATU services as inadequate.
- The perpetrator-victim relationship emerged as a significant factor in relation to several variables including formal mental health history, current marital status and age of participant at the time of the incident. For instance, those assaulted by someone more well known to them were significantly more likely to have been formally diagnosed with a mental health problem in the past.
- Nine out of ten women had attended counselling, either privately or through an RCC and interviews with participants suggest that, for the most part, their experiences were quite positive. Nonetheless, participants were still reporting high (i.e. above-norm) levels of current trauma symptoms. Negative societal reactions to disclosure were viewed across all three stages of the research as particularly damaging.
- The emotional and social consequences of SV, relating in particular to personal relationships and sexual intimacy, were highlighted in all three stages of the research, as the most negative and persistent effects of SV.
- Those women who had experienced SV were experiencing significantly higher levels of recent psychological and negative life stress and lower levels of social support and QoL when compared to their comparison group (i.e. those with no history of SV) counterparts.
- The use of potentially damaging coping strategies was highlighted as a theme throughout the results; these took the form of sexual risk-taking behaviour (DSB levels in Stage Two) and misuse of alcohol and other substances (Stages Two and Three).

- The qualitative interviews with participants highlighted several barriers to disclosure that reflected and amplified those identified in Stage One. These were linked with the shame and guilt felt by women post-assault and their negative experiences of disclosure. There was a strong suggestion from the data that these were influenced, to a large extent by a societal adherence to damaging rape supportive myths.
- Long-term negative effects on sexual and reproductive health were reflected in the elevated levels of women referred for colposcopy services and the emotional and psychological difficulties in attending for regular screening expressed by women from the Stage Three interviews.
- Service providers, in particular, highlighted a number of inadequacies in current service provision including the CJS, services for vulnerable groups, medical and SATU services, and public education and awareness of SV. The need for urgent awareness raising activities to highlight the true impact of SV and related issues was also reflected in the one-to-one interviews that were conducted as part of Stage Three of this study.
- Overall, the findings are consistent with the PTSD model of women's responses to SV, although the results raise several important questions for further research. They also add to our knowledge by highlighting a need to include additional elements in contemporary accounts of post-assault responses, such as the wider and chronic impact on relationships and sexual intimacy and the experience of positive growth that can sometimes arise from a traumatic incident.

The following section discusses the above findings in the context of the research on SV in Ireland (which is limited) and further afield. As indicated earlier, the most comprehensive and up-to-date research on SV in Ireland was published in 2002 (SAVI Report, McGee et al., 2002). Therefore, this provides the most useful benchmark for comparison with the present study, although reference will also be made to the international literature. Some of the key findings relating to the general background and history of participants are discussed first, both in the context of the SAVI report and other research. The impact of SV is then explored followed by a discussion of the

implications of the findings in the light of recent developments in current services. Some of the measures needed to raise an awareness of SV in Irish society, are also described, followed by a discussion on expanding the PTS framework. The chapter concludes with an evaluation of the strengths and limitations of the study and some new research questions and directions for future research.

10.1 Profile, background and history of participants

The women in the SV sample in this study were typically in their late thirties, largely single or separated/divorced and generally well educated. While the age range of the SAVI report was somewhat larger than this study (i.e. 20-80 years and 19-57 years respectively), the former was weighted against general population figures (McGee et al., 2002). In fact, the only group under-represented to any large extent in the SAVI sample was women under 30 years old (McGee et al., 2002). In the current sample, at least half of the participants were aged 37 years or under, while effectively half of that number again were aged 30 years or under. This figure compares favourably with the general population figures for young Irish females used in the SAVI report (23% - based on 2001 Census figures) and suggests that this group of women were targeted in the current study with a fair degree of success.

The possible role of SV and other trauma-specific variables (e.g. relationship to the perpetrator) in influencing the current marital status of participants is discussed later in this chapter. However, the generally high level of educational attainment was an interesting and surprising finding and contrasts sharply with what might be expected in this sample, in view of the typically negative impact of SV on education (Petrak & Hedge, 2002). In fact, several of the service provider interviewees in Stage One alluded to the harmful effects of SV on participants' ability to continue and/or complete their education. In particular, they mentioned the experiences of second level students who had attended their services.

One of the most interesting findings to emerge with respect to the profile of the women in this study relates to their typically high levels of educational attainment, despite the presence of current post-traumatic symptoms consistent with a typical and chronic post-traumatic profile. The literature in this field is variable, in that some studies have found an association between low educational attainment and PTSD severity (e.g. Iversen et

al., 2008) whilst others have not (Breslau et al., 1997b). Nonetheless, any negative effect on educational attainment might be considered intuitively likely given the relatively widespread impact of SV and PTSD in an individual's life (as outlined earlier in Chapter Two). A possible explanation for the high levels of educational attainment in this sample, in the presence of current post-traumatic symptoms, may relate to the time since the incident and the age of participants at the time of the incident. Participants were on average 23 years old at the time of the incident, by which time – at least in some cases - most, if not all, of their formal education would have been completed. In addition, the typically long period of time since the incident (13 years on average) may arguably, have provided participants with ample time, to recover from their experience to the extent that they felt able to go on and pursue third- and fourth-level education in later years.

These findings are particularly interesting when located within the literature on '*post-traumatic growth*'. This refers to the positive changes that may emerge as a result of an individual's experience of trauma (e.g. obtaining an educational qualification) (Tedeschi & Calhoun, 2004). For instance while some authors have found that increased levels of education may be related to less severe PTSD symptoms in rape survivors (e.g. Ullman & Brecklin, 2002; Ullman & Filipas, 2001), other findings from the PTG literature suggest that the presence of PTG does not negate the negative consequences of a traumatic experience (such as post-traumatic symptoms) (Linley, Joseph, Cooper, Harris, & Meyer, 2003; Shakespeare-Finch, Smith, Gow, Embelton, & Baird 2003). In fact, it has been reliably reported that both positive and negative outcomes can effectively co-exist independently of each other within the same person (Linley et al., 2003).

The PTG model, as developed by the leaders in the field (Tedeschi & Calhoun, 1996), is considered both a 'process' and an 'outcome' model, and describes the individual achieving, and subsequently sustaining, at least one positive change in their lives that can be directly attributed to their experience of trauma (Siegel & Scrimshaw, 2000). Positive changes within this model include, but are not limited to: increased feelings of self-efficacy and/or self-reliance; strengthened or improved interpersonal relationships; increased spirituality; and heightened appreciation of life (Grubaugh & Resick, 2007). With respect to survivors of SV, the positive changes that have been reported, vary from

increased protection of survivor's own children from sexual abuse and growing stronger as a person (e.g. McMillen, Zuravin, & Rideout, 1995) to greater empathy and better relationships (e.g. Frazier, Conlon, & Glaser, 2001).

Possible evidence of this process within the current sample (and also of its outcome as shown by the high levels of educational attainment) also emerged in the Stage Three interviews, where several women suggested that education had become an essential resource for them and had often offered them an 'escape' from their post-assault difficulties. Further investigation of the relationship, if any, between symptom severity and growth outcomes would be useful, particularly if positive psychological adjustment could be identified as a protective factor in cases of sexually-related PTSD. However, much of the perceived positive benefits emerging from an experience of trauma have been assessed qualitatively (as in this study) or anecdotally, rather than through the use of psychometric measures (e.g. Posttraumatic Growth Inventory (PTGI), Tedeschi & Calhoun, 1996) (Grubaugh & Resick, 2007).

This level of educational attainment in a trauma sample may also be interpreted as an indication, at least in part, of their recovery from their traumatic experience. Substantial work has focused on the post-traumatic recovery process, particularly within the context of treatment options and outcomes (e.g. Foa & Rothbaum, 1998; Gilboa-Schechtman & Foa, 2001; Resnick, 2001). However, Herman (2001) conducted a landmark study of trauma, which delineates the stages of recovery through which individuals pass in the aftermath of a traumatic event. She posits that the two integral experiences of psychological trauma include disempowerment of the individual and their experience of disconnection from others, and therefore, that their recovery necessitates the empowerment of the survivor and the formation of new connections (Herman, 2001). In addition to the importance of a healing relationship, Herman suggests that the following three stages to recovery are critical: re-establishing a sense of safety in the world; engaging in remembrance and mourning; and re-connecting with ordinary life (Herman, 2001). It is this third, re-connection stage, which is of particular relevance here.

During this third stage, survivors are faced with re-defining their sense of self and planning for their future, based on this re-created self-identity (Herman, 2001). At this stage of recovery, Herman suggests that survivors have a better understanding of

themselves, who they were prior to the trauma, the damage inflicted on them because of their traumatic experience and subsequently a desire to become the person they want to be (2001). As well as re-discovering connection and intimacy within their personal lives, some survivors seek the resolution of their trauma in a much more public forum – an endeavour which Herman terms obtaining a ‘survivor mission’ (2001:207). For these individuals, the meaning of their personal trauma is transformed via social action (Herman, 2001). This ‘survivor mission’ can take the form of pragmatic engagement with organisations or individuals that help others and who have been similarly victimised, or more ‘*abstract intellectual pursuits*’ such as educational, legal or political efforts to raise public awareness about these issues (Herman, 2001:208). While it is not possible to empirically support this claim from the data collected in this study, it is plausible to suggest, that at least for some of the almost two thirds of this sample with third level qualifications, that their experience of SV may have acted as a motivating factor (consciously or unconsciously) in the decisions they made about their future in the 13 years (on average) since their assault.

With regard to other background characteristics, most of the women in the current study (83%), in line with the SAVI figures (79%), were acquainted with the perpetrator. The most recent RCNI figures reported marginally higher rates than in this study, with almost 9 out of every 10 perpetrators (87%) being known to the survivor in some way (RCNI, 2009). This is consistent with the findings from other studies conducted in the UK (e.g. Kelly, Lovett & Regan, 2005; Walby & Allen, 2004), which shows that the perpetrator was known by the victim, to a greater or lesser degree, in the majority of incidents. Likewise, findings from the US show that approximately two thirds of sexual assaults are committed by an offender known to the victim (e.g. friends, acquaintances, intimate partners, and relatives) (Russell, 1990; Tjaden & Thoennes, 2000).

The relationship of the victim to the perpetrator emerged as a significant factor in this study. Research in this area has largely focused on: the role of the victim-offender relationship; on psychological well-being post-assault (Temple, Weston, Rodriguez, & Marshall, 2007; Ullman & Siegel, 1993); on the level of physical injuries as a result of the assault (Kilpatrick et al., 1989; Stermac, Delbove & Addison, 2001); and on (mock) jury decisions (Grubb & Harrower, 2009; Schuller & Klippenstine, 2004) and sentence lengths in criminal prosecutions (McCormick, Maric, Seto, & Barbaree, 1998). One of

the main findings with respect to the victim-perpetrator relationship in the current study, was that younger women (i.e. at the time of the assault) were more likely to be raped/sexually assaulted by a stranger, or an acquaintance, as opposed to a current, or ex-, boyfriend, partner, spouse, or family member.

Both in the U.S and the UK, some limited research (Amir, 1971; Bownes, O’Gorman, & Sayers, 1991) has examined the social context of rape in relation to victim type; for example, are young, attractive women more likely to be assaulted? A recent U.S.-based study by Spivak (2008), examined data from the National Crime Victimization Survey (N=557) and the National Incident Based Reporting System 2004 (N=13,510). Using a criminological perspective, Spivak (2008) assessed the likelihood that victim selection was based on youthfulness and attractiveness (as posited by feminist theory), or on proximity and convenience (as suggested by sociobiological theorists). Although he found a similar victim-age distribution across categories of victim-offender relationship (i.e. stranger, acquaintance, intimate-partner, friend/family member), he concluded that neither theoretical standpoint adequately explains the elevated victimisation risk apparently inherent in younger women (Spivak, 2008).

Closer to home, Muir and MacLeod (2003) conducted a social contextual analysis of 172 rapes and attempted rapes occurring in a large metropolitan area in the UK. Three quarters of their sample were aged 25 years or younger at the time of the rape/attempted rape; this compares favourably with our study where the average age at the time of the incident was 23 years (Muir & MacLeod, 2003). Similarly, according to national Irish statistics, almost half (44%) of those who contacted RCCs for support in 2008 were aged between 17 and 23 years at the time of the assault (RCNI, 2009). Muir and MacLeod’s (2003) analyses of crime data showed that young women (i.e. under 25 years) were at greater risk of assault than older women. In particular, and as in the current study, women within the 15-24 years age bracket were found to be especially vulnerable to rape, or attempted rape, by a stranger or an acquaintance as opposed to an intimate (Muir & MacLeod, 2003). The reasons for this pattern are unclear. One possible, yet empirically untested explanation is, that these young women were less likely to be in a steady or long-term relationships due to their age, thereby making it less likely that the perpetrator would be someone with whom they were, or had been,

involved. Given that the perpetrator is known to the victim in most cases, the risk to younger women of rape or sexual assault by strangers, merits further investigation.

The average age of participants in this study, at the time of the rape/sexual assault, was 23 years. Recent statistics collated by the Dublin RCC, indicate that approximately half of their help-line callers were under the age of 30 whilst a similar proportion (45%) reported an incident of adult rape (DRCC, 2009). This suggests that rape is occurring in a substantial proportion of the younger female population in Ireland, although it is not clear if these crimes are being more often perpetrated by non-intimate partners (i.e. someone less well known to the victim) in this group. However, other Irish research from the domestic violence sector has shown that the lifetime prevalence of SV within an intimate relationship is 8% (Watson & Parsons, 2005). Clearly, given these figures, and some of the research highlighted above, further research is required to examine in more detail the role of the relationship to the perpetrator as a significant risk factor in younger versus older women.

In the current study, women assaulted by a perpetrator better known to them, were also more likely to be single or separated/divorced than those who knew the perpetrator less well. Whilst correlation does not imply causation, this nonetheless, raises the question as to whether or not women's experience of SV, by someone closer to them, is playing a role in their current marital status. Certainly, evidence from the qualitative interviews with these women highlighted (at least in some cases) a troubled relationship history, which they attributed directly to their experience of SV. However, it is more likely that the relationship between these variables is infinitely more complex than these findings would suggest. For example, some researchers propose that certain psychological needs of a victim (e.g. trust safety, intimacy, esteem) form the basis for key pre-existing beliefs, which are often disrupted by this traumatic experience (Resick, 2001). Consequently, the violation of trust inherent in the act of rape by someone close to the victim would, presumably be experienced to a greater degree than if the perpetrator was a stranger. Thus, it is perhaps not unreasonable to assume that a significant sub sample of the women in this study would be currently single or separated/divorced following the trauma of the rape, combined with an impaired ability both to seek out and sustain safe healthy intimate relationships and trust those closest to them.

Petrak and Hedge (2002) argue that many of the typical post-traumatic responses, such as anger and anxiety, contribute to the strain placed on personal relationships following an incident of rape or sexual assault. They add that the partners of these women will often experience distress too, as a result of the incident (Petrak & Hedge, 2002). Morrison et al. (2007) have called this 'secondary traumatisation'; that is, where a 'secondary individual' (e.g. a boyfriend) who is close to the victim of SV, experiences similar trauma symptoms. For example, Nelson and Wampler (2000; 2002) found that non-abused individuals in their sample, whose partner had a history of childhood sexual or physical abuse, exhibited more trauma symptoms than in a comparison group comprised of 65 couples with no history of abuse. While the impact of SV on intimate partners and family members did not emerge directly in the course of the present research, some participants did allude to the distress, confusion and difficulties it had caused in their relationships. For the most part however, when probed, most of the women remarked that, since their initial disclosure of SV to their partners, no further conversations had been initiated by either party on the subject, thereby precluding any further discussion or exploration of the experience.

10.2 Childhood sexual abuse and re-victimisation

An interesting question, in the context of the current study, was the proportion of women with a history of sexual violence and/or abuse prior to their most recent assault (as indicated in Chapter Six, participants were asked to indicate a prior history of sexual violence and/or abuse). Approximately one third of the current sample reported experiencing SV (n=21) and/or sexual abuse (n=24) before the age of 16. This is consistent with the figures for the SAVI report, which found that almost one third of the women in their sample (n=947), reported some level of sexual abuse in childhood (McGee et al., 2002). Importantly however, the SAVI respondents, when asked to record their experiences of sexual abuse, endorsed a much *wider range* of experiences than in the current study, including being forced to watch pornography, having someone expose themselves, as well as several different forms of 'contact abuse' (McGee et al., 2002). The last of these (which is how most people would perhaps best understand the term sexual abuse) was endorsed by fewer women (20%) in the SAVI study, therefore providing a more meaningful benchmark for comparison with the current study. The SAVI finding is also supported by similar figures for the UK, which indicate that

approximately 21% of girls have experienced sexual abuse under the age of 16 years (Cawson, Wattam, Brooker, & Kelly, 2000).

The elevated figure for sexual abuse and SV in childhood in the current sample may be due, in large part, to the fact that all of the respondents had a known history of SV in later life. This supports a small, but growing pool of international research, which suggests that childhood experiences of SV may be a significant risk factor for experiencing SV in adulthood (Barnes, Noll, Putnam, & Trickett, 2009; Classen, Paresh & Aggarwal, 2005; Root, 2008). For example, in a review of 90 empirical studies, Classen et al. (2005) reported that two out of every three individuals who are victimised sexually, will be re-victimised. This finding has also proven to be relatively consistent over time (e.g. Coid et al., 2001; Kessler & Bieschke, 1999; Russell, 1986).

Another more recent study by Walsh, Blaustein, Knight, Spinazzola and van der Kolk (2007) examined childhood sexual abuse (CSA) as a risk factor (n=73) in instances of forced or coerced (based on perpetrator tactics) sexual assault. CSA was found to be the strongest independent predictor of forced sexual assault in adulthood (Walsh et al., 2007). In one large, UK-based cross-sectional survey of women (n=1207) recruited from 13 general medical practices in East London, unwanted sexual intercourse before the age of 16 years, was found to be significantly associated with rape in adulthood (Coid et al., 2001). One possible explanation for this is that CSA places individuals at risk for future victimisation by interfering with their ability to recognise and respond to appropriate environmental cues that alert them to personal risk or danger (Naugle, 1999).

Another point related to the above, is that the sample of women in the current study appeared to be experiencing higher rates of re-victimisation than have been previously found in Ireland. For example, according to the SAVI results, more than one quarter (28%) of the participants had experienced SV *both* as a child (i.e. under 16) and as an adult. Furthermore, penetrative sexual contact as a child (as opposed to non-contact sexual abuse) resulted in a 16-fold increase of women experiencing penetrative abuse as an adult (McGee et al., 2002). While the authors do not suggest a causal relationship between the two, this is also consistent with research conducted elsewhere (Classen et al., 2005; Root, 2008; Barnes et al., 2009). In addition, the re-victimisation rate found in

the current study (approximately one third) was further supported by some of the findings from the qualitative interviews in Stage Three. In fact, all of the, albeit small number of women who took part in Stage Three and who reported a prior history of SV (n=3) (some of whom who were raped aged 16 and 17), made reference to the damage sustained to their sense of boundaries and ability to navigate future sexual encounters safely, as a result of earlier CSA. Another possible explanation for these figures, in keeping with the cultural context of the study, is the increased acceptability of disclosing CSA in recent years in the south of Ireland, due largely to a number of high profile reports on the institutional physical and sexual abuse of children (e.g. The Ryan Report, (Ryan, 2009); The Ferns Report, (Murphy, Buckley, & Joyce, 2005)). Nonetheless, the prevalence of early experiences of SV in this sample, suggests that they are still playing a considerable role in later victimisation.

10.3 The ‘hidden’ impact of sexual violence

A synthesis of previous research on the impact of SV was provided earlier in Chapter Two. Some of the key findings from Stage Two will be reviewed here and discussed in the context of the current research. The qualitative findings will be interwoven throughout to supplement and amplify this discussion, in an attempt to expand the traditional understanding of women’s response to SV, as proposed by the PTSD framework.

The findings from Stage Two of this research showed that the women in the SV sample were characterised by significantly lower levels of QoL and social support than their comparison group participants, as well as significantly higher levels of recent psychological distress and recent negative life events. As anticipated, many of the findings that emerged in relation to the different constructs assessed within this study are typical of this population and well supported in the international literature. These are discussed in more detail below.

10.3.1 Quality of life, social support and relationships

Low subjective ratings of QoL are frequently reported in individuals with a psychiatric history; however, those with PTSD tend to report particularly low rates (Warshaw et al., 1993). Thulesius, Alvebom and Kansson (2004) conducted one of the few European prevalence studies for PTSD (n=1113) and reported that subjective well being (or QoL)

was the factor that was most strongly associated with PTSD following rape and sexual assault; that is, lower QoL was associated with the presence of PTSD symptoms. Another study conducted around the same time by Laffaye and colleagues (2003) found that health-related QoL was significantly lower in women with a history of IPV when compared with a control group; similar findings were reported by Alsaker, Moen, Nortvedt and Baste (2006) in a sample of abused Norwegian women. With regard to social support, it was found, as in previous research (e.g. Schumm et al., 2004), that this diminished during the period after the assault; this is often exacerbated by typical post-traumatic reactions, such as avoidance and withdrawal (Petrak & Hedge, 2002). Likewise, other research that has used the ISEL with women subjected to domestic violence, found that their perceived levels of social support were low following the incident (Constantino & Bricker, 1997; Crane & Constantino, 2003).

In the present study, participants also reported that their ability to form intimate relationships was more negatively affected than their ability to form close friendships. Furthermore, the negative impact of their experience of SV on their relationships and sexual intimacy emerged as a dominant and recurring theme in the qualitative interviews (this finding is discussed in more detail in Section 10.4). Koss, Dinero, Seibel and Cox (1988) examined depression, anxiety and sexual satisfaction in a sample of women who had been raped by strangers, non-romantic acquaintances, casual dates, steady dates or spouses/family members. They found that those women who were raped by their spouse, or a family member, were more likely to report lower ratings of the quality of their relationships than the other groups. Furthermore, Hanson (1990) reported, in a review of studies on the psychological impact of rape on women and children, that high levels of anxiety and depression were relatively common in the immediate post-assault period, although 20% continued to have difficulties one year on. Interestingly, depression and anxiety symptoms, as measured by the TSI in the current study, were the two most commonly reported mental health symptoms/sequelae in this sample.

10.3.2 Mental health status

As shown in Chapter Two, rape and sexual assault have a clear negative impact on the mental health of victims. More than half of the participants in the SV sample reported a previous mental health diagnosis compared with just 5% of the comparison group. In

contrast, prevalence rates from the WHO (2001) suggest that 10% of the general population have been diagnosed with a mental health problem, while a recent Irish study (n=2711) found that one in eight adults were experiencing psychological distress (Tedstone, Doherty, Moran, Kartalova-O'Doherty & Walsh, 2007). The levels found in this study are a source of some concern and highlight the extent of mental health sequelae in this 'at-risk' population. Specific Irish research on SV has provided only limited data on the psychological impact of SV; for example, with regard to PTSD, McGee et al (2002) examined only prevalence rates in relation to the type of the abuse, the time elapsed since the abuse and the timing of the abuse (i.e. either as a child or as an adult). However, they did note that those who experienced childhood sexual abuse in the context of incest (i.e. by someone from their family and therefore well known to them) were more likely to meet the criteria for partial or full PTSD. In fact, they found that the risk of developing PTSD was approximately doubled if participants had previously experienced incest (McGee et al., 2002).

Several of the risk factors for the development of PTSD outlined in Chapter Two, were present in the SV sample in this study including: female gender; experience of rape/sexual assault; a prior history of trauma (i.e. experience of SV before the age of 16 for approximately one third of the sample) and negatively affected interpersonal relationships (i.e. diminished social support). The above-norm TSI scores indicate clearly that individuals, who have experienced SV, may report clinically significant levels of PTS for many years after the event. However, this level of trauma symptoms approximately 13 years after an incident is not unique and has been reported elsewhere (Elliott, Mok & Briere, 2004). In fact, the women in this study, when compared to by work undertaken by Elliott and colleagues, obtained higher scores on all scales of the TSI than a random sample of female adults (n=104) from the general population who had had an experience of adult sexual assault 14 years previously (Elliott, Mok, & Briere, 2004).

The findings also suggest that the relationship to the perpetrator is associated with mental health status; that is, the better known the perpetrator is to the victim, the more likely they were to have been diagnosed with a mental health problem. However, it is difficult to know what other factors may be involved here. Furthermore, the possibility of any comparisons with the literature on this front, are limited because any studies that

have examined trauma and associated negative health outcomes, have tended to focus on stranger or acquaintance rape more than intimate partner sexual assault (Temple, et al., 2007) - despite the now well documented finding that most rapes/assaults are carried out by individuals known to the victims (Kelly, Lovett & Regan, 2005; McGee et al., 2002; Walby & Allen, 2004). It is also worth noting that stranger rape, more often than not, consists of a single incident, whereas rape within an intimate relationship may occur on multiple occasions (Russell, 1990). Whilst the women in the current study were asked to refer only to their most recent incident of rape/sexual assault when providing details on their experience of SV, it is not unreasonable to suggest that they may have been raped/assaulted by the same perpetrator on more than one occasion, particularly in the context of an intimate relationship.

Previous research suggests that as the number of assaults increases, so too do the levels of psychological distress (Follette, Polusny, Bechtle, & Naugle, 1996; Nishith, Mechanic & Resick, 2000). Furthermore, while some authors have found that women who were raped/sexually assaulted by strangers had significantly more post-assault problems with fear and depression (e.g. Thornhill & Thornhill, 1990), others have identified no significant differences in mental health between groups (e.g. stranger/marital/date rapes) (e.g. Kilpatrick et al., 1987; Riggs et al., 1992). Indeed, Petrak and Hedge comment that: *'in the majority of research reports, no significant differences on the levels of psychological symptoms were found between stranger and acquaintances rapes'* (Steketee & Foa, 1987; Koss et al., 1987) (2002:36). However, by way of explanation, the authors go on to suggest, that it seems likely that the victim's interpretation of the incident and the meaning they attach to it (and, therefore, the likelihood of developing a mental health problem), will be influenced in some way by their relationship to the perpetrator (Petrak & Hedge, 2002).

This argument is further supported by Culbertson and Dehle (2001) who suggest that it may be possible to predict the severity of post-trauma sequelae by considering the degree of *'interpersonal relatedness between rape victim and perpetrator'* (2001:993). According to these authors, the nature of this relationship may influence how a woman understands her experience of SV (i.e. does she label it as rape?) and may determine the range of social supports available to her. For example, in their female undergraduate sample (n=96), women assaulted by a spouse or co-habiting partner, reported

significantly more trauma symptoms (specifically hyperarousal and intrusive symptoms) than those assaulted by an acquaintance/date/sexually intimate partner (Culbertson & Dehle, 2001). Furthermore, a more recent study that examined the differing effects of intimate partner and non-partner sexual assault on the mental health of a community sample of women (N=835), showed that an assault by a current or past partner was a significant predictor of PTSD, stress and dissociative symptoms (Temple et al., 2007).

The findings from the current study amplify those reported elsewhere and add new knowledge to support of the calls of previous researchers (e.g. Culbertson & Dehle, 2001; Temple et al., 2007; Ullman, Filipas, Townsend, & Starzynski, 2006) to focus further empirical work on assessing the psychological symptoms and mental health status of victims of intimate versus non-intimate assault. This work would add a new perspective to the area and would have important implications in terms of informing rape education and prevention and treatment programmes which, traditionally, focus on stranger and acquaintance/date rape (Temple, e al., 2007).

It is interesting to note that both the SV sample and the COM group in this study reported almost identical rates of problem drinking during the previous 12 months. Thus, it was not possible to ascertain whether or not alcohol consumption had any mediating role with regard to mental health status (e.g. trauma symptoms, recent psychological distress). However, the authors of the RAPS-4 suggest that the results should be interpreted within the context of the normal drinking patterns of the population of the country in question and that the sensitivity of the measure may be impaired where drinking is more integrated into the culture (Cherpitel et al, 2005). It is well know that alcohol consumption per capita is higher in Ireland than in most other European countries (Ramstedt & Hope, 2005). For example, in 2003, people in Ireland consumed 10.3 litres of alcohol per person, compared with the European average for the same year of 9.6 litres (Mongan et al., 2007). Consumption of alcohol is not only integral to our national identity, but 'binge drinking'²⁷ is a relatively common occurrence for a substantial proportion of the population including both men and women (Mongan, Reynold, Fanagan, & Long, 2007). Therefore, it is possible that the

²⁷ Defined by the Health Promotion Unit as consumption of five or more drinks per drinking occasion by a woman and seven or more drinks per drinking occasion by a man (Mongan et al., 2007).

scores on this measure reflect an elevated pattern of drinking in both groups and that perhaps the cut-off for problem drinking on these standardised measures is too low for an Irish sample.

Nevertheless, the issue of binge drinking within this particular population is a source of concern for reasons other than its effects on physical health (Mongan et al., 2007:23). For example, research conducted in the US has identified childhood sexual abuse (Galaif, Stein, Newcomb, & Bernstein, 2001; Jasinski, Williams & Siegel, 2000) and adolescent experiences of sexual and physical abuse, as strong predictors of binge drinking in adulthood (Kaukinen, 2002). Other research has reported a link between increased binge drinking and elevated rates of mental health problems such as PTSD, depression and anxiety (Bradley et al., 2001). Some have suggested that binge drinking may provide individuals with a means to re-gain a sense of control in their lives by alleviating the distressing symptoms of PTSD, depression and anxiety (Kaukinen, 2002). However, the question remains as to whether PTSD increases binge drinking, or whether binge drinking exacerbates the symptoms of PTSD.

A recent study of PTSD and problem drinking in a sample of female survivors of sexual assault (n=555) examined this question in more detail. (Najdowski & Ullman, 2009). The authors did not find any evidence to support the supposition that the presence of PTSD was influencing problem drinking or indeed vice versa (Najdowski & Ullman, 2009). Interestingly however, an experience of sexual victimisation during the course of their study was found to be associated with increased PTSD symptoms and problem drinking at one-year follow-up (Najdowski & Ullman, 2009). Furthermore, increased binge drinking post-assault has also been found to increase the risk of revictimisation (Gidycz, et al., (2007). Ullman and Najdowski (2009) also identified a number of psychosocial factors (e.g. coping strategies, reactions from people in their informal support networks) that were directly related to increases in problem drinking for revictimised women but not for non-revictimized women (Najdowski & Ullman, 2009).

In sum, there is considerable evidence to indicate that drinking post-assault can increase trauma symptomatology, depression, feelings of anxiety, and revictimisation risk. This suggests that interventions for victimised women with issues related to problem drinking should *'target drinking to cope with assault-related symptomatology, informal*

social networks to improve their supportiveness, and safety issues through risk-reduction education and self-defense training for women when appropriate' (Najdowski & Ullman, 2009: 41). Whilst the evidence from the literature would suggest that problem drinking is related to an experience of SV, it was not possible to examine this in the current study due to the almost identical rates of problem drinking in both the SV and COM groups. As an aside, future research could examine the drinking patterns in Ireland versus other European countries in order to accurately capture the role of alcohol in coping with, and/or exacerbating mental health problems across different cultures.

10.3.3 Use of mental health services

Despite the negative impact of SV on mental health, the women in this study appeared reluctant to engage with formal mental health services. Our findings suggest that counselling was considered more accessible than the psychiatric services or other mental health professionals (e.g. clinical psychologists); the great majority had attended counselling, either privately or through a RCC, at some point after the rape. This suggests that these women were voluntarily accessing formal support irrespective of whether the counselling was sought for the direct and acknowledged (e.g. anxiety, nightmares), or indirect, consequences of SV (e.g. marital difficulties). More significantly, the findings from the sub-group analysis showed that those women who had not engaged with formal mental health services (i.e. those without a formal mental health diagnosis) were experiencing more severe trauma symptoms than those who had received a diagnosis in the past. While it is not possible to determine if a causal relationship exists between these two variables (i.e. whether or not these women have more trauma symptoms because they have not engaged with formal mental health services), it does raise serious concerns about their overall health and well being, as well as the possible negative impact on family members. This is further supported by the findings from the Stage Three interviews, which showed that several of the women reported persistent suicidal ideation for many years after the rape. This also points toward a possible gap in current counselling and support services with respect to the extent that they are specifically targeting (or need to target) trauma symptoms in clients who have experienced SV.

While the factors that influence help seeking in women with a history of SV were not the focus of this research, a brief review of some of the findings from the literature suggest that this lack of engagement with formal mental health services amongst women with a history of SV is not uncommon. (Note: Barriers to services have already been reported and discussed in Chapter Five). For example, in an early study by Golding, Siegel, Sorenson, Burnam and Stein (1989), only 16% of a community sample of sexually assaulted women had disclosed their experience to a mental health professional when compared with almost 60% who had disclosed to a family member or friend. Other research has found that rape victims are more likely to seek treatment from primary care physicians/GPs than from formal mental health services (Koss, Koss & Woodruff, 1991). More recent research found that 40% of a sample of women who had been raped (n=556) had never sought help specifically for emotional problems, despite the fact that this group of women are significantly more likely than the general population to seek such help (Amstadtter et al., 2008).

Other research has shown that women who are raped by a partner or husband are less likely to seek help through formal agencies than those raped by a stranger or an acquaintance (Mahoney, 1999). For instance, Kessler et al. (2001) argue that people do not seek help from a mental health professional due to: (1) a lack of knowledge about the availability of the service; and (2) negative attitudes about using these types of services. Likewise, Conner (2009) argued that the stigma associated with having a formal mental health diagnosis may act as a barrier to engaging with services for these women. For example, the specific effects of stigmatisation may include fear of being judged or being treated differently, not being appreciated or understood and of being discriminated against (Conner, 2009). A recent study undertaken in Ireland showed that 62% stated that they would not like others to know if they had a mental health problem (HSE, 2007). These findings coincide with those from elsewhere, which have found high levels of stigmatisation across a range of jurisdictions (e.g. Hayward, & Bright, 2007, Kelly and Jorm, 2007; Crisp, et al., 2000).

10.3.4 Sexual risk-taking behaviour and its impact on health and well-being

As discussed earlier in Chapter Two, the detailed trauma measure used in this study provided useful insights into the profile of the SV sample within the context of PTSD. According to the information in the test manual, the trauma profile of these women was

typical of a group exhibiting levels of chronic PTSD. Briere (1995) suggests that the trauma profile and pattern of responding evidenced in this group several years after the traumatic event may indicate an integration of these behaviours into the personality of the individuals concerned. Although the DSB (Dysfunctional Sexual Behaviour) scale was the least endorsed of all the TSI sub-scales (i.e. participants reported these symptoms less than any of the other symptoms), the rather curious positive associations found between rates of 'dysfunctional sexual behaviour' and physical QoL warrants closer attention. The following sections look at this in more detail, beginning with a consideration, in the first instance, of dysfunctional sexual behaviour in this group.

As indicated in Chapter Six, the DSB subscale assesses the frequency of problematic sexual behaviour, such as indiscriminate sexual contact with potentially dangerous or dysfunctional individuals, or engaging in unprotected sex. Whilst an increased use of illegal drugs and alcohol after an experience of sexual assault have been routinely reported (e.g. Foa & Riggs, 1993; Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997; Stewart, 1996; Ullman, Filipas, Townsend, & Starzynski, 2005) the more sensitive subject of sexual risk-taking behaviour in this population has received considerably less attention (Davis, Combs-Lane, & Jackson, 2002). Apart from the obvious physical and reproductive health implications involved with sexual risk-taking behaviours (e.g. unwanted pregnancy, increased exposure to STIs and HIV), research suggests that behaviours such as promiscuity and unsafe sex may increase the risk of re-victimisation (Koss & Dinero, 1989; Polusny & Follette, 1995). Furthermore, women with a history of interpersonal victimisation have been found to engage more in risky activities in the past, as well as having a greater likelihood of involvement in such activities in the future (Combs-Lane & Smith, 2002; Davis & Petretic-Jackson, 2000).

One of the hallmark symptoms of PTSD is an engagement in avoidant behaviours and there is some suggestion that this type of activity, as well as other risky behaviours (e.g. excessive alcohol consumption, illicit drug use), may represent an attempt, on the part of the woman, to manage and reduce their distressing symptoms (Nishith, Resick, & Mueser, 2001; Stewart, Conrod, Samoluk, Pihl, & Dongier, 2000). Research by Davis, Combs-Lane and Jackson (2002) investigated the association between lifetime interpersonal victimisation and recent risk-taking behaviours (e.g. substance use and risky sexual behaviours). They hypothesised that characteristics of the victimisation (i.e.

sexual or physical assault, or single or multiple assaults) would be associated with increased engagement in risk taking behaviours. Overall, they found that women with a history of single and multiple sexual assaults, and physical and sexual assaults, had a greater involvement in risk taking behaviours (Davis, Combs-Lane, & Jackson, 2002). They found, in particular, that multiple incidents of victimisation rather than single incidents were more strongly linked to risky behaviours.

The authors go on to suggest that, while participants also demonstrated the typical negative mental health outcomes that might be expected in this group (e.g. PTSD, depression), this experience of multiple victimisations may '*contribute to further changes in behaviour including increased risk taking*' (Davis, Combs-Lane, & Jackson, 2002:623). The information gathered in the current study does not allow for any firm conclusions in this respect, but an important question for future research is whether this increase in risk taking behaviours post-assault is '*directly related to a victimisation history per se or is mediated by some other factors such as PTSD*' (Davis, Combs-Lane, & Jackson, 2002:623). Lastly, the marginally higher scores seen in the current study on the 'sexual concerns' subscale of the TSI suggests that these participants may be using this dysfunctional sexual behaviour '*to achieve distinctly non-sexual goals such as attention, validation, and distraction from internal distress*' (Briere, 1995:16). As suggested earlier by Briere it is possible that these types of behaviours have become such a habitual way of responding that the women no longer question the function of, or motivation behind, them.

Turning to the specific positive association found in this study between dysfunctional sexual behaviour and physical quality of life, this has not been reported in any other studies. It is possible, in the context of what was discussed above, that: (a) these risk taking behaviours serve as an effective way of avoiding and reducing emotional upset and distress; and (b) they have become so ingrained in the women's behavioural repertoire that they no longer question their choices with regard to engaging in sexually risky behaviour. Therefore, an increased level of physical well-being (e.g. having enough sleep or energy) would facilitate the achievement of these goals (i.e. reducing the traumatic symptoms they are experiencing) by such means. If this interpretation is correct, then the women's subjective ratings of their overall QoL may well remain unaffected. However, the exploration of this relationship is a potentially very interesting

area for future investigation, whilst further work is also required to examine some of the behaviours and cognitions underpinning such dysfunctional behavioural patterns.

10.3.5 Impact of SV: Summary

In summary, the findings discussed here, present an interesting and useful profile of the post-assault impact of SV on a sample of Irish women, although it is important to keep in mind the cultural context in which the study was conducted. While the high levels of educational attainment in the SV sample do not appear to have had a substantial 'buffering effect' against the chronic levels of current trauma symptoms, they may suggest some degree of recovery, or post-traumatic growth, several years post-assault. Unfortunately, persistent trauma symptoms have been found to be linked with an increase in sexual risk-taking behaviours and binge drinking - a pattern also hinted at in this sample. As in previous research, there would appear to be some level of revictimisation among women with a history of CSA, while the victim-offender relationship emerged as a significant finding on several levels. There is also a suggestion, from the literature, that younger women may be particularly vulnerable to victimisation. This is supported by our findings where almost 81 per cent of the sample was aged 30 years or younger at the time of the assault. Lastly, in spite of significant levels of trauma symptoms amongst the sample, relatively few had used formal mental health services. The important issue of access to, and use of support services, amongst these women, is discussed in more detail in the following section.

10.4 Service provision

There were a number of issues highlighted here that were worthy of further attention in relation to responses to SV, particularly within the service sector (e.g. the CJS, SATUs). For example, participants in Stages One and Three of this study referred to several important and persistent gaps, in the response by the CJS to victims, as well as the availability and suitability of current SATU services and the way in which wider society responds to victims of SV. Moreover, several of the quantitative findings also implied that a review of certain medical services (e.g. SATU/colposcopy/smear/STI services) for women with an experience of SV was warranted. These and other findings that might shape our future responses to SV are discussed in more detail below.

10.4.1. The CJS and legal responses to SV

Both of the qualitative stages of this research allowed for the exploration of important issues related, amongst other things, to the current state of play regarding the judicial response to victims of SV in Ireland. Participants mentioned, in particular, the treatment of victims who take a case against their alleged perpetrator; the 'no reason policy' by the DPP; and the time it takes for a case to come to trial. Some of these issues have also been documented in a small amount of small-scale research within Ireland (e.g. Bacik, et al., 1998; Leane, et al., 2001). For example, Leane, et al. (2001) identified several inadequacies within the Irish CJS, including delays in rape cases reaching trial, low rates of conviction and a lack of understanding of the psychological impact of rape. The findings reported here, suggest that there has been little progress in providing an effective and compassionate legal response to victims of SV. Indeed, the participants were very explicit about, and openly critical of, some of these legal barriers and the, often-negative, stereotypical attitudes of CJS personnel.

The key legal actors, with whom victims engage, include the Gardaí (police), prosecution and defence lawyers, and judges. Training has been recommended for all of these personnel in relation to rape myths, rape trauma syndrome and sensitivity to victims (Leane et al., 2001). This point was reiterated by participants in Stage Three, who felt that the findings from this research should be used to promote an awareness of, and greater sensitivity to, female victims of rape amongst CJS personnel. This finding might be useful in informing the development of compulsory specialised training for these key legal actors in order to minimise any further distress for victims. Notably, the Cork Sexual Violence Centre launched a step-by-step guide to the legal system for both professionals, and clients proceeding with a rape case (Crilly, 2007). This was designed primarily for victims and their families to inform their decision-making when deciding to take a case and also with the hope that they would be encouraged to seek help and support (Crilly, 2007).

Participants also mentioned the difficulties faced by women who wish to prosecute their alleged perpetrator and, in 2008, the Office of the Director of Public Prosecution (DPP) announced a review of its 'no-reason' policy (DPP, 2008). Under this policy, the DPP, after a review of the book of evidence related to a case, can make a decision not to proceed with a criminal prosecution and is also not legally obliged to provide the

victims of the crime (or the public) with a reason for this decision (Office of the Director of Public Prosecutions, 2006). A number of bodies made submissions to the DPP in light of this announcement, including the DRCC and the RCNI, who urged the office of the DPP to ensure that findings related to why certain cases do not proceed to court, are made public (RCNI, 2008). For example, they emphasised that in order to reduce this 'justice gap' for victims of SV, '*a clear understanding of why cases do not meet the necessary requirements to proceed to court needs to inform efforts to improve all aspects of investigation and case building*' (RCNI, 2008). This is even more important given that Ireland has the lowest attrition rates for rapes cases in Europe (Lovett & Kelly, 2009; Kelly & Regan, 2002). Unfortunately, in October 2008, the DPP announced that they would be providing reasons for not proceeding with cases to family members *only* in cases where a death had occurred (e.g. murder, manslaughter, road traffic accident etc.) (Irish Times, 2008). Therefore, the distress and uncertainty faced by victims of SV who must face the ordeal of a Forensic Medical Examination in order to obtain justice will continue for the foreseeable future.

Reassuringly however, the RCNI just recently launched (December 2009) their findings from a study entitled *Rape and Justice in Ireland: A national study of survivor, prosecutor and court responses to rape*. This was a four-year independent study that examined the early stages of attrition in rape cases by tracking the experience of rape survivors up to the point where their file goes to the DPP and in the subsequent stages of the criminal justice process (Hanly, Healy, & Scriver, 2009). According to the commissioners of the research (i.e. the RCNI), this research focused specifically on: the nature of the factors involved in navigating a rape case through the justice system; the importance of the quality of social support and formal service provision for survivors in progressing a case through the CJS; the possible effects of survivor and 'official' preconceptions on what constitutes "real rape" on the majority of cases that do not fit these criteria. It also explores the factors that influence the DPP's decision to prosecute and those put forward for prosecution in both successful and unsuccessful court cases (Hanly, Healy, & Scriver, 2009). According to information in the press release, the report concludes with a call for comprehensive reform of the justice system with the aim of achieving more effective prosecution of rape cases, as well as proposing concrete suggestions to help in the prevention of the crime

10.4.2 SATUS and medical responses to SV

Very few of the women in this sample attended a SATU following their assault (11%), but for those who did, their experiences with medical personnel were mixed. Stakeholders, in particular, noted several persistent and consistent gaps in the nature and extent of SATU services in Ireland. For example, currently, all four fully-operating SATUs in Ireland face several challenges including: the recruitment and retention of trained FMEs; the sometimes conflicting roles of nursing staff to provide appropriate out-of-hours cover (e.g. one of the SATUs relies on nurses from the Gynaecological Ward of the adjacent hospital); and the limited scope of service provision (e.g. Waterford SATU services are only available to victims who proceed to court) (O'Shea, 2006). Comparable challenges exist within the UK. For instance, Coy, Kelly and Foord (2007) report that fewer than one in four local authorities have a specialised SV support service (2007). Furthermore, Northern Ireland does not have a Sexual Assault Referral Centre (SARC) whilst it's only RCC lost its government funding in July 2006 (Coy et al., 2007). Thus, the geographical spread of services and unstable sources of funding, as in Ireland, mean that many regions are grossly under-served.

However, since this study began, there have been further developments in this field and, in 2007; the Irish government announced its plans to establish two further SATUs in Ireland – one in the Midlands and a second in the west of the country (Health Service Executive (HSE), 2007). Since then, a SATU unit has opened in Mullingar Regional Hospital (Midlands) in February 2009 and in Galway (West) just recently (August 2009) (Irish Times, 2009). While the Irish government also announced funding of €1.5m for SATUs for the remainder of 2007 and €2.5m for every year thereafter, the current state of funding for these and many other public services within the health sector, remain uncertain (HSE, 2007). Nonetheless, these developments come in timely response to a national review (O'Shea, 2006) of sexual assault treatment services and address, at least in part, some of the legitimate concerns raised by participants in this study.

The O'Shea report (2006) also recommended the introduction of a pilot programme in forensic nursing in Ireland. This would allow nurses to obtain a higher diploma in order to qualify as a clinical nurse specialist in forensic nursing, thereby addressing some of the issues with SATU services in retaining trained doctors for this role; this solution has

proved popular (and successful) both in the US and Europe (O' Shea, 2006). Encouragingly, eight nurses graduated with this qualification in April of this year (Irish Times, 2009). While these developments are most welcome, the findings from the current study, suggest that there is still considerable scope for improvement and for the implementation of some of the other key recommendations in the O' Shea report, such as: standardising existing services, including the scope of services offered and the involvement of support workers; and commissioning needs-led research in the area of rape and sexual assault (O'Shea, 2006). The more up-to-date findings reported here also suggest that endeavours to promote a greater uptake of the SATU service and the provision of a 24-hour SATU service nationwide, would be a welcome, if not essential development. Unfortunately, the current downturn in the economy may pose an obstacle to implementing these recommendations and to ensuring that ring-fenced funding for the SV sector is provided into the future.

One of the recurring findings throughout all stages of this research was the profound effect of SV on the sexual and personal relationships of the women in the study. In addition, some of the ineffective coping strategies described by the participants (e.g. alcohol abuse, sexual risk-taking behaviours), may place them at even higher risk for long-term sequelae, such as compromised sexual and reproductive health, and higher risk of STIs. This was also highlighted in Stage One and is supported by results from several other studies in the field (e.g. Campbell et al., 2004; Combs-Lane & Smith, 2002; Kimerling & Calhoun, 1999; Koss et al., 1990). Evidence of this increased risk to reproductive and sexual health was also evident in the relatively large proportion of women in the SV sample (approximately one in five) who had previously attended a colposcopy clinic. While national figures for this type of service utilisation are not routinely available (due to the lack of a national database), the recent launch (September 2008) of *Cervical Check*, through the National Cancer Screening Service (NCSS), may provide some indication of the anticipated referrals for colposcopy that might be expected in the general population.

Cervical Check aims to provide free cervical screening to all women in Ireland between the ages of 25 and 60 years (NCSS, 2008). On average, there are 180 new cases of cervical cancer diagnosed in Ireland each year and 73 deaths (NCSS, 2008). Cervical screening is accepted internationally as an effective preventative health measure and has

the potential to reduce the incidence rates by up to 80% (NCSS, 2008). The NCSS expects to screen approximately 300,000 (of the 1.1 million women aged between 25-60 years in Ireland) annually and, of those, it is anticipated that 2-5% would be referred for colposcopy services. Thus, the sample of women in this study would appear to have a substantially greater utilisation of these services (in the past) when compared to the anticipated referral rates for the general population. Additionally, their overall rate was also much higher than in the COM group (12%) and while it is not possible to infer a causal relationship between a history of SV and colposcopy referrals, these figures do merit further attention, albeit with the recognition that the relationship between rape and high-risk sexual behaviours involves a complex interplay of factors (Campbell, et al., 2004). The findings reported here should inform future policy and service development by highlighting a need to provide comprehensive, long-term, medical care that is specifically tailored to this vulnerable population.

Some of the Stage Three participants also alluded to the distress and difficulties that they experienced when attending for regular cervical smears, or STI testing. Therefore, future research could examine more closely (a) some of the issues around the uptake and use of these (and other health) services and (b) the levels of awareness amongst health professionals about the unique needs of SV survivors. This is important in order to inform the development of appropriate and responsive sexual and reproductive (and other) health services. It is clear from the current research that, whilst many of the issues highlighted by participants have existed for some time, positive changes have begun to take place with regard to developments in legislation and policy, as well as the setting up of a dedicated organisation such as *Cosc*, all of which signify important progress in this field. The findings reported in this study, if considered seriously, provide clear support for the continuation and development of these efforts for the foreseeable future.

10.5 Societal responses to SV: Dismantling a ‘rape supportive’ culture

Perhaps one of the most salient and pervasive findings in this study was the range of responses that victims of SV received from their families and wider society, following the assault. Indeed, even the perception (as opposed to the actual experience) of a negative reaction (i.e. that they would be blamed) was sufficient in some cases to ensure a sustained silence amongst some of the women. Many of the remarks by stakeholders

and service-users alike emphasised the need for an urgent re-education of the general public around SV, its impact and the need for appropriate and sensitive responses to these vulnerable women. These findings support those from elsewhere (e.g. Klaw et al., 2005; Lonsway et al, 1998; Schewe, 2006) and suggest that the presence, and public acceptance, of rape myths and stereotypes play a critical role in sustaining and supporting a 'rape supportive' culture in Irish society (see also Chapter Three). The next section explores the related issue of effective education and prevention.

10.5.1 Preventing sexual violence: Awareness-raising and education

The findings reported in Stage One of this study, are broadly consistent with the small pool of qualitative studies which have been conducted with counsellors/RCC staff in both the US (Logan, Evans, Steveson, & Jordan, 2005; O'Sullivan & Carlton, 2001) and Australia (e.g. Carmody, 1997). As indicated earlier, there appears to be a cautious, but growing awareness of this crime in Ireland and its impact on women, their families, neighbourhoods and communities. Arguably however, as long as the blame continues to be placed largely at the feet of victims, the societal problem of SV will remain unacknowledged. The findings reported here, suggest that a substantial shift is required, in the first instance, in our collective thinking about rape (e.g. who is a perpetrator; who is a victim).

Several authors purport that it is unrealistic to eliminate the problem of SV, given its historical existence and widespread prevalence (Brownmiller, 1975; Sisco, Becker, & Beck, 2008). While research into SV (e.g. traumatic outcomes, victims and perpetrator characteristics) has a lengthy and well-established history, the notion of prevention strategies (e.g. to increase awareness of SV and to reinforce victims' links with community resources) has only recently begun to emerge (Sisco et al., 2008). Becker and Reilly (1999) suggest that the prevention of sexual victimisation should be based on the concept of reducing harm and situated within a public health framework consisting of primary, secondary and tertiary prevention strategies (Sisco et al., 2008). The findings from the current study suggest that primary prevention strategies are particularly important and should, therefore, serve as a focus for policy makers and practitioners.

Likewise, the World Health Organisation (WHO) highlighted an urgent need for the primary prevention of sexual violence, including violence that occurs within intimate relationships (Harvey et al, 2007). The concept of primary prevention, in the context of SV, means '*reducing the number of new instances of intimate-partner violence (IPV) or sexual violence by intervening before any violence occurs*' (Harvey et al., 2007: 5). Importantly, this concept emphasises a dual approach to the problem of SV. The authors propose a range of primary prevention strategies in the form of early childhood, family-, school-, and community-based approaches, interventions to reduce alcohol and substance misuse, public information and awareness campaigns, and working with men and boys (Harvey et al., 2007). However, they also assert that these strategies should be implemented in tandem with interventions designed to assist survivors, in order to address some of the risk factors for SV while simultaneously making necessary supports and resources available to those who require them (Harvey et al., 2007).

Two of the areas within this framework - highlighted in particular by the findings from the current study - relate to awareness raising and public education. A growing body of literature purports that rape prevention education can elicit the cognitive, emotional, and behavioural changes required to develop an appropriate level of 'rape consciousness'²⁸, within society (e.g. Klaw et al, 2005; Lonsway et al, 1998). An interesting and groundbreaking, albeit dated, study in the US, found that, one in four undergraduate women across 32 college campuses, had experienced sexual assaults, typically by someone who was known to them (Koss et al., 1987). As a direct result of this research, all of the participating universities initiated rape education programmes aimed at preventing SV (Klaw et al., 2005). While the initial focus of many of these programmes was effective communication and self-defence, researchers (and service providers) are increasingly recognising the need to direct attention toward challenging the cultural norms that support rape (Klaw et al., 2005). For example, another US-based study, which examined students' experiences of attending an intensive semester-long rape education programme (n=74), found that participants were less accepting of rape myths, both in the short and longer term (Lonsway et al., 1998).

²⁸ A reduction in adherence to rape supportive beliefs.

More recently, Fisher, Daigle and Cullen (2008) examined the role of research in developing appropriate and effective rape prevention programmes and risk reduction interventions within the general population. They identified several key guiding concepts, which, they argue, should be incorporated into rape prevention endeavours. These included: the need for primary prevention education throughout the life span (for both men and women); a deliberate focus on disclosure and the accessing of appropriate support from formal support providers (e.g. police, doctors); and the development of wider social networks such as family and friends (Fisher et al., 2008). They also reported that the results of existing evaluation studies of rape education programmes are mixed, due in large part, to a range of methodological limitations. Nonetheless, they note some evidence to suggest these programmes have been useful in: increasing awareness/knowledge about rape (including the negative impact of rape); as well as the characteristics of victims and perpetrators; improving the availability of appropriate health and support services; and reducing rape myths/rape supportive attitudes (Fisher et al., 2008).

It is reassuring to note that this move toward primary prevention and awareness-raising is becoming increasingly evident within certain service sectors in Ireland. For example, a significant development in raising the profile of SV in Ireland since this research began has been the implementation, in 2007, of *Cosc* (Women's Health Council, 2007). As indicated earlier, *Cosc* works closely with state and non-governmental service providers and some of their research activities, to date, have included: a mapping of services provided by both State and non-State organisations to those affected by domestic, sexual and gender-based violence/abuse; a survey of the programmes on domestic, sexual and gender-based violence/abuse currently delivered in post-primary schools in Ireland; an examination of court system responses to domestic, sexual and gender-based violence/abuse and models of best practice; a mapping of programmes working with perpetrators of domestic violence/abuse and an examination of models of best practice; and a survey of the prevalence of sexual violence/abuse in the general population.

The findings from *Cosc*'s first study on attitudes to domestic violence, were launched last year (*Cosc*, 2009). One of its primary responsibilities has been the development of a national strategy on domestic, sexual and gender-based violence which will set out the

general vision and objectives and actions needed to tackle these crimes over the next five years (2010-2014). As mentioned earlier in Chapter Three, a series of nationwide consultation meetings with stakeholders have already taken place and the strategy is due for publication and initial implementation at the beginning of 2010.

More recently, funding has been made available through *Cosc*, for local and national awareness-raising activities by relevant bodies and organisations designed to: increase awareness about the nature and extent of domestic, sexual and gender-based violence and the services available for those experiencing these forms of violence; and to identify and change the attitudes and behaviours that contribute to these forms of violence (<http://www.cosc.ie> 12/10/09). These developments suggest the beginnings of a stirring in our collective consciousness that will hopefully increase our knowledge of this crime and begin to eradicate some well-known (and ultimately harmful) myths and stereotypes. While some of the Irish RCCs run external education and training courses, these are, for the most part, not funded. Arguably, the need for more funding for extra staff should not be at the expense of explicit attempts at prevention (as recommended by WHO, Harvey et al., 2007). Furthermore, according to McGee et al. (2002), this training and education, in the context of locating SV within a public health framework, should be funded solely by the Irish government.

Reassuringly, the findings presented here, provide further empirical validation for, and should help to inform further the framework of, the national strategy on domestic, sexual and gender-based violence, which is currently under development. Several of the issues identified, coincide with those emanating from the public consultation process that was undertaken with stakeholders in order to inform strategy development. For example, under the 'prevention' theme, service providers (as in the current study) highlighted the need to work with victims in order to encourage reporting which they proposed could be achieved by helping to decrease the level of shame and guilt felt by victims (i.e. which plays a role in non-reporting). According to *Cosc*, it is also critical to raise societal awareness in wider society through a sustained advertising campaign using a range of media (e.g. similar to the 'Don't Drink and Drive' campaign) (*Cosc*, 2009). As in the present study, the stakeholder participants also felt that attempts to challenge rape myths and stereotypes should be incorporated into education and awareness raising activities. They also recommended formal and non-formal education

approaches that should be focused on a number of key groups (e.g. children and teens, adults, and professionals).

Education initiatives targeted at multi-levels of society are clearly needed to create a less hostile environment and culture, where victims of SV can safely seek help, pursue and secure justice, and heal from the trauma of their experiences. Klaw et al. assert that '*intensive, sustained rape education efforts play a vital role in dismantling rape supportive culture*' (2005: 61). Notably however, the WHO indicates that the complex behaviours associated with SV may not be irrevocably changed using public information campaigns in isolation (Harvey et al., 2007). Thus, a longer term, multi-pronged approach comprising several of the components highlighted in the literature, may be required in order to properly tackle this problem. Nonetheless, there is sufficient evidence from the current study to suggest that a *process* of change around prevention and awareness raising should be initiated as early as possible (both in Ireland and elsewhere) in order to change how we, as a society, understand and respond to SV. The next section will discuss some of the other findings from this research in the context of the PTS framework.

10.6 Expanding the PTSD framework

The difficulties observed amongst the SV group in the current study, clearly illustrate the many 'ripple' effects of SV in a woman's life; despite this, the consequences of this crime have been conceptualised, in large part, within a trauma framework (Morrison et al., 2007). Arguably, it may be necessary to expand and develop further this conceptualisation in order to truly map the effects of rape/sexual assault (Morrison et al., 2007). This is discussed in more detail below.

As summarised in Chapter Two, the PTS framework is the most widely accepted and empirically supported model of women's post-assault responses (Goodman, Koss & Russo, 1993; Herman, 2001). However, several authors have criticised its applicability and adequacy as a fully explanatory account of the widespread effects of SV (e.g. Campbell, Dworkin & Cabral, 2009; Wasco, 2003). One particular critic, Sharon Wasco, (discussed in detail in Chapter Two), highlights a number of issues, including the fact that PTSD symptoms constitute only a fraction of the harm arising from rape and that the traumatic event, in and of itself, is often not the only source of harm to

victims (Wasco, 2003). Wasco concludes her critique with a number of suggestions for researchers and practitioners alike, that may help to improve the current PTS model and create 'more inclusive diagnostic criteria for rape harm' (2003:315). Some of the findings from the present study will now be discussed in the context of these recommendations.

Wasco's (2003) first suggestion to expand the traditional PTS model draws on the work of feminist researchers and practitioners (mainly from the US) who have attempted to re-locate rape and its impact, within a framework that recognises the influence of societal institutions (e.g. the CJS) and the predominant culture (e.g. religion, mass media) on SVAW. One increasingly popular perspective, in recent years, is what has been called an *ecological model* of psychological trauma (Heise et al., 1999; Campbell, Dworkin & Cabral, 2009). This framework attempts to account for the considerable variation in responses seen in women who have experienced SV (e.g. not all women who experience SV develop PTSD) by integrating a wide range of variables including those identified from traditional research (e.g. assault characteristics, Riggs et al, 1992), as well as more recently explored constructs (e.g. social networks and sociocultural context, Scott, Lefley, & Hicks 1993) (Wasco, 2003). This theory (and other theories of its genre) purport that PTSD is likely to be just one of the possible range of symptoms that victims of rape may experience (Wasco, 2003).

Researchers have also investigated the role of specific extra-individual variables within this theoretical framework, such as: negative reactions to disclosure from family, friends or formal support providers (e.g. the police, legal and medical professionals) and the social stigma experienced by victims post-assault (Wasco, 2003). As highlighted in Chapter Two, and supported by the findings reported here, the impact of unsupportive and 'victim-blaming' reactions to disclosure, can often exacerbate the emotional and psychological effects of rape and combine to act as a barrier to service utilisation. The findings reported here, support the inclusion of this element within an appropriate framework, by reiterating the need for a more compassionate societal and community response to rape survivors. The process of dismantling rape myths, raising public awareness and improving rape victims' experiences of medical and legal services has the potential, not only to aid women's recovery post-assault, but also to increase the likelihood of these crimes being reported in the first place.

The trauma profile presented by the women in this study provides clear support for the trauma response model. The results confirm the existence of classic PTSD symptoms (e.g. avoidant behaviours, hyper arousal) within the sample, as well as a range of associated symptoms (e.g. depression, anger and irritability). However, as shown by the findings in Stage Two and in some of the one-to-one interviews in Stage Three, the effects of SV on these women, have been both pervasive and chronic, and were evident in areas not explicitly delineated by PTSD diagnostic criteria (e.g. effects on their sexual relationships, intimacy, self-esteem and identity).

Wasco (2003) proposes that an improved account of the impact of rape/sexual assault should encompass a wider range of post-rape responses, such as the effects of rape on physical and sexual health and the interpersonal effects of rape. Again, the findings presented as part of this study, confirm and support this argument. Other studies have also confirmed the 'radiating' impact of rape and sexual assault on partners, family members and friends (Ahrens & Campbell, 2000; Connop & Petrak, 2004; Cwik, 1996). However, it could be argued that the PTS model should be expanded further to convey more effectively the wider and permeating impact of SV in other areas of women's lives including their sexual relationships, their ability to engage in, and maintain, healthy intimate relationships, and their self-esteem and self-confidence. Furthermore, whilst the SAVI study included only limited data on the consequences of SV (n=190), one of the main themes identified from the analysis of responses to open-ended questions - as in the case of the present study - was the effect on participants' interpersonal relationships, including trust issues, relationship difficulties and difficulties with sexuality (McGee et al., 2002). As already mentioned, a woman's interpretation of the incident (which is influenced by her relationship with the perpetrator) may also play a role in the degree to which her personal relationships are affected (Petrak & Hedge, 2002).

Palmer (1991) proposed the term 'chronic shock' to better understand the long-term effects of rape. Unlike the PTS model, which identifies, as the genesis for many of these symptoms (e.g. avoidance, hypervigilance), the intense fear and horror experienced as part of the assault, Palmer's model focuses on the violation of trust that is an inherent element of the assault (Wasco, 2003). This model, which is supported by the work of

other theorists (e.g. Herman, 1992; Brown, 1991), purports that the most significant effects of rape are manifested at the interpersonal level (Wasco, 2003). Again, these include some of the effects seen in the current study including: a reduced ability for intimacy; a feeling of disconnection from others; and a distorted sense of loyalty in relationships (i.e. the pattern of abusive relationships exhibited by some of the participants).

The trauma response model also fails to account for positive responses to rape, which might at first seem counter-intuitive, but which, on closer inspection, appear entirely plausible (e.g. activism, efforts to help others) (Wasco, 2003). These were also evident in the present study, albeit in an indirect way. For example, several women, when probed, cited their involvement with support organisations for women experiencing domestic violence and/or SV and even their motivation for participating in this research. They commented that, without their own personal experience, they would never have considered getting involved with such work (or this research) and that their contribution, in this way, transformed an element of their traumatic experience into something worthwhile and good. Interestingly, Taylor (1983) proposed a theory of cognitive adaptation in an attempt to explain this kind of positive response to a threatening (or traumatic) event. Her work with cancer patients and their families (n=78) identified three themes central to this process including: (1) a search for meaning in the experience; (2) an attempt to regain mastery over the event, in particular, and over one's life more generally; and (3) an effort to restore self-esteem through self-enhancing evaluations (Taylor, 1983).

Another more recent proposed explanation for positive post-trauma responses has emerged from the growing body of literature on PTG, which was briefly mentioned earlier (Tedeschi & Calhoun, 1996). Several studies, conducted in recent years, have examined this in a wide range of populations including: patients with chronic illness (Edwards, 2006); disaster survivors (Melerski, 2008); bereaved individuals (Dobson, 2004); and those who have experienced sexual assault and sexual abuse (Woodward & Joseph, 2003). According to Tedeschi and Calhoun (2004), PTG reflects a development in an area of an individual's life that was not there, prior to the trauma. This may manifest itself in the form of: enhanced and more meaningful personal relationships; an increased appreciation for life; and an elevated appreciation of one's own personal

strength (Tedeschi & Calhoun, 2004). The authors comment that: *'the individual has not only survived, but has experienced changes that are viewed as important...posttraumatic growth is not simply a return to baseline – it is an experience of improvement that for some persons is deeply profound'* (Tedeschi & Calhoun, 2004:4). While it is unclear why some people experience PTG and others do not (Woodward & Joseph, 2003), the evidence would appear to be sufficiently compelling at this stage, for it to be considered for inclusion in any future possibly enhanced model. While the development of a complete model for the understanding of the impact of SV is beyond the scope of this research, the findings reported here and elsewhere, suggest some interesting avenues for further exploration and development.

10.7 Evaluation of the study

10.7.1 Strengths of study

As mentioned earlier, very little is known about the impact of SV on women in Ireland. Most of the research that has been undertaken in this sector has focused on assessing elements of, and experiences with, the CJS (Bacik et al., 1998; Hanly, Healy, & Scriver, 2009; Leane et al., 2001), as well as the prevalence of SV and beliefs and attitudes around it (McGee et al., 2002). The current study is the first to date, within an Irish context, which has attempted to explore, document and comprehensively describe – women's experiences of SV in an Irish context. The study findings also represent an important addition to the international literature, particularly in the extent to which they provide important detailed insights into service provider and service-user views, as well as providing a useful basis for developing and expanding further the PTS explanatory framework around sexual trauma.

A key strength of the study - and one rooted in the ontology of the project - was the use of a multi-stage, mixed methods approach, the advantages of which have already been outlined in Chapter Four. For example, McGee et al (2002) did not set out to investigate, in detail, the consequences of SV, although they suggested that such an investigation would be better suited to alternative methodologies such as those employed here. Thus, the largely quantitative assessments in Stage Two, involved the use of a battery of reliable and psychometrically robust measures which provided a detailed snapshot of these women's lives in terms of their overall psychological, physical and social well being and functioning, often many years after the assault.

These data were supplemented and amplified in the qualitative stages, each of which facilitated a more in-depth exploration of some of the key issues (some of which were very sensitive) and which, in particular, allowed the women in this study to 'tell their own stories'. Thus, the triangulation of data from different sources provided detailed insights into these women's lives, whilst enhancing the overall validity of the collective findings emanating from all three stages of the research.

Another strength of this study was the relative success of the recruitment and sampling procedures and the inclusion of a matched comparison group. With regard to the former, much of the research in rape and sexual assault has taken advantage of the ease of access afforded by university students (e.g. Fisher, Cullen & Turner 2000; Koss et al., 1987), or women attending treatment clinics for PTSD (e.g. Nishith, Resick & Mueser, 2001) in order to achieve large sample sizes. Those researchers who successfully sourced women directly from the community tend to have had the advantage of substantially more funding and, in most cases, multiple researchers (e.g. Kilpatrick et al., 1985).

There were considerable logistical, practical and ethical challenges in the current study, but deliberate attempts were made to recruit women from the general population, in an attempt to achieve a more representative sample. Despite these difficulties, the sample size achieved was very respectable in size (and appropriately diverse in terms of the profile of participants), particularly in the context of a lone fieldworker/researcher with only limited resources. Furthermore, based on anecdotal evidence, another Irish study that is currently underway, with the same population, but with significantly more resources, achieved only a moderately larger sample size ($n \approx 100$) (Hanly, Healy, & Scriver, 2009). On balance, the recruitment materials and methods used here – which were informed to some extent by the findings from Stage One - should also provide useful guidance for future researchers in this field. Furthermore, the inclusion of a matched comparison group (albeit recruited using snowball sampling), added an interesting dimension to the study in providing a useful yardstick for comparison with the SV sample; this helped to establish the extent to which the latter were affected by their experiences when compared to women without such an experience, albeit not within a perfectly controlled design.

As indicated above, this type of research tends to be characterised by multiple ethical challenges related, not only to recruitment, but also to the posing of sensitive and personal questions to an already traumatised population and assuring complete confidentiality and anonymity. A key strength of this study was that it attempted to address, insofar as possible, many of these challenges. One of the personal goals of the researcher was that women who took part would feel that their experience had been an empowering one. This is also a tenet of WHO (Ellsberg & Heise, 2005) research guidelines with this population. The pre-, during, and post-data collection contact with participants was designed to facilitate this and anecdotal evidence from the interaction with participants in Stage Two, would suggest this was successful. Furthermore, the willingness by the great majority of participants to be contacted for Stage Three of the study provided further endorsement of the strong rapport that had been established with the researcher and the sensitive and respectful nature of all interactions. This was also illustrated through the research feedback briefly reported in the previous chapter.

10.7.2 Limitations of the study

Research with vulnerable populations invariably presents particular challenges to researchers including: estimating the size of hidden populations; securing access to these populations; asking sensitive questions in a survey or interview format; and handling sensitive data (Lee, 1993). As reported earlier, SV is a notoriously under-reported crime (McGee et al., 2002) and, as a result, prevalence/population estimates tend to be, at best, unreliable. Access to women who have been subjected to SV is also difficult due to the stigma attached to, and the largely hidden nature of, this crime. Consequently, the participants were all self-selecting; most had contact with formal support services (especially counselling services) whilst a significant majority were also well educated. Therefore it is possible that this may have led to some degree of sampling bias, although access to these women by any other means, tends to be ethically and practically problematic. Nonetheless, the findings from all three stages converged in a logical and meaningful way, whilst the results for the sample as a whole, are consistent with those seen elsewhere (insofar as comparisons across studies are possible), including the SAVI study; this provides a reasonable 'proxy' indication that the sample was fairly typical of women in Ireland who have been exposed to SV.

A related point to that articulated above, relates to the selection of the comparison group, which, whilst matched to the SV sample, was recruited using snowball sampling. Again, the representativeness of this sample may be in question. Despite this, it was considered important to recruit, insofar as possible, from the wider community. In addition, there was nothing in the profile of this group to suggest that they were, in any way, atypical of women in the general population. Problem drinking in both groups was comparable although recent evidence suggests that increasing numbers of women in Ireland are drinking more (Mongan et al., 2007).

The design of Stage Two was also cross-sectional in nature and therefore was characterised by the usual weaknesses of this type of design (e.g. based in some cases on retrospective recall with no follow-up). The sample size was also smaller than anticipated at the outset, although still respectable given the hidden nature of this population within the community.

Finally in spite of the many 'checks and balances' put in place to enhance the validity and reliability of the qualitative findings, member checks of the qualitative interviews were deliberately omitted. In view of the aim of the study, to accurately represent the 'hidden' impact of SV, member checks would have provided additional reassurance. However, research with this type of vulnerable population is fraught with ethical concerns (e.g. participant distress and participant burden) and it was considered inappropriate to return to participants a third time (i.e. after they had already participated in Stage Two and Three) in order to seek their verification of the transcribed accounts of their interviews. Nonetheless, confidence in the findings of the research can be assured by the range of other strategies employed in this regard (see Chapter Four).

10.8 Directions for future research and new research questions

This study presents a number of interesting avenues for further research, some of which have already been mentioned; these include the role of the victim-perpetrator relationship in post-rape symptomatology and consequences, the role of CSA in adult revictimisation and the relationship between risk taking behaviour and the experience of SV, or PTSD symptoms. Several additional directions for future research will be

discussed here, followed by a brief summary of new research questions highlighted by the findings from this study.

Firstly, given the inherent 'drink culture' in Ireland, the incidence of problem drinking pre- and post-assault and any role it may have in mediating the effects of SV (i.e. in reducing trauma symptoms), offers an important possibility for future research, particularly within a cross-country comparative context. However, care must be taken when discussing victim drinking patterns because the incorporation of an alcohol consumption debate within the context of SV may potentially increase the risk of progressing rape supportive attitudes amongst the wider public.

Men were deliberately omitted from this study despite the fact that one in ten men in Ireland were found to have experienced 'contact sexual assault' as an adult compared to one in five women (McGee et al., 2002). Very little is known about male victims of rape and sexual assault, primarily because they represent a substantially smaller proportion of the SV population. Furthermore, men tend to be reluctant to report SV due to the widely-held myths and stereotypes that imply, for example, that men cannot be raped (Mezey & King, 1992), as well as the increased stigma associated with this crime (Felson & Paré, 2005). Throughout the course of the research, the exclusion of men from the study was a recurring question from participants (especially the service provider interviewees in Stage One) and at the time of writing, we know of only one study – currently underway – that is focusing on male survivors of SV in Ireland.

Another under-researched, yet vulnerable population within Ireland (and highlighted in Stage One of this research), are immigrant women. Ireland's population has changed dramatically in the last 10 to 15 years due to large-scale immigration. Furthermore, a recent report by the WHC identified immigrant women in Ireland as being particularly vulnerable to physical and sexual violence (WHC, 2009). This changing profile, as illustrated in Chapter Five, has presented some services with specific challenges related to providing culturally appropriate support, as well as the issues associated with non-English speaking women. It is important that Ireland responds appropriately and effectively to these women and indeed, in many of the RCCs, this appears to be happening, albeit in only a localised way; for example, some RCCs print their information in different languages, others have sourced funding for a cultural and ethnic

liaison worker. Furthermore, in 2008, the DRCC launched the first ever handbook for interpreters who work specifically in the area of rape, sexual assault and other trauma, suggesting a growing awareness of this need amongst service professionals. While these developments are encouraging, more research is needed to inform culturally sensitive approaches to supporting these women.

With regard to other aspects of service provision, the women's use of sexual health services (e.g. colposcopy clinic) in this study was unusually high and this has obvious personal and financial implications. Further national and international research could examine the effects of SV on sexual and reproductive health in order to reduce the incidence of post-assault complications and subsequently reduce the burden on health services. In addition, it would be useful to examine the experiences of these women with these types of services following their assault, with a view to improving their personal care-taking and health behaviours and their overall experiences of such services. Additional attitudinal surveys could also be undertaken with a view to offering appropriate training and education for health professionals.

While it is not clear from the research reported here, as to whether or not women with a history of SV were deliberately not engaging with formal mental health services, there is some suggestion that this was the case. Further research should examine the role of contact (or lack thereof) with mental health services in helping victims to better cope with their trauma symptoms and to identify the facilitative and inhibitive factors in the help-seeking process for this group of women (and men). More broadly, while this research identified several personal barriers to accessing services amongst participants, further research could be conducted into the factors that inhibit and promote disclosure and this information subsequently conveyed to current service providers. This work could also be used to inform any proposed awareness-raising initiatives by informing the general public of appropriate and sensitive responses to victims, and the services available to them. Broadening this point of contact to these services (i.e. by making more people aware of the services available to victims of SV) would, not only provide victims with more support, but would also help to generate more positive attitudes.

This research clearly illustrated the impact of pervasive myths and stereotypes on participants' self-blame and guilt, which, in turn, pose a barrier to accessing services.

Thus, it is important to implement, evaluate and promote effective awareness raising campaigns and public education programmes. For example, care must be taken to ensure that these do not inadvertently reinforce the implicit beliefs on which many rape attitudes tend to be based, whilst also incorporating the critical elements needed to successfully communicate positive messages. While prevention research encourages the inclusion of alcohol and substance use education as a means of reducing the incidence of SV (Harvey et al., 2007), there is perhaps a risk that any over-indulgence in these substances on the part of a prospective victim, will act as another mechanism by which to apportion blame to the victim, thereby sustaining a (damaging) rape supportive culture.

Lastly, one of the more interesting findings to emerge from this research was the experience of PTG by participants. There has been limited research in this field with this type of population (e.g. Woodward & Joseph, 2003). A further more detailed exploration of this phenomenon within an Irish context, or perhaps within the context of a cross-national study, would make a worthwhile contribution to this field whilst also helping to promote a more realistic and comprehensive account of women's experiences.

In the context of the previous discussions, new research questions that have clearly emerged from the findings reported here include:

- Are younger women more at risk of SV in Ireland and are they more likely to be assaulted by a stranger rather than somebody they know?
- What is the impact of being raped by a stranger versus an acquaintance, in terms of mental health?
- What role does alcohol misuse have in the management or exacerbation of PTSD symptoms and other mental health problems post-assault?
- Does an experience of SV and/or a diagnosis of PTSD increase sexual risk-taking behaviours post-assault?

- What protective factors can be identified that can help women recover from this experience?
- What evidence is there for PTG in Irish women with an experience of SV?
- What can be done to improve mental health services uptake in this population?
- What is the level of awareness amongst medical professionals about the prevalence and incidence of SV and the sensitivities surrounding service provision for these women?

10.9 Conclusion

The collective findings from this study, in conjunction with the findings from elsewhere, suggest that sexual violence against women ought to be strategically positioned on the national and international policy agenda. The findings presented here should help to raise an awareness of, and change our responses to, this important issue whilst also informing policy and practice in the SV sector – both in Ireland and elsewhere. In particular, this study has highlighted a number of challenges to our traditional conceptualisation of SV and our responses to it. Women who experience SV survive and very often go on to lead productive lives. Arguably however, their care and support ought to be maintained in the medium to longer term and adapt to the demands placed upon them by normal life experiences (e.g. having children, sexual health care). It is also important that we question the way that we, as a society, think about SV and what constitutes a victim or perpetrator, in order to create an environment where these women can heal and go on to manage the impact of this experience on their life. An evidence-based, co-ordinated and inter-agency response is required to address the issues raised here and, in particular, to dismantle persistent societal rape myths and to improve service provision. This may be achieved through ongoing school- community- and media-based education and awareness raising initiatives.

The current study findings represent a valuable contribution to our understanding and knowledge of the ‘hidden’ impact of SV, particularly within an Irish context, whilst also highlighting ways in which we might improve our understanding of this crime and its

effects. The damaging and long-lasting effects on personal and intimate relationships were clearly highlighted across all three stages of this research. A change in our conceptualisation of SV, its effects and our responses to it as a society, is required in order to address the rape supportive attitudes towards SV that still tend to be in evidence in Ireland. This study provides an empirical basis from which to inform that change by providing a deeper understanding of SV and its effects and highlighting, in particular, the wide ranging negative impact that this crime can have in the lives of Irish women. The findings also add a fresh perspective that will add to the debate in this area, both in Ireland and elsewhere. Several new ideas that might inform that debate might include the following:

- An acknowledgment of the chronic and pervasive nature of the impact of SV as evidenced in this sample.
- The importance of formal mental health services in alleviating trauma symptoms, which appear to persist in spite of widespread engagement with counselling services.
- The critical need for public rape education and awareness raising in order to successfully tackle this enduring social problem (e.g. this will improve disclosure experiences for victims, hopefully reduce their own self-blaming tendencies, and possibly result in a reduction of the incidence of the crime in the first place).
- The development of a contemporary trauma response model in understanding the responses of women to SV, would be enhanced by incorporating the findings reported here and, in particular, those on the damaging and lasting effects on personal and sexual relationships, self-esteem and self-confidence.

An additional theoretical aim of the study was to contribute toward expanding and developing our traditional understanding of the impact of trauma and women's typical responses to SV. Historically, our understanding of the effects of SV do not allow for (and to some extent still do not allow for) the possibility for growth and recovery in

rape victims. There were a number of findings reported here that potentially add new theoretical and practical insights to this area. For example, the high level of educational attainment in the presence of chronic trauma symptoms was unexpected and whilst further replicative work in this area is required, this finding suggests a re-evaluation of the way that SV affects individuals in the long-term and perhaps the course of PTSD as a disorder.

Revictimisation rates were considerably higher in this study than in the, albeit limited, research previously undertaken in Ireland. It is not known to what extent this reflects a higher incidence rate alone, or a higher rate of disclosure and, again, further research in this area is required. The additional finding of significantly worse mental health amongst the SV women, when compared with their comparison group counterparts, clearly indicates a need for a co-ordinated and targeted intervention programme across services that will not only access these women (particularly those who do not contact formal services), but which will also help to alleviate the suffering of those who do. The findings here also point to serious gaps in current service provision within the CJS, and medical and SATU services. If taken seriously, these findings should prompt a review of current medical care utilisation by women who have experienced SV, with a view to improving their experience and their physical, sexual and reproductive health over their lifetime.

Importantly, the findings represent a useful addition to the current debate on the extent to which the PTSD framework provides an adequate account of women's responses to SV. A more comprehensive account of women's post-rape responses could endeavour to incorporate many, if not all of the findings and issues highlighted here (and elsewhere). Some examples of these in the current study include: engaging in detrimental health-risk behaviours (e.g. alcohol abuse, sexual risk-taking behaviour); emotionally withdrawing from the social support critical to recovery; and subscribing to unhelpful myths and stereotypes about typical rape victims (and scenarios) which poses an important barrier to accessing services. The development of a comprehensive and inclusive trauma response model - through the kind of work undertaken here - has the potential to benefit numerous populations beyond survivors/victims of sexual violence.

Several directions for future research and research questions have been outlined here, but on a policy and practice level, the findings should also inform the important area of rape prevention and awareness raising both in Ireland and elsewhere. As mentioned earlier, one desired outcome from this study would be the implementation of carefully co-ordinated 'Don't Drink and Drive' style campaign for the prevention of SV. Previously socially acceptable practices, such as drinking and driving, are considered almost taboo in current times. While the factors influencing the occurrence of SV are perhaps more complex, the premise of overtly associating this social problem with social undesirability may be sufficiently powerful to encourage the beginnings of change, if not in its incidence, at least in how we respond to victims of SV. However, such efforts must not be at the cost of providing adequate and well-resourced support services. In particular, there should be an increased emphasis on improving the experience of victims within the health and judicial systems. This emerged as an important finding in stages one and three of this study.

Furthermore, the triangulation of evidence from the current study underpins an urgent need for a greater awareness of rape (and its impact) and rape prevention strategies across all levels of society and future policies in schools, in the community, (e.g. within voluntary groups) and in the workplace should be implemented to achieve that goal. The process of addressing SV, whilst also responding appropriately to the needs of victims, is a challenge that should begin perhaps, with an acknowledgement of SV as a serious societal problem. Promoting ownership of the problem and implementing appropriate interventions and awareness-raising initiatives should help to foster a more supportive and understanding society, in which victims of SV can ultimately feel more protected and secure.

In conclusion the final words in this thesis will be left to one of the women who agreed to take part in this study:

'I think in a developed society, it's a huge embarrassment and shame upon us all that this level of base violence...not only happens, but happens with permission...and we permit it by not talking about it...it demeans us all.' (A 29-year-old woman raped by an acquaintance when aged 20).



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Appendices

Appendix 1: Excerpts from departmental guidelines on working alone

Appendix 1: Declaration in relation to Guidance for Safe Working Practice in Psychological Research	<i>20</i>
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1. GUIDELINES FOR CONDUCTING RESEARCH WITH HUMAN PARTICIPANTS

This document has been devised in order to provide detailed safety guidance to staff and students when conducting psychological research with both human participants and animals. The staff in the Department recognise that the personal safety and health of students and other researchers/staff members should be protected at all times when conducting research. Therefore, it is important that staff and students conducting research on human participants/subjects or animals within or outside the Department of Psychology read these guidelines. **NB. All students are also required to complete and return the Declaration section at the end of this document to the Departmental Office.** Please note that you will be unable to begin or continue your research if you fail to complete this declaration, or if it becomes clear that you are (or have been at any stage) in breach of these guidelines. All postgraduate students and researchers working in the department are also obliged to attend a compulsory seminar designed to supplement and expand upon the guidelines presented here. This will be devised and delivered as and when required by Dr Sinéad McGilloway and Dr Yvonne Barnes-Holmes. Please also consult the University Safety Policy Statement which is available from the Departmental office.

1.1 Working generally within the Department

Under most circumstances, the testing of participants proceeds without incident. However, occasional difficulties may arise and it is imperative, therefore, that these guidelines are read and followed by all students and staff.

- If you are interviewing, assessing or testing a participant in the department, please ensure that you have a landline telephone number (or at the very least a mobile number) and address for them before they come in. Please telephone in advance to confirm that this is a correct number. Ensure that this is filed in a place known to your supervisor or to a colleague.
- Make sure that someone knows: (a) that you are seeing this person; (b) where the assessment or testing is being conducted; and (c) when you are due to finish. Please introduce the participant by name to this colleague if possible.
- Please dress appropriately and not in a way that could make anyone of a different age, background, race, or gender feel uncomfortable.

- Wherever possible, try to ensure that you are seated nearest to the door. If possible, leave the door slightly ajar.
- If you have any doubts or worries about the prospective participant, please terminate the session immediately and inform your supervisor. In some cases, it may be better to leave the room and to let the participant finish while reporting the difficulty to your supervisor or the Head of Department. Please ensure that you inform all of these people of the difficulties after the event. If, at any time, you feel *under physical threat*, find a plausible excuse, *leave the room immediately* and call security on *Ext. 3589/3929 (01 708 3589/3929* from a mobile).
- If a participant faints, or becomes visibly ill or distressed in your presence, contact the University Medical Centre immediately (Ext.3878) or phone Ext.3333 for campus emergencies. In some situations, you should take care to check if any participants have epilepsy as a seizure may be triggered by a visually-demanding or flickering computer screen.
- Staff or students who are testing out of normal office hours should ensure that another person whom they know is also present in the department. Please ensure that this person knows when you are due to finish, and report to him/her when you have finished.
- Should you see anyone in the building whom you regard as behaving suspiciously, or in the department whom you do not recognise, do not confront, but phone security on *Ext. 3589/3929* and seek assistance/advice from any available source.
- Please note that prospective participants have not been 'vetted' and that people recruited from posters on campus may not necessarily be students. Therefore, you must be aware of the pitfalls of handing out a **personal mobile phone number**. (An alternative might be to ask prospective participants to leave their contact details in a small sealed 'post box' attached underneath the poster/notice). Researchers should report any cases of inappropriate or persistent calls or contact from participants to their supervisor and Head of Department.
- If any participant asks for help or advice for psychological or other problems, please state firmly that it is not appropriate for you to give such advice because you are not qualified to do so, and direct them to their GP, or to their local A&E department.

1.2 Conducting assessments or interviews outside the Department

University policy states that ‘The responsibility for ensuring that there are effective arrangements for the health and safety of field workers ultimately lies with the Head of Department’. Furthermore, the Head of Department must ensure that those appointed to undertake fieldwork are authorised, adequately trained and judged to be sufficiently competent to do so. However, the supervisor is primarily responsible for assessing the level of risk (if any) involved and implementing safe systems of work. With regard to the latter, the following guidelines must be adhered to at all times by students and staff.

Where possible, the research should be conducted in a convenient and preferably quiet public place (eg. a quiet café/restaurant or a hotel lobby (outside of mealtimes)). If, in the case of undergraduate research, this is not possible, then two people should preferably make the initial home visit unless there are valid reasons to suggest otherwise. For all other postgraduates and research staff, the following precautions must be taken when *making a home visit*:

- Staff/students must always carry a charged mobile phone.
- There should be a clear ‘checking-in’ procedure to the supervisor, or another member of staff or colleague where appropriate (this includes postdoctoral fellows) when they have been on a home visit. The member of staff must have a record of the time of the visit, the name and address, and the telephone number. They must also know the mobile phone number of the researcher.
- All students and staff should carry photographic id that clearly indicates their status and affiliation. This should be shown before entering anyone’s home.
- As part of the introduction to the participant, the researcher should say ‘*I just have to call my supervisor*’. The researcher should then ring the designated staff member (or another colleague) in the presence of the participant and say ‘I’m in xxxx’s house, and will be finished at approximately xx’.
- If a researcher fails to ring the designated staff member (or other colleague) at the appointed time, that person should immediately try to make contact with him/her. If unsuccessful, another member of staff should be contacted and where appropriate, the relevant emergency services phoned.

- If you have any doubts or worries about the prospective participant, please terminate the session immediately and find a plausible excuse to leave. You should inform your supervisor as soon as possible afterwards. If, at any time, you feel under *physical threat*, find an excuse to leave the room immediately and call the appropriate services. Try not to panic – if you stay calm, you will be more able to think clearly and stay safe.
- A personal alarm should be carried at all times and the relevant services contacted in the event of an emergency. Some personal alarms are available within the department. Please contact your supervisor if you require one.
- Make sure that you tell your supervisor if you have any problems or difficulties that might affect your safety in carrying out the fieldwork (eg. disability, medical condition, mental health problem).
- Ensure that you are familiar with the routes to, and the exact location of, where you are going.
- See the leaflet entitled '*Working Safely in other People's Homes*' published by the Suzy Lamplugh trust (available from the departmental office).
- If any participant asks for help or advice for psychological or other problems, please state that it would not be appropriate for you to provide such help because you are not qualified to do so. Instead, direct them to their GP, or to the A&E department at their local hospital. In specific projects, it may also be advisable to provide some or all participants with information leaflets and help line numbers etc. (eg. of mental health support organisations).

1.2.1 Further guidelines for assessing patient participants and other vulnerable groups (eg. people with mental health problems)

- Patients should be well briefed about what to expect of the session before the visit in question.
- A first home visit by staff or students to participants who are brain damaged or who are known to have a serious mental health problem **MUST** always be made by two people.
- All patient participants must be provided with an Information Sheet which should, where possible, be distributed to them and their families at least 48 hours before the first visit.

- If you are using computers, or tests requiring a table, you should make sure in advance that, on a home visit, the facilities exist for you to properly carry out your test.
- It is particularly difficult to find a quiet environment when assessing or testing at home, and so it is worth discussing whether you will be able to get peace and quiet in a room on your own with the participant for the time you require. Many houses have dogs, doorbells, televisions, and curious relatives sitting watching!
- In general, patient participants should not be tested, or be required to complete questionnaires or engage in any other research activity for more than one hour without a break. A maximum of two 60-minute sessions in any one day is a reasonable guideline, although there are exceptions where people have travelled a long distance.
- People who have suffered a stroke, or who are terminally ill (or have some other illness or disability) may often develop pain and discomfort when, for instance, being asked to stare for long periods at a computer screen, or when asked to complete lengthy questionnaires or interviews. Therefore, they should be frequently monitored for pain and discomfort, and testing/assessment stopped if necessary. Results may be deemed invalid if people are in pain, or over-fatigued.
- There are some ethical problems surrounding payment to patients for participation in research. Patients should be given reasonable travel and out-of-pocket expenses if they travel from home (eg. to cover taxi fares and/or refreshments).

1.2.2 A brief note on research with children: protecting their safety

This section deals with issues of safety when conducting research with children. The Department recognises that it has a duty of care to children with whom it is in contact for research purposes. Ethical guidelines on conducting research with children may be obtained from the departmental office.

- It is important to make clear and documented plans for data collection. Records should be kept of arrangements made with parents/guardians, teachers and schools.
- Arrangements should be made to conduct the research in a suitable setting, from a safety point of view. For example, in schools, it is important to ask for the use of a room that is close to a central office (ie. if conducting one-to-one

interviews/experiments) such as a staff room or the Principal's room, where an adult with responsibility for the children can easily see the student and the child. Students conducting research should not spend time alone with a child in a setting such as a private home, school, or an agency, even if an adult in authority asks them to do so. Neither is it advisable for students to leave the premises with a child in the absence of a carer or guardian.

NB. For further information on personal safety when dealing with human participants, please refer to the departmental copy of *Personal Safety for Health Care Workers* (1995) by P. Bibby (Ashgate: Suzy Lamplugh Trust). (In particular, see Chapters 14-16).

1.3 Guidelines for conducting electrophysiological research with human participants (EEG/ERP)

All personnel working with EEG/ERP may do so only after they have received adequate training in the use of electrophysiological techniques, either at NUIM, or one of the collaborating institutions of the Department of Psychology (eg. TCD, St. Vincent's Hospital, Fairview, Nathan Kline Institute, NY). New postgraduates and all undergraduates may only carry out electrophysiological data acquisition in the presence of a trained postgraduate student, trained postdoctoral researcher, or staff member with experience of EEG/ERP acquisition.

1.3.1 Participant safety and comfort

At all times, staff/students carrying out electrophysiological research should attempt to ensure the maximum comfort and safety of the research participant, and participants should be encouraged to inform the experimenter if they feel that any part of the procedure is uncomfortable or painful. Electrode caps should be placed gently on participants with the FPz electrode located 4 cm from the nasion; participants should be consulted as to the comfort of the cap before electrode application begins. Participants should be covered with a barber's smock during preparation, and seated in a comfortable chair throughout the set-up process. Application of electrode gel should not require the physical abrasion of the participant's scalp, and all gels and adhesive tape/pads should be tested 24 hours before testing on the participant's forearm to ensure an allergy is not present. Loose electrodes (e.g. electro-oculograms, nasion reference electrodes etc.) should be affixed to the participant using surgical tape and adhesive pads in such a way as to neither occlude vision, nor to cause discomfort. The EEG amplifier should not be switched on until all electrodes have been applied to the participant. In the event of poor impedance signal from the participant, gel may be worked gently through the hair toward the

Appendix 2: Stakeholder Background Questionnaire (SBQ)



NUI MAYNOOTH

Ollscoil na hÉireann Má Wíod

STAKEHOLDER BACKGROUND QUESTIONNAIRE

Please note that ALL of the information you provide will be treated with this entirely confidential

Please tick the appropriate boxes or insert your answer in the spaces provided.

1. Please indicate your gender: Female Male

2. Please indicate your approximate age:

Age Range	Tick
20 – 29 years	<input type="checkbox"/>
30 – 39 years	<input type="checkbox"/>
40 – 49 years	<input type="checkbox"/>
50 – 59 years	<input type="checkbox"/>
60 – 69 years	<input type="checkbox"/>

3. What is your current job title? _____

4. For approximately how long have you held your current position?

Years ____ Months _____

5. Could you give a brief description of the responsibilities/duties of your current position?

6. Approximately how long have you been involved in this particular area of service provision (i.e. counselling, rape crisis centre, refuge or Women's Aid, Sexual Assault Treatment Units) for women who have experienced sexual violence?

_____ years

7. What do you think are the 3 main barriers for women in accessing appropriate services, having experienced sexual violence?

1. _____

2. _____

3. _____

8. In your experience, what are the 3 biggest gaps in services (if any) for women who have experienced sexual violence in Ireland today?

1. _____

2. _____

3. _____

9. How would you rate the services currently available to women who have experienced sexual violence? (Please circle the applicable response)

1 = very poor

2 = poor

3 = fair

4 = good

5 = very good

10. Based on your experiences with survivors of sexual violence, how much stigma do you think is associated with this crime in Ireland today? (Please circle the applicable response)

1 = none 2 = a little 3 = a moderate/fair amount 4 = a lot

11. What is the most rewarding aspect(s) of your current job?

12. What is the least rewarding aspect of your current job?

Appendix 3: Service Provider Interview Schedule (SPIS A-D)

Service Provider Interview Schedule (SPIS)

SECTION A: DOMESTIC VIOLENCE SERVICES

1. Can you briefly describe your organisation and the type of services you provide?
2. How do women generally access (or are referred) to your services?
3. What are the main barriers (if any) to women accessing your services?
4. What do you think can be done to try to encourage women to access the services that are currently available?
5. In your experience, approximately what percentage of the women with whom you come into contact have experienced sexual violence?
6. What are the immediate problems facing women who have experienced sexual violence?
7. What are the more long-term problems (or effects) facing women who have experienced sexual violence?
8. What do you think can be done to address some of the problems that you have mentioned?
9. What key elements do you feel are necessary for providing high quality and responsive services for women who have experienced sexual violence?
10. What would be your main concerns with the carrying out of this kind of research with women who have been exposed to sexual violence?
11. What do you think would be the best and most sensitive way to recruit women for this study?
12. Do you know of any other organisations that provide services for women who have experienced sexual violence?
13. If you were doing this research, what other service providers would you speak to?
14. What other kind of research do you think you would like to see being undertaken in this area?

SECTION B: SEXUAL ASSAULT TREATMENT UNITS (SATUs)

1. Can you briefly describe your organisation and the types of services you offer to women that have experienced sexual violence?
2. How long has this unit been in operation?
3. Can you describe your staffing arrangements?
4. Approximately how many service-users do you see on an annual basis? What is the gender breakdown?
5. Generally, how are women referred to your service?
6. Can you describe the main sorts of problems/difficulties that women face in the immediate aftermath of a sexually violent incident?
7. In your experience, what are the more long-term effects of a sexually violent incident in a woman's life?
8. What do you think can be done to address some of the problems that you have mentioned?
9. What key elements do you feel are necessary for providing high quality and responsive services for women who have experienced sexual violence?
10. What would be your main concerns with the carrying out of this kind of research with women who have been exposed to sexual violence?
11. What do you think would be the best and most sensitive way to recruit women for this study?
12. Do you know of any other organisations that provide services for women who have experienced sexual violence?
13. If you were doing this research, what other service providers would you speak to?
14. What other kind of research do you think you would like to see being undertaken in this area?

SECTION C: RCNI MEMBER CENTERS

1. Can you tell me some of the history of this center?
 - a. When it was opened?
 - b. How many staff you have (part-time, full-time, volunteers)?
 - c. Your opening hours? Help-lines (if any)?
 - d. The types of services you offer including outreach services?
 - e. How many people contact on average each year? Or how many ring help-line?
 - f. How many males/females? Age ranges?
 - g. How many in individual counselling? How many court/SATU accompanied (if applicable)?
 - h. Average length of time in counselling?
 - i. Figures for the different types of incidents that people report
2. What are the main difficulties and biggest challenges that these women face in accessing your services?
3. What are the main difficulties and biggest challenges that these women face after the assault in your experience?
4. In your experience, what are the main areas of women's lives impacted upon by their experience of sexual violence (immediately and more long-term)?
5. What gaps in services have you identified that should be addressed to help women that have been raped or sexually assaulted?
6. What are some of the key elements that you feel are necessary for high quality service provision in responding to women who have experienced sexual violence?
7. What would be your main concerns with the carrying out of this kind of research with women who have been exposed to sexual violence?
8. What would be the best and most sensitive way to recruit women for this study?
9. Do you know of any other organisations that provide services for women that have experienced sexual violence?
10. If you were doing this research what other service providers would you speak to?
11. What other kind of research do you think you would like to see being undertaken in this area?

SECTION D: RAPE CRISIS NETWORK OF IRELAND (RCNI)

1. Can you describe the role of the RCNI in Ireland?
2. Can you explain your role in the organisation?
3. What are the main difficulties and biggest challenges that these women face in accessing services after an assault?
4. In your experience, what are the main areas of women's lives impacted upon by their experience of sexual violence?
5. What gaps in services have you identified that should be addressed to help women that have been raped or sexually assaulted?
6. What are some of the key elements that you feel are necessary for high quality service provision in responding to women who have experienced sexual violence?
7. What would be your main concerns with the carrying out of this kind of research with women who have been exposed to sexual violence?
8. What would be the best and most sensitive way to recruit women for this study?
9. Do you know of any other organisations that provide services for women that have experienced sexual violence?
10. If you were doing this research what other service providers would you speak to?
11. What other kind of research do you think you would like to see being undertaken in this area?

Appendix 4: RCNI Newsletter article on research study

EXPLORING THE IMPACT OF SEXUAL VIOLENCE: A RESEARCH STUDY AT NUI MAYNOOTH

Background

The true impact of sexual violence on the lives of young women living in Ireland (or elsewhere in these islands) is unknown despite the substantial increase in reported sexual offences in Ireland since 1950. Several international studies have examined the impact of rape and sexual assault with respect to overall health, resource loss and substance use. However, no research, to date, has adopted a multi-dimensional and multi-method approach specifically aimed at this vulnerable sub-group. Furthermore, whilst a substantial amount of the research in the area of rape and sexual violence focuses on the presence or absence of post-traumatic symptoms such as flashbacks and nightmares, some leaders in this field are now suggesting that our traditional notions of trauma fail to capture the true complexities of women's experiences of sexual violence.

Exploring the impact of sexual violence

This, coupled with how little we know about the impact on women of sexually violent crime, has led to the development of an innovative and exciting research project that is to begin this month at the Department of Psychology, NUI Maynooth (NUIM). The research - entitled "The hidden costs of sexual violence: A multi-dimensional approach to the impact and experience of trauma" - will be conducted by Caroline Kelleher (pictured right) under the Supervision of Dr Sinéad McGilloway (Senior Lecturer). (Funding for the study has been secured

from the Irish Research Council for Humanities and Social Sciences (IRCHSS). Under this scheme, projects are selected for their excellence and their potential to contribute to the development of Ireland 'as a knowledge society'. What is most encouraging, perhaps, is that the funding of a project of this nature indicates that the crime of sexual violence and its effects are being taken more seriously than in the past.

Why this study is important

The NUIM study will attempt to explore, and reach a better understanding of, the often-insidious consequences of this sexual crime in the life of a sample of survivors of sexual violence. This multi-stage and multi-method project aims to provide a detailed insight into the impact of trauma on the lives of young Irish women who have been exposed to sexual violence. During the first stage of the study, the researchers hope to conduct short interviews with a number of key stakeholders operating at the forefront of service provision. These may include co-ordinators of some of the RCNI and Sexual Assault Treatment Units (SATUs), as well as RCNI staff. In these interviews, participants will be asked about their knowledge of, and/or experiences with, women who have been raped or sexually assaulted (e.g. identifying barriers to accessing help; major difficulties encountered by women in the aftermath of a sexually violent incident)

and to identify any gaps they feel are present in the current system of service provision. It is hoped that the information from these initial interviews will be used to inform the remaining stages of the study when the researchers plan to interview women who have experienced sexual violence.

In the second and third stages of the study, a sample of approximately 150 young women will be asked to take part in the research which will involve, in the first instance, the completion of a number of questionnaires which will assess different aspects of the women's lives including their general health, interpersonal support, and quality of life. A smaller number of women, with their consent, will be

contacted at a later date for a more in-depth interview based on their experiences. Concerns for the confidentiality and emotional welfare of participants will be at the forefront of this study and each stage will be conducted mindful of the sensitivities surrounding research of this kind. The study has been submitted and approved by the NUIM Ethics Committee. Safeguards built into the design of the study and information gathered from interviews with key individuals currently working in service provision will ensure that the rights and dignity of



Caroline Kelleher of the Dept. of Psychology, NUI Maynooth. Caroline is originally from Cork and returned to college as a mature student in 2001 to pursue a degree in psychology.

the participants are protected at all times.

The potential value of the findings from this study cannot be overstated. There can be little doubt that more research of this kind is needed to raise public awareness, to increase access to, and availability of, information and services and to influence policy and practice. With the invaluable co-operation and the courage of the many survivors out there, this project represents an important step in the right direction.

Caroline Kelleher, NUIM

Appendix 5: Stakeholder Information Sheet



NUI MAYNOOTH

Oilscéal na hÉireann Má Nuad

THE 'HIDDEN' COSTS OF SEXUAL VIOLENCE: A MULTIDIMENSIONAL APPROACH TO THE IMPACT AND EXPERIENCE OF TRAUMA

We would like to invite you to take part in an important research study which explores women's health and well-being and their experiences of sexual violence. Before you decide whether or not you would like to take part, it is important for you to understand why the research is being done and what it will involve. Please take a few minutes to read carefully through the following information and discuss it with others if you wish. Also, please ask us if there is anything that is not clear, or if you would like more information.

What is the purpose of this study?

The purpose of this research project is to try to gain an insight into the genuine impact of sexual violence on the lives of Irish women. It is hoped that the findings from this study will be used to raise an awareness of the important issue of sexual violence in Ireland today and perhaps to inform the development of appropriate support services.

Why have I been asked to take part?

You have been asked to take part in the first stage of this research project because you have been identified as a key stakeholder operating at the frontline in service provision for people that have experienced sexual violence. Conducting interviews with individuals with your kind of firsthand experience will set the context for, and inform the development of, the remainder of the study. In the later stages of this study the researchers hope to survey about 150 women who have experienced sexual violence. A further sub sample of this number (with their consent) will take part in in-depth interviews designed to explore their experience of sexual violence and its impact on their lives. The researchers feel that speaking to the people who contact survivors of sexual violence virtually on a daily basis is vital to, firstly, seek your opinions on what *you* feel these women need in terms of services and support and secondly, to obtain your views and advice on how best to recruit participants while simultaneously ensuring their emotional and psychological well-being.

Who is funding the research?

This research is funded by the Irish Research Council for the Humanities and Social Sciences (IRCHSS).

Who has approved this study?

This research has been approved by the ethics committee of the National University of Ireland, Maynooth. The research is also supported by the Rape Crisis Network of Ireland.

What happens if I decide to take part?

If you decide to take part the researcher will arrange an interview with you at a time and place that is convenient for you. With your permission, this interview will be tape-recorded but you have the right to refuse this if you so desire. Firstly, you will be asked to sign an informed consent form after which you will be asked to complete a brief background questionnaire. The questions you will be asked as part of the interview will cover topics such as barriers to services that women experience, short-term and long-term requirements of women who have experienced sexual violence. In addition, advice on this study will be sought with respect to recruiting participants. This interview should not take up more than an hour of your time.

Will my taking part in this research be kept confidential?

Yes, all information which is collected about you during the course of the research will be kept **strictly confidential**. Any tapes from the interview will be transcribed and then destroyed when the research is completed. The interview tapes from each of the interviews will be stored in a secure location on campus at all times and will be identified using a code or number to ensure your anonymity. All information will be held under lock and key and will be accessed only by the Researcher and will not be distributed to any other unauthorised individual. Your organisation will *not* have access to your responses at any stage.

What will happen to the results of the research?

The research will be written up in report format and will hopefully be published in journals and presented at conferences. A copy of the research will be available in approximately two to three years' time.

Who do I contact if I have a question?

Please feel free to address any questions to Caroline Kelleher (the researcher) or Dr. Sinéad McGilloway (the Research Supervisor) who is also available on the telephone to discuss the study with you. Tel: (01) 708 4765/6052

Alternatively, you may write to:

Ms Caroline Kelleher or Dr Sinéad McGilloway, Department of Psychology, John Hume Building, NUI Maynooth, Maynooth, Co. Kildare, Ireland.

THANK YOU FOR TAKING THE TIME TO READ THIS

Appendix 6: Stakeholder Consent Form



NUI MAYNOOTH

Óliscéal na nÉireanna Mí Nua

For Office Use only

Stakeholder Consent Form

Title of Project: The 'hidden costs' of sexual violence

Name of Researcher: Caroline Kelleher

Please initial box

- 1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.
- 2. I understand that my participation is voluntary and that I am free to withdraw from the research at any time (and withdraw my data), without giving any reason.
- 3. I understand that the interview I will be participating in will be taped and that the tape will be destroyed once the research has been completed.
- 4. I understand that all information will be treated in the **strictest confidence** and my anonymity is guaranteed. **All** information (including tapes etc.) will be held and kept in a locked cabinet at work which will be accessed solely by the researcher and will not be distributed to any other unauthorised individual. These data may be accessed by me at my discretion and at any time.
- 5. I agree to take part in the above study.

Name of participant

Signature
Date:

Caroline Kelleher

Name of researcher

Signature
Date:

If during your participation in this study, you feel that the information and guidelines that you were given have been neglected or disregarded in any way, or if you are unhappy about the process, please contact the Secretary of the National University of Ireland Maynooth Ethics Committee at pgdean@nuim.ie 01 708 6018. Please be assured that your concerns will be dealt with in a sensitive manner.

Appendix 7: Study posters and leaflets

WHAT DOES IT FEEL LIKE TO BE YOU...



...AFTER SOMEONE HAS VIOLATED YOU SEXUALLY WITHOUT YOUR CONSENT?

- Are you Irish and female?
- Are you currently 18 years or older?
- Has someone violated you sexually without your consent since the age of 16?

Participating in this important research will take about one hour of your time and will involve questions about your overall health and well-being, social relationships & quality of life since this event. It is hoped that the information gathered from this study will inform and improve services for other women that find themselves in the same situation.

All information will be kept strictly confidential and your anonymity is guaranteed.

For any further details or questions, or if you wish to take part, please contact Caroline Kelleher by phone on 087 638 5729 (Mon: 7pm - 10pm, Wed and Fri: 10am – 3pm), or by email caroline.kelleher@nuim.ie or by post, to Caroline Kelleher at Dept. of Psychology, John Hume Building, NUI Maynooth, Co. Kildare. More information is also available at the following web address: <http://psychology.nuim.ie/CarolineKelleher.shtml>

WHY IT'S IMPORTANT TO CONSIDER TAKING PART

- The full impact of sexual violence on the lives of Irish women is relatively unknown – in spite of a substantial increase in reported sexual offences over the last 50 years.
- The study will provide important information to inform and improve services for women who find themselves in a similar situation.
- Every voice counts – the more women who take part in this study, the more impact it is likely to have.

HOW TO TAKE PART IN THE RESEARCH

For further details about the research and what is involved, or to arrange to take part, please contact Caroline Kelleher:

- By phone or text: 087 638 5729
Mon: 7pm – 10pm
Wed and Fri: 10am – 3pm
- By email:
Caroline.Kelleher@nuim.ie
- By post to: Caroline Kelleher,
Department of Psychology
John Hume Building,
NUI Maynooth,
Maynooth,
Co. Kildare

All the information you provide will be kept strictly confidential and your anonymity is guaranteed at all times



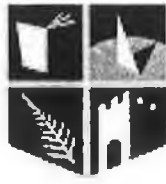
NUI MAYNOOTH
Dlíscail na hÉireann M^a Nead

What does it feel like to be you...



...after someone has violated you sexually without your consent?

Appendix 8: Poster and leaflet feedback form



NUI MAYNOOTH

Ollscoil na hÉireann M^o N^oad

The 'hidden' costs of sexual violence: a multi-dimensional approach to the impact and experience of trauma

POSTER AND LEAFLET FEEDBACK FORM

1. What was your first impression when you saw the poster/leaflet?

2. What are your thoughts on the colours and the picture used?

3. How do you feel about the overall language and tone of the poster/leaflet?

4. What are your thoughts on the information provided in the poster and leaflets?

P.T.O ⇒

5. Please feel free to offer any other additional comments or suggestions below.

Thank you very much for taking the time to complete this. Your opinions and expertise in this area are much appreciated.

Appendix 9: Organisation letter(s) re. displaying study posters



NUI MAYNOOTH
Ollscoil na hÉireann Má Nuad

The 'hidden' costs of sexual violence: A research study exploring the impact of sexual violence on the lives of Irish women

Principal aim of the study: is to describe and explore the impact of sexual violence on the lives of young Irish women. Even today many rape myths persist. The occurrence of sexual violence within the context of an intimate relationship is often more hidden than it traditionally is, as the partners of these perpetrators rarely 'fit' the societal stereotype of a classic 'rape victim'. In addition, research has shown that many Irish women have never told anyone what has happened to them let alone contacted a service

What do we need?

- We need up to **150 women who are Irish, currently over 18 and have had an experience of sexual violence since the age of 16**

What will it involve?

- Participants will be asked to complete a selection of questionnaires asking them about the impact that their experience has had on areas like their health, relationships and quality of life
- This process should take approximately an hour of their time, at a suitable time and location where their safety and confidentiality can be ensured
- All information gathered will be treated confidentially and their anonymity is guaranteed

Why are we asking for your help?

- The involvement of your organisation and volunteers/workers in the promotion of this research is *vital* to its success – the more women we can encourage to participate the more influential the findings can be
- Rape Crisis Centers and Domestic Violence Refuges and Support Services from all over Ireland are being asked to support this research but we also want to access women who are possibly not in direct contact with these services
- By encouraging the women you know and support, to consider taking part, you will be helping to provide them with a voice that in many instances goes unheard

What can you do to help?

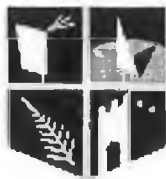
- Contact, the researcher, Caroline Kelleher at the Department of Psychology, John Hume Building, NUI Maynooth, Maynooth, Co. Kildare on (01) 708 6086 or via email at caroline.kelleher@nuim.ie for more information on the study and to order the posters and leaflets
- Display the posters and leaflets in your premises and at other suitable locations
- Encourage women you know to consider taking part. They can contact the researcher either directly, or through your organisation

Please note: We are very aware of the ethical and safety issues surrounding this kind of research and the fact that in some cases women may still be living in a potentially violent situation. We have spent a considerable amount of time looking at these issues and speaking with people who work in this area. Each potential participant will be addressed on a case-by-case basis in order to ensure both her physical and emotional safety at all times.

Caroline Kelleher

This research is being funded by the Irish Research Council for Humanities and Social Sciences

Appendix 10: Information sheets for organisations



NUI MAYNOOTH

Gaircúil na hÉireann Mhí Saor

EXPLORING THE IMPACT OF SEXUAL VIOLENCE

A research study at NUI Maynooth

Study aims: The principal aim of the study is to describe and explore the impact of sexual violence on the lives of young female rape victims/survivors (18-30 yrs). The key objectives and three stages of this study are to: (1) undertake a series of one-to-one interviews with key service providers working in the area of rape and sexual trauma; (2) to undertake a cross-sectional questionnaire-based survey of a sample of young women ($n \cong 100-150$) who have experienced sexual violence (i.e. rape/sexual assault), in order to assess a range of outcomes relating to: mental health, stress and trauma; Quality of Life (QoL); general physical health and well being; social support; life events; and service needs; and (3) to conduct a series of in-depth interviews with a smaller sample of young women with a view to exploring in more detail their experience of sexual trauma and its impact on their lives.

Background

The true impact of sexual violence on the lives of women living in Ireland is unknown despite the substantial increase in reported sexual offences in Ireland since 1950. In addition, rape and sexual assault in the context of an intimate relationship is perhaps even more hidden as partners of these perpetrators rarely 'fit' the societal stereotype of a classic 'rape victim'. In spite of increasing attention being brought to this area in more recent years, the pervasive effect of specifically sexual violence (while acknowledging the other elements of a violent relationship) has not been recorded. Several international studies have examined the impact of rape and sexual assault in a variety of populations with respect to overall health, resource loss and substance use. However, no research, to date, has adopted a multi-dimensional and multi-method approach specifically aimed at this vulnerable sub-group. Furthermore, whilst a substantial amount of the research in the area of rape and sexual violence focuses on the presence or absence of post-traumatic symptoms such as flashbacks and nightmares, some leaders in this field are now suggesting that our traditional notions of trauma fail to capture the true complexities of women's experiences of sexual violence.

Exploring the impact of sexual violence

This fact, coupled with how little we know about the impact on women of sexually violent crime, has led to the development of an innovative and exciting research project that will begin data collection shortly at the Department of Psychology, NUI Maynooth (NUIM). The research - entitled "*The hidden costs of sexual violence: A multi-dimensional approach to the impact and experience of trauma*" - will be conducted by Caroline Kelleher (pictured right)



under the Supervision of Dr Sinéad McGilloway (Senior Lecturer). Funding for the study has been secured from the Irish Research Council for Humanities and Social Sciences (IRCHSS). Under this scheme, projects are selected for their excellence and their potential to contribute to the development of Ireland 'as a knowledge society'. What is most encouraging, perhaps, is that the funding of a project of this nature indicates that the crime of sexual violence against all women, and its effects are being taken more seriously than in the past. The NUIM study will attempt to explore, and reach a better understanding of, the often-insidious consequences of this sexual crime in the life of a sample of survivors of sexual violence.

Stages of the study

Stage One (one-to-one interviews with stakeholders) as outlined above is now complete. A number of key stakeholders operating in this area were identified, approached and interviewed. Conducted all over Ireland they included staff from several national Rape Crisis Centres (RCCs), SATUs, the Rape Crisis Network of Ireland and a smaller number of domestic violence support services. As well as this stage being critical in securing a suitable sample of women who have experienced sexual violence it has also illuminated the subtlety of the many myths and stereotypes inherent in this area. By sourcing potential participants through both the RCCs and the domestic violence support services and refuges it is hoped that many of these wrongly held beliefs can be revisited, in addition to providing important information that can be used to inform service delivery across both sectors.

In Stage Two (beginning shortly) of the study, a sample of approximately 150 women will be asked to take part in the research which will involve, in the first instance, the completion of a number of questionnaires which will assess different aspects of the women's lives including their general health, interpersonal support, and quality of life. For the third and final stage, a smaller number of women, with their consent, will be contacted at a later date for a more in-depth interview based on their experiences.

Ethical issues and participant safety

Concerns for the confidentiality, emotional welfare and physical safety of participants are at the forefront of this study and each stage has been designed and is being conducted, mindful of the sensitivities surrounding research of this kind. The study has received ethical approval from the to the

NUI Maynooth Ethics Committee. I have also consulted with the British Psychological Society Professional Code of Ethics as well as the World Health Organisation guidelines in this area (*Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence Against Women*). The safeguards and protocols built into the design of the study, in conjunction with the information gathered from interviews with key individuals currently working in service provision in this area, will ensure that the rights and dignity of the participants are protected at all times.

As a result of the interviews conducted in Stage One several of the organisations I have dealt with have kindly offered the use of their premises for the purposes of meeting with these women. While I appreciate that not all organisations are in a position to do this, this is practically very convenient for me but perhaps more importantly it will also provide the women concerned with a safe and confidential environment for the duration of their participation in the study and in many cases one which they are already familiar with. The field work I have already conducted has made me cognisant of the complexities (and sometimes danger) associated with some women agreeing to take part in this kind of research and I am more than happy to work with each organisation and individual, on a case by case basis, adapting and modifying my procedures where necessary.

The importance of this study

The involvement of your organisation in the promotion of this research is important. Your endorsement of it by displaying the posters and leaflets (anonymous business cards where more appropriate) will greatly assist me in ensuring that a nationally representative sample of women will take part making the results more credible and generalisable to the wider population.

The potential value of the findings from this study cannot be overstated. There can be little doubt that more research of this kind is needed to raise public awareness, to increase access to, and availability of, information and services and to influence policy and practice. With the invaluable co-operation and the courage of the many survivors out there, this project represents an important step in that direction.

To obtain further information on this study, what it will involve and how you can become involved please contact Caroline Kelleher at the Department of Psychology, John Hume Building, NUI Maynooth, Maynooth, Co. Kildare (01) 708 6086.

Alternatively I am happy to address any questions, queries or concerns you may have via email at caroline.kelleher@nuim.ie

Appendix II: Researcher business cards

NUI Maynooth
Department of Psychology
Caroline Kelleher
Researcher

Department of Psychology,
NUI Maynooth
Co. Kildare

Phone: 087 638 5729
Mon: 7pm-10pm, Wed and Fri: 10am-3pm
Email: caroline.kelleher@nuim.ie



NUI Maynooth
Department of Psychology

Caroline Kelleher
Researcher

Department of Psychology,
NUI Maynooth
Co. Kildare
Phone: 087 638 5729
Mon: 7pm-10pm
Wed and Fri: 10am-3pm
Email: caroline.kelleher@nuim.ie

Appendix 12: The Background, Experiences and Services Questionnaire (BESQ)

Office use only
I.D.: _____
Date: _____

BACKGROUND, EXPERIENCES AND SERVICES QUESTIONNAIRE

SECTION A: ABOUT YOUR EXPERIENCE OF SEXUAL VIOLENCE

This section asks you for some information about your experience of sexual violence. If you have experienced more than one incident, please refer to the most recent incident when answering these questions.

A1. How old were you at the time of the incident? Age: _____

A2. Approximately how long ago did this incident take place?

Years _____ Months _____

The next question asks you about the type of assault you experienced. We would like to apologise for the graphic nature of the language, but this is the only way that we can accurately describe your experience.

A3. Which of the following describes best what happened to you?
(Please tick the appropriate box)

1. Someone made you have sex without your consent. <i>(By sex, we mean penetration of your vagina by a man's penis)</i>	<input type="checkbox"/>
2. Someone made you have oral sex without your consent <i>(By oral sex, we mean a man putting his penis in your mouth)</i>	<input type="checkbox"/>
3. Someone made you have anal sex without your consent. <i>(By anal sex, we mean a man putting his penis in your anus)</i>	<input type="checkbox"/>
4. Someone put fingers in your vagina without your consent	<input type="checkbox"/>
5. Someone put another object in your vagina without your consent.	<input type="checkbox"/>

A4. What was your relationship to the person who did this to you?
(Please circle the number of the appropriate response)

- | | |
|--|--|
| 1 Stranger | 6 Boyfriend/Girlfriend* |
| 2 Acquaintance | 7 Spouse/Partner* |
| 3 Friend | 8 Ex-boyfriend/Ex-girlfriend* |
| 4 Workmate/Colleague | 9 Ex-spouse/Ex-partner * |
| 5 Someone you were/had*
been on a date with | 10 Other <i>(please specify below)</i>
_____ |

* Please delete as appropriate

A5. Sexual assaults do not always result in additional physical injury. Please indicate if you suffered any further physical injuries or physical consequences as a result of the assault? *(Please circle all that apply)*

- 1 None
- 2 Minor (e.g. bruises, cuts, scratches)
- 3 Severe (e.g. knocked unconscious, broken bones, internal injuries)
- 4 Sexually transmitted infections
- 5 Pregnancy
- 6 Other *(please specify)* _____

A6. Before the age of 16, did you experience any form of sexual violence?

Yes No

A.7 Before the age of 16, did you experience any form of sexual abuse?

Yes No

SECTION B: YOUR EXPERIENCE OF ACCESSING SERVICES

This section includes questions on your experience of telling someone for the first time and accessing services, such as your local Rape Crisis Centre (RCC).

B1. Who was the first person you told about what had happened to you? (e.g. one of your parents, a close friend, your brother or sister, an acquaintance, a counsellor etc.)

B2. Thinking back to that person, how would you rate their initial/first reaction to what you had told them? *(Please circle the appropriate response)*

1	2	3
Generally supportive	Neither supportive nor unsupportive	Not supportive

B3. Since your experience, have you ever attended counselling either privately or through your local Rape Crisis Centre (RCC)?

Yes No

*(If you have responded 'No' to this question, please proceed to **question B5**)*

B3.1. If 'yes', please indicate if : Private counselling RCC counselling

(i) If you are currently receiving counselling, please state for how long

Years _____ Months _____

(ii) Or if you have finished, for how long did you attend counselling?

Years _____ Months _____

B4. In general, how frequently did you*, or do you*, (* please delete as appropriate) attend for counselling sessions (one-to-one and/or group) (*Please circle the appropriate response*)

- 1 Once a week
- 2 Twice a week or more
- 3 Fortnightly
- 4 Monthly
- 5 Other (*please give details*) _____

B5: If you have never made contact with a RCC, could you explain briefly your reason(s) for not doing so?

B6. We would also like to know what other organisations/agencies/individuals you have contacted for support and/or information/advice as a result of your experience. In the space provided below, please briefly outline any other organisations/agencies/individuals you have contacted for support and/or information/advice as a result of your experience. (e.g. domestic violence services, Samaritans, psychiatrist, Gardaí, social worker, voluntary services, GP, priest etc.). If 'None', please state this below.

If you contacted a Rape Crisis Centre (RCC) at any stage after the incident for counselling, please answer the following questions. If these questions are not applicable to you, please proceed to Section C.

B7. Approximately how soon after the incident did you make contact with your local Rape Crisis Centre (RCC) either by phone, or in person?

Years _____ Months _____

B8. Was there was a waiting period for you to see a counsellor at the RCC which you contacted?

Yes No

B8.1 If 'Yes', please indicate for approximately how long you had to wait?

Days _____ Weeks _____ Months _____

B8.2 If 'Yes', how did you feel about having to wait, at the time?

B9. In general, how frequently did you*, or do you*, (*please delete as appropriate) attend the RCC for counselling sessions (one-to-one and/or group)? (*Please circle the appropriate response*)

- 1 Once a week
- 2 Twice a week or more
- 3 Fortnightly
- 4 Monthly
- 5 Other (*please give details*) _____

B10. Overall in your experience, how helpful do you think is the counselling offered by your RCC ? (*Please circle the appropriate response*)

1	2	3	4
Not helpful	A little helpful	Moderately helpful	Very helpful

B11. If 'Not helpful', how do you think the service could be improved?

SECTION C: THE IMPACT ON YOUR LIFE

This section asks you questions about different aspects of your life and if you feel they have been affected, as a result of your experience. Some of them ask about both positive and negative aspects. Please remember that every woman is different and there are no right or wrong answers. You may find that some of these questions do not apply to you, but please read all of the questions carefully, just in case.

Education and employment

C1. Please indicate whether you were at 'school/college' or 'working/not working' at the time of the incident. *(Please circle applicable response)*

- | | |
|---|---------------------------------|
| 1 Attending secondary school | <i>Please go to Question C2</i> |
| 2 Attending college/post-Leaving Cert. Training | <i>Please go to Question C2</i> |
| 3 Employed | <i>Please go to Question C4</i> |
| 4 Unemployed | <i>Please go to Question C6</i> |

C2. Did you take any time off school/college in the 6 months immediately after the incident?

- Yes No

C2.1: If yes, approximately how much time did you take off in the 6 months after the incident?

C3. How much do you think your experience affected your ability to complete your education? *(Please circle the appropriate response)*

- | | | | |
|------------|----------|---------------|-------|
| 1 | 2 | 3 | 4 |
| Not at all | A little | A fair amount | A lot |

Please proceed to Question C6.

C4. Did you take any time off work in the 6 months immediately after the incident?

- Yes No

C4.1: If 'Yes', approximately how much time did you take off in the 6 months after the incident?

C5. Are you still in the same job that you were in at the time of the incident?

Yes No

C5.1: If 'No', could you briefly give your reason(s) for leaving the job?

C6: Are you currently employed?

Yes No

If you have answered 'Yes' to this question, please proceed to question C7. If you have answered 'No' to this question, please proceed to question C8.

C7. To what extent has your experience of sexual violence impacted on your ability to perform your job on a daily basis? (*Please circle the appropriate response*)

1	2	3	4
Not at all	A little	A fair amount	A lot

C8. To what extent has your experience of sexual violence affected your ability to secure and maintain employment? (*Please circle the appropriate response*)

1	2	3	4
Not at all	A little	A fair amount	A lot

SECTION D: RELATIONSHIPS AND HEALTH

D1. How much do you think your experience of sexual violence has impacted negatively on your relationships with those closest to you (e.g. mother, father, siblings, partner, children, friends)? (*Please circle the appropriate response*)

1	2	3	4
Not at all	A little	A fair amount	A lot

D2: How much do you think your experience has affected your ability to form;

(i) close friendships ? *(Please circle the appropriate response)*

1	2	3	4
Not at all	A little	A fair amount	A lot

(ii) intimate relationships? *(Please circle the appropriate response)*

1	2	3	4
Not at all	A little	A fair amount	A lot

D3. Please indicate below if you have attended or availed of any of the following services in the *first 3 months after* your experience of sexual violence?
(**Note:** You may have accessed some of these through your GP, a Family Planning Clinic or a Casualty Department or Out-Patient Department of a hospital. Please record a response for all)

(Please circle either 'Yes' or 'No' after each of the medical services listed below)

1 Emergency Contraception	Yes	No
2 Sexual Assault Treatment Unit	Yes	No
3 Cervical Screening/Smear Clinic	Yes	No
4 Sexually Transmitted Infections/Genito-urinary Clinic	Yes	No
5 Other <i>(Please specify)</i> _____		

D4. Since your experience, do you routinely (at least once a year or in the case of a smear every 3-5 years) avail of the following medical services? *(Please circle either 'Yes' or 'No' after each of the medical services listed)*

1 Cervical screening/Smear clinic	Yes	No
2 Sexually Transmitted Infections/Genito-urinary Clinic	Yes	No

D5. Have you ever attended any of the following clinics either publicly or privately?
(Please circle either 'Yes' or 'No' after each of the medical services listed below)

- | | | |
|--------------------------------|-----|----|
| 1 Early Pregnancy Unit | Yes | No |
| 2 Colposcopy Clinic | Yes | No |
| 3 Fertility Clinic | Yes | No |
| 4 Psycho-sexual counselling | Yes | No |
| 5 Other (please specify) _____ | | |

D6. Have you ever been formally diagnosed (i.e. by a medical or mental health professional) with a mental health problem (e.g. depression, anxiety etc.)?

- Yes No

If you have answered 'No' to this question, please proceed to question D7.

D6.1. If 'Yes', please indicate below the name of the diagnosis you received

D6.2. Approximately how long ago did you receive this diagnosis?

D6.3. Please detail briefly any treatment(s) (e.g. medication, therapy etc.) you have received for this and the duration of each. If 'None,' please state this below.

<u>Type of treatment</u>	<u>Duration</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

D7. Alcohol and drug use

The following brief questions look at alcohol and drug use. Some of these may not be applicable to you, but please read them carefully just in case.

D7. Do you drink alcohol? *(Please tick the appropriate box)*

Yes No

If you have answered 'No' to this question, please proceed to question D8.

D7.1 If 'Yes', typically how often? *(Please circle the applicable response)*

- 1 Daily
- 2 Every few days
- 3 Weekly
- 4 Fortnightly
- 5 Monthly
- 6 Only on special occasions
- 7 Other (please specify) _____

D7.2 If 'Yes', how many drinks would you usually have in one sitting
(on average)?

Please indicate by ticking either 'Yes' or 'No' to the following questions. Your confidentiality and anonymity are guaranteed so please be honest in your responses.

D7.3 During the last year have you had a feeling of guilt or remorse after drinking?

Yes No

D7.4 During the last year has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?

Yes No

D7.5 During the last year have you failed to do what was normally expected from you because of drinking?

Yes No

D7.6 Do you sometimes take a drink when you first get up in the morning?

Yes No

D8. Do you use, or have you ever used, non-prescription drugs? (*Please tick the appropriate box*)

Yes, in the past Yes, currently No

If you have answered 'Yes in the past' or 'No' to this question, please proceed to question D9.

D8.1 If you answered 'Yes currently', how often? (*Please circle the applicable response*)

- 1 Daily
- 2 Every few days
- 3 Weekly
- 4 Fortnightly
- 5 Monthly
- 6 Other (*please specify*) _____

D8.2 If 'Yes', which drugs would you normally use?

Please indicate by ticking either 'Yes' or 'No' to the following questions. Your confidentiality and anonymity are guaranteed so please be honest in your responses.

D8.3 During the last year have you had a feeling of guilt or remorse after drug use?

Yes No

D8.4 During the last year has a friend or family member ever told you about things you said or did while you were using drugs that you could not remember?

Yes No

D8.5 During the last year have you failed to do what was normally expected from you because of drug use?

Yes No

D8.6 Do you sometimes use drugs when you first get up in the morning?

Yes No

D9. Please indicate below, whether or not each of the following areas of your life have been affected by your experience of sexual violence. Please also record (using the scale provided) the extent to which you feel that this area has been affected in either a positive, or a negative way.

After each item in the table, place an X in the first column if that area has been affected. Use the next column to record how positively or negatively you feel this area of your life has been affected. Please answer every item.

E.g.

Areas of Your Life	Has been affected	Positive or Negative rating
Personal finances	X	-1

Very negative	Moderately negative	Slightly negative	No impact	Slightly positive	Moderately positive	Very positive
-3	-2	-1	0	+1	+2	+3

Areas of Your Life	Has been affected	Positive or Negative rating
Personal finances		
Occupation/ Work life		
Education		
Physical health (inc. sexual health)		
Mental health		
Self-esteem/Self-confidence		
Personal relationships		
Sexual relationships		
Social life		
Everyday life		
Other (please specify)		

D10: Overall, how much of a *negative* impact do you think your experience of sexual violence has had on your life? (**Please circle the appropriate response**)

1	2	3	4
Not at all	A little	A fair amount	A lot

D11: Sometimes negative experiences can have positive effects in the longer term. Overall, how much of a *positive* impact (if any) has your experience of sexual violence had on your life? (**Please circle the appropriate response**)

1	2	3	4
Not at all	A little	A fair amount	A lot

SECTION E: CONCLUSION

E1. Are there any other services or assistance that you would have liked to avail of immediately after, or in the months/years that followed, your experience?

Yes No

E1.1 If 'Yes', please say a little more about what you would have liked to avail of at the following times :

(a) immediately after the incident:

(b) in the months or years that followed:

E2. What kinds of things, if any, prevented you from accessing the help that you felt you needed, after your experience? If 'None', please state this below.

SECTION F: ABOUT YOU

The following information is only necessary in order to provide us with a profile of the kind of people that have taken part in the study. This information will not be reported individually, but on a group basis and your anonymity is guaranteed.

F1. What age are you? _____

F2. What is your country of origin? _____

F3: Do you have any children?

Yes No

F3 (a): If yes, how many children do you have _____

F4. Which of the following best describes your current marital status?
(Please circle the number of the appropriate response)

- 1 Single
- 2 Steady relationship
- 3 Living with a partner
- 4 Married
- 5 Separated/Divorced
- 6 Widowed
- 7 Other (please specify) _____

F5. What is your current occupation?(optional)

F6. What is the **highest** level of education that you have successfully completed (e.g. Junior Cert., Leaving Cert., Bachelor's Degree, etc.)? (Please circle the appropriate response)

- 1 Junior Certificate
- 2 Leaving Certificate
- 3 Trade Training
- 4 Post Leaving Certificate (PLC)/ Regional Technical College (RTC)
- 5 University Qualification (Degree)
- 6 Post Graduate Qualification
- 7 Other (please specify) _____

Thank you for agreeing to participate in this research. Your responses will provide extremely valuable information on women's experiences of sexual violence in Ireland. We are very grateful for the time and effort you have given to completing all of these questionnaires and the courage you have shown in sharing your experiences with us.

Appendix 13: General Health Questionnaire (GHQ-12)

General Health Questionnaire

Instructions

This questionnaire looks at any medical complaints you have had and how your health is in general over the last few weeks.

Please answer ALL of the questions simply by circling the answer which you think most nearly applies to you.

Remember that we are interested in present and recent complaints, not those that you had in the past. Your answers will remain anonymous so please be honest.

The General Health Questionnaire



Please read this carefully.

We should like to know if you have had any medical complaints and how your health has been in general, *over the last few weeks*. Please answer ALL the questions simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.

Thank you very much for your co-operation.

Date

HAVE YOU RECENTLY:

1 - been able to concentrate on whatever you're doing?	Better than usual	Same as usual	Less than usual	Much less than usual
2 - lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
3 - felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
4 - felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
5 - felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
6 - felt you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual
7 - been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
8 - been able to face up to your problems?	More so than usual	Same as usual	Less able than usual	Much less able
9 - been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
10 - been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
11 - been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
12 - been feeling reasonably happy, all things considered?	More so than usual	About same as usual	Less so than usual	Much less than usual

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Appendix 14: The Life Experiences Survey – Modified version (LES-M)

LES – Life Experiences Survey

Instructions

In the following questionnaire there is a list of events that sometimes brings about change in the lives of those who experience them and which necessitate social adjustment.

Please *tick* those events that you have experienced in the recent past and indicate whether you have experienced each event in the *past 6 months*. Please be sure that all tick marks are directly across from the items to which they correspond.

Your answers will remain anonymous so please be honest. Please ask the researcher if you need any help to complete this questionnaire.

Listed below are a number of events which sometimes bring about change in the lives of those who experience them and which necessitate social readjustment. Please *tick* those events which you have experienced in the recent past and indicate whether you have experienced each event in the *past 6 months*. Be sure that all tick marks are directly across from the items to which they correspond.

Also, for each item checked below, please indicate the extent to which you viewed the event as having either a positive or negative impact on your life at the time the event occurred. That is, indicate *the type and extent of impact* that the event had. A *rating of -3* would indicate an extremely negative impact. A *rating of 0* suggests no impact either positive or negative. A *rating of +3* would indicate an extremely positive impact. Please ask the interviewer if you need help to complete this questionnaire.

	0-6 mths	Very negative	Moderately negative	Slightly negative	No impact	Slightly positive	Moderately positive	Very positiv
1. Marriage	-3	-2	-1	0	+1	+2	+3
2. Detention in hospital or other institution.....	-3	-2	-1	0	+1	+2	+3
3. Death of spouse	-3	-2	-1	0	+1	+2	+3
4. Death of a close family member:	-3	-2	-1	0	+1	+2	+3
a. mother	-3	-2	-1	0	+1	+2	+3
b. father	-3	-2	-1	0	+1	+2	+3
c. brother	-3	-2	-1	0	+1	+2	+3
d. sister	-3	-2	-1	0	+1	+2	+3
e. grandmother	-3	-2	-1	0	+1	+2	+3
f. grandfather	-3	-2	-1	0	+1	+2	+3
g. other (please specify)	-3	-2	-1	0	+1	+2	+3
5. Death of a close friend	-3	-2	-1	0	+1	+2	+3
6. Minor law violations (traffic tickets, disturbing the peace, etc)	-3	-2	-1	0	+1	+2	+3
7. Pregnancy: Self/wife/girlfriend*	-3	-2	-1	0	+1	+2	+3
8. Changed work situation (different work responsibility, major change in working conditions, working hours, etc)	-3	-2	-1	0	+1	+2	+3
9. Loss of job.....	-3	-2	-1	0	+1	+2	+3
10. Major change in financial status (a lot better off or a lot worse off).....	-3	-2	-1	0	+1	+2	+3
11. Major change in closeness of family members (increased or decreased closeness).....	-3	-2	-1	0	+1	+2	+3

*delete as appropriate

-
12. Gaining a new family member (through birth, adoption, family member moving in).....
 13. Serious illness or injury of close family member:
 - a. father
 - b. mother
 - c. sister
 - d. brother
 - e. grandfather
 - f. grandmother
 - g. spouse
 - h. other (*please specify*).....
 14. Divorce/separation/break-up of relationship*
 15. Reconciliation with mate/partner
 16. Major change in number of arguments with spouse or partner
(a lot more or a lot less arguments)
 17. Change in spouse's work (loss of job, beginning new job, retirement, etc).....
 18. Major change in usual type and/or amount of recreation or social activities.....
 19. Abortion: self/wife/girlfriend*
 20. Major personal illness or injury
 21. Major change in living conditions of family (building new home, remodelling, deterioration of home, change of residence, neighbourhood, etc).....
 22. Serious injury or illness of close friend
 23. Son or daughter leaving home (due to marriage, college etc)
 24. Leaving home for the first time
 25. Occurrence of a dramatic event (e.g. witnessing a serious accident).....
 26. Other(*please specify*)
 27. Other(*please specify*)
 28. Other(*please specify*)
-

*delete as appropriate

Appendix 15: Trauma Symptom Inventory (TSI)



Item Booklet

John Briere, PhD

Please read all of these instructions carefully before beginning. Mark all of your answers on the accompanying answer sheet and write only where indicated. **DO NOT** write in this item booklet.

On the answer sheet, please write your name, the date, your age, your sex, and your race in the spaces provided.

This questionnaire contains 100 items describing experiences that may or may not have happened to you. Please circle the one answer that best indicates how often each of the following experiences have happened to you **in the last 6 months**.

Circle 0 if your answer is NEVER; it has not happened at all in the last 6 months. 0 1 2 3

Circle 1 or 2 if it has happened in the last 6 months, but has not happened often. 0 1 2 3

Circle 2 if your answer is OFTEN; it has happened often in the last 6 months. 0 1 2 3

Circle 3 if your answer is OFTEN; it has happened often in the last 6 months. 0 1 2 3

If you make a mistake or change your mind, **DO NOT ERASE!** Make an "X" through the incorrect response and then draw a circle around the correct response.

Please answer each item as honestly as you can. Be sure to answer every item. You can take as much time as you need to finish the TSI.

0 1 2 3
Never Often

In the last 6 months, how often have you experienced:

1. Nightmares or bad dreams
2. Trying to forget about a bad time in your life
3. Irritability
4. Stopping yourself from thinking about the past
5. Getting angry about something that wasn't very important
6. Feeling empty inside
7. Sadness
8. Flashbacks (sudden memories or images of upsetting things)
9. Not being satisfied with your sex life
10. Feeling like you were outside of your body
11. Lower back pain
12. Sudden disturbing memories when you were not expecting them
13. Wanting to cry
14. Not feeling happy
15. Becoming angry for little or no reason
16. Feeling like you don't know who you really are
17. Feeling depressed
18. Having sex with someone you hardly knew
19. Thoughts or fantasies about hurting someone
20. Your mind going blank
21. Fainting
22. Periods of trembling or shaking
23. Pushing painful memories out of your mind
24. Not understanding why you did something
25. Threatening or attempting suicide
26. Feeling like you were watching yourself from far away
27. Feeling tense or "on edge"
28. Getting into trouble because of sex
29. Not feeling like your real self
30. Wishing you were dead
31. Worrying about things
32. Not being sure of what you want in life
33. Bad thoughts or feelings during sex
34. Being easily annoyed by other people
35. Starting arguments or picking fights to get your anger out

the last 6 months, how often have you experienced:

16. Having sex or being sexual to keep from feeling lonely or sad
17. Getting angry when you didn't want to
18. Not being able to feel your emotions
19. Confusion about your sexual feelings
10. Using drugs other than marijuana
11. Feeling jumpy
12. Absent-mindedness
13. Feeling paralyzed for minutes at a time
14. Needing other people to tell you what to do
15. Yelling or telling people off when you felt you shouldn't have
16. Flirting or "coming on" to someone to get attention
17. Sexual thoughts or feelings when you thought you shouldn't have them
18. Intentionally hurting yourself (for example, by scratching, cutting, or burning) even though you weren't trying to commit suicide
19. Aches and pains
50. Sexual fantasies about being dominated or overpowered
51. High anxiety
52. Problems in your sexual relations with another person
53. Wishing you had more money
54. Nervousness
55. Getting confused about what you thought or believed
56. Feeling tired
57. Feeling mad or angry inside
58. Getting into trouble because of your drinking
59. Staying away from certain people or places because they reminded you of something
60. One side of your body going numb
61. Wishing you could stop thinking about sex
62. Suddenly remembering something upsetting from your past
63. Wanting to hit someone or something
64. Feeling hopeless
65. Hearing someone talk to you who wasn't really there
66. Suddenly being reminded of something bad
67. Trying to block out certain memories
68. Sexual problems
69. Using sex to feel powerful or important
70. Violent dreams

0 1 2 3
Never Often

In the last 6 months, how often have you experienced:

71. Acting "sexy" even though you didn't really want sex
72. Just for a moment, seeing or hearing something upsetting that happened earlier in your life
73. Using sex to get love or attention
74. Frightening or upsetting thoughts popping into your mind
75. Getting your own feelings mixed up with someone else's
76. Wanting to have sex with someone who you knew was bad for you
77. Feeling ashamed about your sexual feelings or behavior
78. Trying to keep from being alone
79. Losing your sense of taste
80. Your feelings or thoughts changing when you were with other people
81. Having sex that had to be kept a secret from other people
82. Worrying that someone is trying to steal your ideas
83. Not letting yourself feel bad about the past
84. Feeling like things weren't real
85. Feeling like you were in a dream
86. Not eating or sleeping for 2 or more days
87. Trying not to have any feelings about something that once hurt you
88. Daydreaming
89. Trying not to think or talk about things in your life that were painful
90. Feeling like life wasn't worth living
91. Being startled or frightened by sudden noises
92. Seeing people from the spirit world
93. Trouble controlling your temper
94. Being easily influenced by others
95. Wishing you didn't have any sexual feelings
96. Wanting to set fire to a public building
97. Feeling afraid you might die or be injured
98. Feeling so depressed that you avoided people
99. Thinking that someone was reading your mind
100. Feeling worthless

Appendix 16: World Health Organisation Quality of Life – Brief version
(WHOQOL-BREF)

The World Health Organisation Quality of Life Questionnaire

Instructions

The following questions (1-26) ask you how you feel about your quality of life, health, or other areas of your life.

Please choose the answer that appears most appropriate by circling the corresponding number.

If you are unsure about which response to give to a question, the first response you think of is often the best one. Please keep in mind your standards, hopes and pleasures and concerns.

We ask that you think about your life **in the last four weeks**.

All of your responses will be kept confidential so please be honest.

WHOQOL-BREF

The following questions ask how you feel about your quality of life, health, or other areas of your life. I will read out each question to you, along with the response options. **Please choose the answer that appears most appropriate.** If you are unsure about which response to give to a question, the first response you think of is often the best one.

Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life **in the last four weeks.**

		Very poor	Poor	Neither poor nor good	Good	Very good
1.	How would you rate your quality of life?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
2.	How satisfied are you with your health?	1	2	3	4	5

The following questions ask about **how much** you have experienced certain things in the last four weeks.

		Not at all	A little	A moderate amount	Very much	An extreme amount
3.	To what extent do you feel that physical pain prevents you from doing what you need to do?	5	4	3	2	1
4.	How much do you need any medical treatment to function in your daily life?	5	4	3	2	1
5.	How much do you enjoy life?	1	2	3	4	5
6.	To what extent do you feel your life to be meaningful?	1	2	3	4	5

		Not at all	A little	A moderate amount	Very much	Extremely
7.	How well are you able to concentrate?	1	2	3	4	5
8.	How safe do you feel in your daily life?	1	2	3	4	5
9.	How healthy is your physical environment?	1	2	3	4	5

The following questions ask about how completely you experience or were able to do certain things in the last four weeks.

		Not at all	A little	Moderately	Mostly	Completely
10.	Do you have enough energy for everyday life?	1	2	3	4	5
11.	Are you able to accept your bodily appearance?	1	2	3	4	5
12.	Have you enough money to meet your needs?	1	2	3	4	5
13.	How available to you is the information that you need in your day-to-day life?	1	2	3	4	5
14.	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5

		Very poor	Poor	Neither poor nor good	Good	Very good
15.	How well are you able to get around?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
16.	How satisfied are you with your sleep?	1	2	3	4	5
17.	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
18.	How satisfied are you with your capacity for work?	1	2	3	4	5
19.	How satisfied are you with yourself?	1	2	3	4	5

20.	How satisfied are you with your personal relationships?	1	2	3	4	5
21.	How satisfied are you with your sex life?	1	2	3	4	5
22.	How satisfied are you with the support you get from your friends?	1	2	3	4	5
23.	How satisfied are you with the conditions of your living place?	1	2	3	4	5
24.	How satisfied are you with your access to health services?	1	2	3	4	5
25.	How satisfied are you with your transport?	1	2	3	4	5

The following question refers to how often you have felt or experienced certain things in the last four weeks.

		Never	Seldom	Quite often	Very often	Always
26.	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	5	4	3	2	1

Appendix 17: Interpersonal Support Evaluation List (ISEL)

ISEL – Interpersonal Support Evaluation List

Instructions

This questionnaire is made up of a list of statements about yourself and your social relationships, each of which may or may not be true about you. For each statement circle the response **“definitely true”** if you are sure it is true about you and **“probably true”** if you think it is true but are not absolutely certain. Similarly, you should circle the response **“definitely false”** if you are sure the statement is false and **“probably false”** if you think it is false but are not absolutely certain.

All of your responses will be kept confidential so please be honest.

ISEL – Interpersonal Support Evaluation List

1. There are several people that I trust to help solve my problems.

Definitely False Probably False Probably True Definitely True
 0-----1-----2-----3

2. If I needed help fixing an appliance or repairing my car, there is someone who would help me.

Definitely False Probably False Probably True Definitely True
 0-----1-----2-----3

3. Most of my friends are more interesting than I am.

Definitely False Probably False Probably True Definitely True
 0-----1-----2-----3

4. There is someone who takes pride in my accomplishments.

Definitely False Probably False Probably True Definitely True
 0-----1-----2-----3

5. When I feel lonely, there are several people I can talk to.

Definitely False Probably False Probably True Definitely True
 0-----1-----2-----3

6. There is no one that I feel comfortable to talking about intimate personal problems.

Definitely False Probably False Probably True Definitely True
 0-----1-----2-----3

7. I often meet or talk with family or friends.

Definitely False Probably False Probably True Definitely True
 0-----1-----2-----3

8. Most people I know think highly of me.

Definitely False Probably False Probably True Definitely True
 0-----1-----2-----3

9. If I needed a ride to the airport very early in the morning, I would have a hard time finding someone to take me.

Definitely False Probably False Probably True Definitely True
 0-----1-----2-----3

10. I feel like I'm not always included by my circle of friends.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

11. There really is no one who can give me an objective view of how I'm handling my problems.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

12. There are several different people I enjoy spending time with.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

13. I think that my friends feel that I'm not very good at helping them solve their problems.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

14. If I were sick and needed someone (friend, family member, or acquaintance) to take me to the doctor, I would have trouble finding someone.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

15. If I wanted to go on a trip for a day (e.g., to the mountains, beach, or country), I would have a hard time finding someone to go with me.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

16. If I needed a place to stay for a week because of an emergency (for example, water or electricity out in my apartment or house), I could easily find someone who would put me up.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

17. I feel that there is no one I can share my most private worries and fears with.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

18. If I were sick, I could easily find someone to help me with my daily chores.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

19. There is someone I can turn to for advice about handling problems with my family.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

20. I am as good at doing things as most other people are.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

21. If I decide one afternoon that I would like to go to the cinema that evening, I could easily find someone to go with me.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

22. When I need suggestions on how to deal with a personal problem, I know someone I can turn to.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

23. If I needed an emergency loan of €100, there is someone (friend, relative, or acquaintance) I could get it from.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

24. In general, people do not have much confidence in me.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

25. Most people I know do not enjoy the same things that I do.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

26. There is someone I could turn to for advice about making career plans or changing my job.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

27. I don't often get invited to do things with others.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

28. Most of my friends are more successful at making changes in their lives than I am.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

29. If I had to go away on a trip/holiday for a few weeks, it would be difficult to find someone who would look after my house or apartment (the plants, pets, garden, etc.).

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

30. There really is no one I can trust to give me good financial advice.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

31. If I wanted to have lunch with someone, I could easily find someone to join me.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

32. I am more satisfied with my life than most people are with theirs.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

33. If I was stranded 10 miles from home, there is someone I could call who would come and get me.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

34. No one I know would throw a birthday party for me.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

35. It would be difficult to find someone who would lend me their car for a few hours.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

36. If a family crisis arose, it would be difficult to find someone who could give me good advice about how to handle it.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

37. I am closer to my friends than most other people are to theirs.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

38. There is at least one person I know whose advice I really trust.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

39. If I needed some help in moving to a new house or apartment, I would have a hard time finding someone to help me.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

40. I have a hard time keeping pace with my friends.

Definitely False Probably False Probably True Definitely True
0-----1-----2-----3

Appendix 18: SV sample participant information sheet



NUI MAYNOOTH

Ollscoil na hÉireann Má Nuad

“What does it feel like to be you...after someone has violated you sexually without your consent?”

Participant Information Sheet

We would like to invite you to take part in an important research study which explores women’s health and well-being and their experiences of sexual violence. Before you decide whether or not you would like to take part, it is important for you to understand why the research is being done and what it will involve. Please take a few minutes to read carefully through the following information and discuss it with others if you wish. Also, please ask us if there is anything that is not clear, or if you would like more information.

What is the purpose of this study?

The purpose of this research project is to try to gain an insight into the genuine impact of sexual violence on the lives of Irish women. It is hoped that the findings from this study will be used to raise an awareness of the important issue of sexual violence in Ireland today and perhaps to inform the development of appropriate support services.

Why have I been asked to take part?

You have been asked to take part in this research because you have been identified as someone who has experienced sexual violence.

Who is funding the research?

This research is funded by the Irish Research Council for the Humanities and Social Sciences (IRCHSS).

Who has approved this study?

This research has been approved by the ethics committee of the National University of Ireland, Maynooth, Co. Kildare.

Do I have to take part?

No, you are under no obligation to take part in the research. However, we hope that you will agree to take part and give us some of your time to discuss your health and well-being and life experiences. It is entirely up to you to decide whether or not you would like to take part. If you decide to do so, you will be given this Information Sheet to keep and you will also be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time (and withdraw your information) without giving a reason. You may not answer any questions with which you are

uncomfortable. Please note, also, that the interview does not constitute any kind of counselling or intervention.

What happens if I decide to take part?

First, you will be asked to sign a consent form. This consent form will be kept separate from any other information you provide at all times so it will be impossible to identify *your* responses specifically. You will then be asked to complete a number of simple and mostly brief questionnaires. The first few questionnaires include questions about your health, relationships, self-esteem etc. In the final questionnaire, you will be asked some details about your experience of sexual violence and the services you received. **Please note:** Some of the questions included in this study will be sexually explicit and include questions on topics such as violence, alcohol and drug use and sexual function. As previously mentioned, you do *not* have to answer any questions with which you are uncomfortable. After completing this final questionnaire, you will also be asked if you would be interested in taking part in a follow-up interview with the researcher at a later date. Your participation in today's study **does not** put you under any obligation to take part in the follow-up interview and you will not be contacted unless you have stated that you wish to take part. Caroline, the researcher, will be on hand throughout to answer any questions you may have. Should you find the interview in any way distressing, please tell the researcher at once. Please contact any counsellor at your local RCC if you feel the need to do so as a result of taking part in this research. *(The researcher can provide you with these contact details if you so wish)*

What about if I feel upset or distressed during or after taking part?

As already mentioned you do not have to answer any question you feel uncomfortable answering and you are perfectly entitled to withdraw from the study at any point without having to give a reason. That includes requesting that your data be removed from the study even after you have taken part. If at any point while completing the questionnaires, or if while taking part in the follow-up interview, you find yourself becoming distressed, it is important that you inform the researcher immediately. We understand that talking about your experience might be difficult and it is perfectly normal to feel this way. If you find, in the days and weeks after taking part that you are upset or distressed as a result and feel you need support *please* contact your nearest Rape Crisis Centre who can provide free and confidential counselling (a list of nationwide centres is available on www.rcni.ie). Alternatively the Dublin Rape Crisis Centre offers a confidential, 24-hour telephone helpline, 7 days a week staffed by trained counsellors who are available to listen to you and any concerns you may have in regard to issues of rape, sexual assault, sexual harassment or childhood sexual abuse – **1800 788 888**.

How long will the whole process take?

The completion of all questionnaires should take no longer than one hour, although this can vary from person to person.

Will my taking part in this research be kept confidential?

Yes, all information that is collected about you during the course of the research will be kept **strictly confidential**. The researcher will assign a unique number to the questionnaires you complete making it impossible to identify you. All of the questionnaires gathered will be stored in locked filing cabinets, when not in use, and upon publication of the research they will be destroyed. Any tapes from the follow-up interview will be transcribed and also then destroyed when the research is completed. Similar to the questionnaires, the interview tapes from each of the interviews will be stored in a secure location on campus at all times and will be identified using a code or number to ensure your anonymity. All information will be held under lock and key and will be accessed only by the Researcher and will not be distributed to any other unauthorised individual.

What will happen to the results of the research?

The research will be written up in report format and will hopefully be published in journals and presented at conferences. A copy of the research will be available in approximately two to three years' time.

Who do I contact if I have a question?

Please feel free to address any questions to Caroline Kelleher (the researcher) or Dr. Sinéad McGilloway (the Research Supervisor) who is also available on the telephone to discuss the study with you. Tel: (01) 708 4765/6052

Alternatively, you may write to:

Ms Caroline Kelleher or Dr Sinéad McGilloway, Department of Psychology, John Hume Building, NUI Maynooth, Maynooth, Co. Kildare, Ireland.

THANK YOU FOR TAKING THE TIME TO READ THIS.

Appendix 19: SV sample participant consent form



No. _____
**For Office Use
only**

NUI MAYNOOTH

Ollscoil na hÉireann Má Nuad

Participant Consent Form

Title of Project: "What does it feel like to be you...after someone has violated you sexually without your consent?"

Name of Researcher: Caroline Kelleher

Please initial each box

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw from the research at any time (and withdraw my data), without giving any reason and in the knowledge that my legal rights and my access to, or use of services will not be affected.
3. I understand that all information will be treated in the **strictest confidence** and my anonymity is guaranteed. All information will be held and kept in a locked cabinet at work which will be accessed solely by the researcher and will not be distributed to any other unauthorised individual. This data may be accessed by me at my discretion and at any time.
4. I agree to take part in the above study.

Name of participant

**Signature
Date:**

Caroline Kelleher

Name of researcher

**Signature
Date:**

If during your participation in this study you feel that the information and guidelines that you were given have been neglected or disregarded in any way, or if you are unhappy about the process please contact the Secretary of the National University of Ireland Maynooth Ethics Committee at pgdean@nuim.ie of 01 708 6018. Please be assured that your concerns will be dealt with in a sensitive manner.

Appendix 20: SV sample follow-up interview card

FOLLOW UP INTERVIEW

Over the next few months, I will be conducting follow-up interviews to explore further some of the issues relating to women's experience of sexual violence. I am interested in hearing about your experience and how it has impacted on your life. Please understand that consenting to be contacted in the future does not put you under any obligation to participate – you are perfectly entitled to change your mind. If you do not consent today, feel free to keep my details (discreet cards available on request) close to hand and to contact me at any point in the future if you change your mind.

Are you willing to be contacted again for the follow-up study?

Yes No (Tick as appropriate)

If you have ticked **Yes**, please complete the following section.

CONTACT DETAILS

I understand that some people may feel uneasy about giving me their name and address. Please remember, you do not have to give your full details – as little or as much as your comfortable with – or simply just enough for me to be able to contact you (for example your first name and telephone number or email address)

NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

EMAIL ADDRESS: _____

Thank you very much for taking part in this survey. Your responses will provide extremely valuable information on women's experiences of sexual violence in Ireland. I am very grateful for the time and effort you have given to completing all of these questionnaires and the courage you have shown in sharing your life and story with me. Thank you.

Appendix 21: SV sample postal protocol

INSTRUCTIONS

***Please read carefully
Thank you.***

INSTRUCTION SHEET FOR RESEARCH ON THE IMPACT OF SEXUAL VIOLENCE

Dear Participant,

Thank you very much for agreeing to participate in this important research. All of the information that you provide during this process will be treated in the **strictest confidence**. Your **anonymity is guaranteed** so please be honest when responding. In order to be able to rely on the results of this research, it is important that you follow the instructions carefully.

Thank you very much.
Caroline Kelleher (Researcher)

Checklist of documents enclosed

Below is a checklist of all documents, including all of the questionnaires that are included in this pack. Most of these are fairly brief and you may not have to complete all sections of the questionnaires. Please go through this list carefully and place a tick in each box to indicate that this document has been read and/or completed by you. If you are missing any of the documents (or any pages) listed below, or have any questions, please contact the researcher by phone on 087 638 5729 or by email at carolinekelleher@nuim.ie as soon as possible.

1. Participant Information Sheet (2 pages of white paper)
2. *The World Health Organisation Quality of Life Questionnaire (3 pages of pink paper)
3. *General Health Questionnaire (2 pages of blue paper)
4. *Life Experiences Survey (LES) (3 pages of green paper)
5. ISEL (3 pages of yellow paper)
6. TSI Questionnaire (2 pages of lilac paper)
7. TSI Answer Sheet (single sheet with green print)
8. Background, Experiences and Services Questionnaire (7 pages of cream paper)
9. Follow-up Interview Form (single blue card)
10. One stamped addressed envelope

* Stapled together

General Instructions

Please read these instructions carefully and proceed as indicated.

- Read each document, and complete each of the questionnaires in the exact order they are presented in this pack.
- Please set aside an adequate length of time (approx 40-60 mins.) in a comfortable location where you are unlikely to be interrupted
- If necessary, take a break during the filling out of these questionnaires, but where possible, complete the questionnaire you are currently working on
- It is important to record an answer for every question (i.e. all those applicable to you), so please take some time to check that you have not missed a question before moving onto the next questionnaire. **(N.B.** Please check the back and front of each page to ensure that you have answered all questions).
- If at any time you feel upset or distressed during the process of completing the questionnaires, or in the days and weeks that follow, *please* contact your local Rape Crisis Centre for support or ring the national Rape Crisis help-line which is confidential and open 24 hours a day on **1800 778 888**.

Step by step guidelines

1. Please read the Participant Information Sheet. If you have any questions before proceeding, please contact the researcher.
2. Read the instructions for the *World Health Organisation Quality of Life Questionnaire* and fill it out.
3. Read the instructions for the *General Health Questionnaire* and fill it out.
4. Read the instructions for the *Life Experiences Survey* and fill it out. Read carefully through the list of events on each page and indicate if any of these events have happened to you in the last 6 months by placing a tick under the *0-6 months* column opposite the event. For each event that you tick, please indicate using the scale provided whether this event had a positive or negative impact on your life at the time that it happened.
5. Read the instructions for the *ISEL* and fill it out.
6. Read the instructions for the *TSI* and record your responses for each of the statement on the answer sheet provided. Please **DO NOT WRITE** on the questionnaire. Remember, these statements refer to your experiences over the last 6 months.

7. Please complete the *Background, Experiences and Services Questionnaire*. Please read the instructions for each section carefully and ensure that you record an answer for all questions that are applicable to you. If you are unsure how to respond, please either contact the researcher, or indicate this on the questionnaire.
 8. Well done - you are now finished all of the questionnaires!
 9. If you are interested in participating in a more in-depth interview with the researcher at a later stage in this project, please read the Follow-Up Interview Form (blue card) and fill in your details. This information will be kept separately from the questionnaires. Participants will be selected randomly. Please note that consenting to be contacted in the future does not put you under any obligation to participate.
-

RETURNING COMPLETED QUESTIONNAIRES

Please return the completed questionnaires as soon as you can, but within the next two weeks at the very latest.

- The Participant Information Sheet is yours to keep.
- Please place the following in the stamped addressed envelope and return to the researcher:
 - ALL of the completed questionnaires
 - The Follow-Up Interview card (only if you are agreeable to speak to the researcher at a later date).

The researcher will arrange to contact you at a convenient time shortly after you have completed the questionnaires, but please do not hesitate to contact her with any questions or queries you may have at any stage during this process.

Thank you again for participating in this study. Your time and honesty are sincerely appreciated. Now, please begin the first questionnaire.

Caroline Kelleher (Researcher)

Appendix 22: Table showing details on the control variables used to frequency-distribution match the SV sample and the COM group

Table A22: Frequency distribution matched details (frequencies and percentages reported) for SV sample (n = 65) and COM group (n = 57) on three control variables: Age, marital status and education

Variable	SV sample n (%)	COM group n (%)
Age		
<i>Mean /Std dev. (years)</i>	36.69/9.28	35.39/14.03
<i>Range (years)</i>	19-57	20-62
<i>Under 40 years of age</i>	42 (66)	38 (68)
<i>Over 40 years of age</i>	22 (34)	18 (32)
Current marital status		
<i>Single</i>	25 (39)	12 (21)
<i>Steady relationship</i>	10 (15)	16 (28)
<i>Living w/partner</i>	10 (15)	8 (14)
<i>Married</i>	8 (12)	20 (35)
<i>Separated/Divorced</i>	9 (13)	1 (2)
<i>Other</i>	3 (6)	0 (0)
Education level		
<i>Junior Certificate</i>	1 (2)	5 (9)
<i>Leaving Certificate</i>	8 (12)	13 (23)
<i>Post Leaving Cert/RTC</i>	11 (17)	1 (2)
<i>University degree</i>	17 (26)	18 (32)
<i>Post-graduate qualification</i>	22 (34)	17 (30)
<i>Other</i>	6 (9)	2 (4)

Note. SV = Sexual violence; RTC = Regional technical college.

Appendix 23: COM group information sheet, Health and background questionnaire, consent form and postal protocol



NUI MAYNOOTH

Ollscoil na hÉireann Má Nuad

Participant Information Sheet

We would like to invite you to take part in an important research study that explores women's health and well-being. Before you decide whether or not you would like to take part, it is important for you to understand why the research is being done and what it will involve. Please take a few minutes to read carefully through the following information and discuss it with others if you wish. Also, please ask us if there is anything that is not clear, or if you would like more information.

What is the purpose of this study?

The purpose of this research project is to try to gain an insight into lives of Irish women. It is part of a much larger study that is looking at the impact of sexual violence on the lives of Irish women. It is hoped that the findings from this study will be used to raise an awareness of the important issue of sexual violence in Ireland today and perhaps to inform the development of appropriate support services. In order to make reliable comparisons between our results and women in the general population, it is important that we include a group of women who have *never had an experience of sexual violence* in either childhood or adulthood. Unfortunately if you have ever had an experience of sexual violence you are *not* eligible to participate in this current study. However, you may be interested in taking part in another part of the study. Please let the researcher know if you would like some more information about this.

Who is funding the research?

This research is funded by the Irish Research Council for the Humanities and Social Sciences (IRCHSS).

Who has approved this study?

This research has been approved by the ethics committee of the National University of Ireland, Maynooth, Co. Kildare.

Do I have to take part?

No, you are under no obligation to take part in the research. However, we hope that you will agree to take part and give us some of your time. If you decide to do participate, you will be given this Information Sheet to keep and you will also be asked to sign a consent form. Even if you decide to take part, you are still free to withdraw at any time (and withdraw your information) without giving a reason. You do not have to answer any questions with which you are uncomfortable.

What happens if I decide to take part?

First, you will be asked to sign a consent form. This consent form will be kept separate from any other information you provide at all times so it will be

impossible to identify *your* responses specifically. You will then be asked to complete a number of simple and mostly brief questionnaires.

For the purposes of this research it is important that we know that you *have not* ever had an experience of sexual violence either in your childhood or in adulthood. That is why we have put questions relating to this into the first questionnaire we ask you to complete. It also includes questions about various areas of your life including drug and alcohol use, usage of women's medical services and some background information. The second questionnaire asks about the occurrence of a range of different life events over the last 6 months. The third questionnaire you will be asked to fill out includes questions about your physical health, your quality of life etc. and the following one briefly asks about your general health over the last few weeks. The final one asks questions about your relationships, self-esteem, and interpersonal support. Please remember, you do not have to answer any questions with which you are uncomfortable. Feel free to ask the researcher any questions you may have about this process, at any stage.

How long will the whole process take?

The completion of all questionnaires should take no longer than 30 minutes, although this can vary from person to person.

Will my taking part in this research be kept confidential?

Yes, all information that is collected about you during the course of the research will be kept **strictly confidential**. The researcher will assign a unique number to the questionnaires you complete making it impossible to identify you. All of the questionnaires gathered will be stored in locked filing cabinets, when not in use, and upon publication of the research they will be destroyed. All information will be held under lock and key and will be accessed only by the Researcher and will not be distributed to any other unauthorised individual.

What will happen to the results of the research?

The research will be written up in report format and will hopefully be published in journals and presented at conferences. A copy of the research will be available in approximately two years' time.

Who do I contact if I have a question?

Please feel free to address any questions to Caroline Kelleher (the researcher) or Dr. Sinéad McGilloway (the Research Supervisor) who is also available on the telephone to discuss the study with you. Tel: (01) 708 4765

Alternatively, you may write to:

***Ms Caroline Kelleher or Dr Sinéad McGilloway, Department of Psychology,
John Hume Building, NUI Maynooth, Maynooth, Co. Kildare, Ireland.***

THANK YOU FOR TAKING THE TIME TO READ THIS.

Health and Background Questionnaire

*Before taking part in this study it is important that we ask you if you have ever experienced sexual violence (e.g. rape, sexual assault or sexual abuse) either as an adult or as a child. For the purposes of this study we need women who have **never** had an experience of sexual violence so please answer the first two questions for our records. All information will remain anonymous and your confidentiality is guaranteed so please be honest in your responses.*

A1. Have you ever in your lifetime (either as a child or as an adult) experienced any form of sexual violence (e.g. rape/sexual assault)? *(Please tick the appropriate box)*

Yes No

A2. Have you ever in your lifetime (either as a child or as an adult) experienced any form of sexual abuse? *(Please tick the appropriate box)*

Yes No

Please note: *If you have ticked 'Yes' to either of the questions above please do not complete any further sections. If you would like to take part in another part of the study examining the impact of sexual violence in the lives of Irish women please contact the researcher on 087 638 5729 for more information. You can also visit <http://psychology.nuim.ie/CarolineKelleher.shtml>*

Section B: Physical and mental health

The following section asks you a number of questions about different areas of your life and health. They include questions about your use of women's medical services and your mental health.

B1. Please indicate below if you have attended or availed of any of the following medical/health services in the last 12 months?

Note: You may have accessed some of these through your GP, a Family Planning Clinic or a Casualty Department or Out-Patient Department of a hospital. Please record a response for all.

(Please circle either 'Yes' or 'No' after each of the medical services listed below)

1 Emergency Contraception	Yes	No
2 Cervical Screening/Smear Clinic	Yes	No
4 Sexually Transmitted Infections/Genito-urinary Clinic	Yes	No
5 Other <i>(Please specify)</i> _____		

B2. Do you routinely (at least once a year or in the case of a smear every 3-5 years) avail of the following medical services? *(Please circle either 'Yes' or 'No' after each of the medical services listed)*

- | | | |
|---|-----|----|
| 1 Cervical screening/Smear clinic | Yes | No |
| 2 Sexually Transmitted Infections/Genito-urinary Clinic | Yes | No |

B3. Have you ever attended any of the following clinics either publicly or privately? *(Please circle either 'Yes' or 'No' after each of the medical services listed below)*

- | | | |
|---------------------------------------|-----|----|
| 1 Early Pregnancy Unit | Yes | No |
| 2 Colposcopy Clinic | Yes | No |
| 3 Fertility Clinic | Yes | No |
| 4 Psycho-sexual counselling | Yes | No |
| 5 Other <i>(please specify)</i> _____ | | |

B4. Have you ever been formally diagnosed (i.e. by a medical or mental health professional) with a mental health problem (e.g. depression, anxiety etc.)?

- Yes No

If you have answered 'No' to this question, please proceed to question C1.

B4.1. If 'Yes', please indicate below the name of the diagnosis you received

B4.2. Approximately how long ago did you receive this diagnosis?

B4.3. Please detail briefly any treatment(s) (e.g. medication, therapy etc.) you have received for this and the duration of each. If 'None,' please state this below.

<u>Type of treatment</u>	<u>Duration</u>
1. _____	_____
2. _____	_____
3. _____	_____

Section C and D: Alcohol and drug use

The following brief questions look at alcohol and drug use. Some of these may not be applicable to you, but please read them carefully just in case.

C1. Do you drink alcohol? *(Please tick the appropriate box)*

Yes No

If you have answered 'No' to this question, please proceed to question D1.

C1.1 If 'Yes', typically how often? *(Please circle the applicable response)*

- 1 Daily
- 2 Every few days
- 3 Weekly
- 4 Fortnightly
- 5 Monthly
- 6 Only on special occasions
- 7 Other (please specify) _____

C1.2 If 'Yes', how many drinks would you usually have in one sitting *(on average)*?

Please indicate by ticking either 'Yes' or 'No' to the following questions. Your confidentiality and anonymity are guaranteed so please be honest in your responses.

C1.3 During the last year have you had a feeling of guilt or remorse after drinking?

Yes No

C1.4 During the last year has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?

Yes No

C1.5 During the last year have you failed to do what was normally expected from you because of drinking?

Yes No

C1.6 Do you sometimes take a drink when you first get up in the morning?

Yes No

D1. Do you use, or have you ever used, non-prescription drugs?
(Please tick the appropriate box)

Yes, in the past Yes, currently No

If you have answered 'Yes in the past' or 'No' to this question, please proceed to question E1.

D1.1 If you answered 'Yes currently', how often? (Please circle the applicable response)

- 1 Daily
- 2 Every few days
- 3 Weekly
- 4 Fortnightly
- 5 Monthly
- 6 Other (please specify) _____

D1.2 If 'Yes', which drugs would you normally use?

Please indicate by ticking either 'Yes' or 'No' to the following questions. Your confidentiality and anonymity are guaranteed so please be honest in your responses.

D1.3 During the last year have you had a feeling of guilt or remorse after drug use?

Yes No

D1.4 During the last year has a friend or family member ever told you about things you said or did while you were using drugs that you could not remember?

Yes No

D1.5 During the last year have you failed to do what was normally expected from you because of drug use?

Yes No

D1.6 Do you sometimes use drugs when you first get up in the morning?

Yes No

SECTION E: ABOUT YOU

The following information is only necessary in order to provide us with a profile of the kind of people that have taken part in the study. This information will not be reported individually, but on a group basis and your anonymity is guaranteed.

E1. What age are you? _____

E2. What is your country of origin? _____

E3: Do you have any children?

Yes No

E3 (a): If yes, how many children do you have _____

E4. Which of the following best describes your current marital status?
(Please circle the number of the appropriate response)

- 1 Single
- 2 Steady relationship
- 3 Living with a partner
- 4 Married
- 5 Separated/Divorced
- 6 Widowed
- 7 Other (please specify) _____

E5. What is your current occupation?(optional)

E6. What is the **highest** level of education that you have successfully completed (e.g. Junior Cert., Leaving Cert., Bachelor's Degree, etc.)? (Please circle the appropriate response)

- 1 Junior Certificate
- 2 Leaving Certificate
- 3 Trade Training
- 4 Post Leaving Certificate (PLC)/ Regional Technical College (RTC)
- 5 University Qualification (Degree)
- 6 Post Graduate Qualification
- 7 Other (please specify) _____

Thank you for agreeing to participate in this research. We are very grateful for the time and effort you have given to completing these questionnaires.



NUI MAYNOOTH

Ollscoil na hÉireann Má Nuad

Participant Consent Form

Women's health and well-being

Name of Researcher: Caroline Kelleher

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw from the research at any time (and withdraw my data), without giving any reason and in the knowledge that my legal rights will not be affected.
3. I understand that all information will be treated in the **strictest confidence** and my anonymity is guaranteed. All information will be held and kept in a locked cabinet at work that will be accessed solely by the researcher and will not be distributed to any other unauthorised individual. This data may be accessed by me at my discretion and at any time.
4. I agree to take part in the above study.

Name of participant

Signature
Date:

Caroline Kelleher

Name of researcher

Signature
Date:

If during your participation in this study you feel that the information and guidelines that you were given have been neglected or disregarded in any way, or if you are unhappy about the process please contact the Secretary of the National University of Ireland Maynooth Ethics Committee at pgdean@nuim.ie of 01 708 6018. Please be assured that your concerns will be dealt with in a sensitive manner.

INSTRUCTIONS

***Please read carefully
Thank you.***

INSTRUCTION SHEET FOR RESEARCH STUDY ON WOMEN'S HEALTH & WELL-BEING

Dear Participant,

Thank you very much for agreeing to participate in this important research. All of the information that you provide during this process will be treated in the **strictest confidence**. Your **anonymity is guaranteed** so please be honest when responding. In order to be able to rely on the results of this research, it is important that you follow the instructions carefully.

Many thanks. Caroline Kelleher (Researcher)

Checklist of documents enclosed

Below is a checklist of all documents, including all of the questionnaires that are included in this pack. Most of these are fairly brief and you may not have to complete all sections of the questionnaires. Please go through this list carefully and place a tick in each box to indicate that this document has been read and/or completed by you. If you are missing any of the documents (or any pages) listed below, or have any questions, please contact the researcher by phone on 087 638 5729 or by email at carolinekelleher@nuim.ie as soon as possible.

1. Participant Information Sheet (1 page of white paper)
2. Health and Background Questionnaire
(3 pages of cream paper)
3. Life Experiences Survey (LES) (3 pages of green paper)
4. The World Health Organisation Quality of Life Questionnaire
(3 pages of pink paper)
5. General Health Questionnaire (GHQ) (2 pages of blue paper)
6. Interpersonal Support List (4 pages of yellow paper)
7. One stamped addressed envelope

General Instructions

Please read these instructions carefully and proceed as indicated.

- Read each document, and complete each of the questionnaires in the exact order they are presented in this pack.
- Please set aside an adequate length of time (approx 20-30 mins.) in a comfortable location where you are unlikely to be interrupted

Please turn over →

- It is important to record an answer for every question (i.e. all those applicable to you), so please take some time to check that you have not missed a question before moving onto the next questionnaire.
(**N.B.** Please check the back and front of each page to ensure that you have answered all questions).

Step by step guidelines

1. Please read the Participant Information Sheet. If you have any questions before proceeding, please contact the researcher.
2. Read the instructions for the *Health and Background Questionnaire* (cream paper) and fill it out.
3. Read the instructions for the *Life Experiences Survey* (green paper) and fill it out. Read carefully through the list of events on each page and indicate if any of these events have happened to you in the last 6 months by placing a tick under the *0-6 months* column opposite the event. For each event that you tick, please indicate using the scale provided whether this event had a positive or negative impact on your life at the time that it happened.
4. Read the instructions for the *World Health Organisation Quality of Life Questionnaire* (pink paper) and fill it out.
5. Read the instructions for the *General Health Questionnaire* (blue paper) and fill it out.
6. Read the instructions for the *ISEL* (yellow paper) and fill it out.
7. Well done – you have now completed all of the questionnaires!

RETURNING COMPLETED QUESTIONNAIRES

Please return the completed questionnaires as soon as you can, but within the next two weeks at the very latest.

- The Participant Information Sheet is yours to keep.
- Please place the following in the stamped addressed envelope and return to the researcher:
 - ALL of the completed questionnaires

Thank you again for participating in this study. Your time and honesty are sincerely appreciated. Now, please begin the first questionnaire.

Appendix 24: Results of one sample t-tests between the SV sample and (i) the general population norm group and (ii) the trauma history norm group on the TSI.

Table A24: Results from a series of one-sample t-tests on the trauma symptom measure between the SV sample and the general population norm group.

TSI Clinical Scale	SVS sample	*General population	t(df)	Sig. (η^2) (2-tailed)
	M (SD)	M (SD)		
<i>Dysphoric Mood</i>				
AA	12.70 (5.86)	7.68 (5.22)	6.70 (60)	.000 (.4)**
D	12.77 (6.13)	7.10 (6.13)	7.02 (60)	.000 (.5)**
AI	13.25 (6.27)	8.31 (6.24)	6.45 (60)	.000 (.4)**
<i>Post-traumatic Stress</i>				
IE	12.98 (6.67)	6.03 (5.55)	8.15 (60)	.000 (.5)**
DA	13.51 (6.48)	7.15 (6.15)	7.67 (60)	.000 (.5)**
DIS	10.64 (5.87)	5.46 (5.00)	6.89 (60)	.000 (.5)**
<i>Sexual Difficulties</i>				
SC	9.39 (6.65)	4.06 (5.27)	6.26 (60)	.000 (.4)**
DSB	5.57 (6.85)	2.29 (3.94)	3.74 (60)	.000 (.2)**
<i>Self Dysfunction</i>				
ISR	12.63 (6.36)	6.46 (5.94)	6.85 (60)	.000 (.4)**
TRB	5.75 (4.23)	2.66 (3.35)	5.71 (60)	.000 (.4)**

Note. SV = Sexual violence; TSI = Trauma Symptom Inventory.

* Normative sample scores are taken from studies conducted by Elliott (1993) and Elliott & Brière (1994) (n = 291, adult females, aged 18 – 54 years).

** p < .0005, 2-tailed

Table A24: Results from a series of one-sample t-tests on the trauma symptom measure between the SV sample and the trauma history norm group.

TSI Clinical Scale	SVS sample	*Trauma history sample	t(df)	Sig. (η^2) (2-tailed)
	M (SD)	M (SD)		
<i>Dysphoric Mood</i>				
<i>AA</i>	12.70 (5.86)	14.56 (5.35)	-2.47 (60)	.016 (.1)*
<i>D</i>	12.77 (6.13)	15.36 (6.20)	-3.23 (60)	.002 (.2)**
<i>AI</i>	13.25 (6.27)	15.06 (6.22)	-2.26 (60)	.028 (.1)*
<i>Post-traumatic Stress</i>				
<i>IE</i>	12.98 (6.67)	12.57 (6.38)	0.49 (60)	.630
<i>DA</i>	13.51 (6.48)	13.73 (5.98)	-0.27 (60)	.790
<i>DIS</i>	10.64 (5.87)	13.58 (6.42)	-3.91 (60)	.000 (.2)**
<i>Sexual Difficulties</i>				
<i>SC</i>	9.39 (6.65)	10.57 (2.68)	-1.38 (60)	.172
<i>DSB</i>	5.57 (6.85)	4.64 (5.88)	1.07 (60)	.291
<i>Self Dysfunction</i>				
<i>ISR</i>	12.63 (6.36)	15.07 (6.21)	-3.73 (60)	.000 (.2)**
<i>TRB</i>	5.75 (4.23)	6.50 (4.64)	-1.38 (60)	.174

Note. SV = Sexual violence; TSI = Trauma Symptom Inventory.

1. Trauma history sample (Brière et al., 1995) (n = 261, female psychiatric inpatients and outpatients).

*p<.05; ** p<.005, two-tailed.

Appendix 25: Tables showing the means and standard deviations obtained for the SV sample and the COM group on the LES-M, WHOQOL-BREF, ISEL and GHQ-12. (Appropriate population norms are also presented).

Table A25a: Mean scores and standard deviations obtained from the SV sample (N = 62) and the COM group (N = 57) compared with accepted population norms for the LES-M.

LES-M Score	SV Sample (N = 62) M (SD)	COM group (N = 57) M (SD)	*Norm (N = 171 females) M (SD)
<i>Negative change</i>	7.32 (7.06)	2.54 (2.76)	5.64 (6.43)
<i>Positive change</i>	3.31 (3.61)	2.72 (3.29)	6.71 (5.51)
<i>Total change</i>	10.63 (8.30)	5.26 (4.63)	12.35 (8.82)

* Sarason et al. (1978)

Table A25b: Table presenting the means and standard deviations for the SV sample (N = 65) and the COM group (N = 56) across the four domains of the WHOQOL-BREF (range 4-20). Population norms from a comparable sample are also presented for context.

WHOQOL-BREF Domain	SV sample M (SD)	COM group M (SD)	*Norm M (SD)
<i>Physical</i>	11.95 (1.94)	13.33 (1.64)	14.2 (3.1)
<i>Psychological</i>	12.08 (2.49)	13.93 (1.99)	14.0 (2.8)
<i>Social</i>	11.30 (4.06)	15.27 (3.68)	14.4 (3.1)
<i>Environment</i>	13.58 (2.68)	15.71 (2.50)	13.9 (2.6)

* Population norms taken from Skevington, Lofty, & O'Connell (2004) (N = 6270, adult females).

Table A25c: Table presenting the means and standard deviations for the SV sample (N = 64) and the COM group (N = 55) for the four subscales of the ISEL as well as the Total ISEL figure. Norms from a comparable sample are also presented for comparison.

Subscale of the ISEL	SV sample M (SD)	COM group M (SD)	*Norm M (SD)
<i>Appraisal</i>	20.02 (7.23)	25.49 (4.53)	26.7 (6.0)
<i>Tangible</i>	21.30 (6.70)	26.38 (3.86)	24.6 (5.2)
<i>Self-esteem</i>	18.92 (5.02)	21.13 (4.07)	19.4 (3.8)
<i>Belonging</i>	18.77 (6.46)	24.55 (3.75)	24.2 (5.4)
<i>Total ISEL</i>	79.00 (21.19)	97.55 (13.32)	N/A

* Comparative norms taken from Turner-Cobb, Sephton, Koopman, Blake-Mortimer & Spiegel (2000) (N = 103, adult females, Mean age (SD) 53.2 (10.5) years).

Table A25d: Table illustrating the means and standard deviations for the SV sample (N = 65) and the COM group (N = 57) on the GHQ-12 in addition to the frequency and percentage achieving 'caseness' from each group.

GHQ-12	SV sample M (SD)	COM group M (SD)
<i>Total GHQ score</i>	4.89 (3.85)	1.89 (2.89)
<i>Threshold score</i>	4	2
<i>Percentage (N) of sample scoring threshold score and above</i>	57% (37)	33% (19)

Appendix 26: Table showing the results from a paired samples t-test between the SV sample and the COM group on their mean scores on the individual items of the GHQ-12.

Table A26: Results from a paired samples t-test between the SV sample and the COM group on their mean scores on the individual items of the GHQ-12.

GHQ-12 items	SV sample M (SD)	COM group M (SD)	t (df)	p value (η)
<i>Item 2: Lost sleep</i>	0.51 (0.50)	0.14 (0.35)	4.32 (56)	.000* (.3)
<i>Item3: Useful part in things</i>	0.33 (0.48)	0.09 (0.29)	3.22 (56)	.002* (.2)
<i>Item 4: Capable of making decisions</i>	0.35 (0.48)	0.11 (0.31)	3.06 (56)	.003* (.2)
<i>Item 6: Couldn't overcome difficulties</i>	0.37 (0.49)	0.12 (0.33)	3.22 (56)	.002* (.2)
<i>Item 11: Worthless person</i>	0.33 (0.48)	0.09 (0.29)	3.22 (56)	.002* (.2)

Note. Non-significant results are not reported. SVS = Sexual violence sample; CG = Comparison group; GHQ-12 = General Health Questionnaire (12item). Bonferroni adjusted alpha level: * $p < .004$, 2-tailed.

Appendix 27: Table showing the new categorical variables created by collapsing the background variables for chi-square tests for independence.

Table A27: Table showing the new categorical variables created by collapsing the background variables for the chi-square tests for independence.

Original variable	Collapsed variable (n)
1. Age at time of incident	Group 1: Younger (≤ 22 years) (38) Group 2: Older (≤ 276 months/23 years) (26)
2. Time since the incident (months)	Group 1: Short time (≤ 84 months) (23) Group 2: Medium time (85-204 months) (23) Group 3: Long time (≥ 205 months) (19)
3. Relationship to perpetrator	Group 1: Less known* (36) Group 2: Well known* (29)
4. History of mental illness	Group 1: No diagnosis (30) Group 2: Diagnosed with a MH problem (35)
5. Problem drinking	Group 1: No problem drinking (NPD) (32) Group 2: Problem drinking (PD) (33)
6. Current age (years)	Group 1: Younger (≤ 36 years) (33) Group 2: Older (≥ 37 years) (32)
7. Current marital status	Group 1: Not in a relationship (NIR)** (37) Group 2: In a relationship (IR)** (28)
8. Level of completed education	Group 1: Degree (D)*** (39) Group 2: No degree (ND)*** (26)

Note. MH = Mental health.

* Less known (perpetrator) = Stranger + Acquaintance + Friend + Workmate/Colleague + Other; Well known (perpetrator) = Someone you were/had been on a date with + Boyfriend + Spouse/partner + Ex-boyfriend + Ex-spouse/Ex-partner + Other.

** NIR = Single + Separated/Divorced + Other; IR = Steady relationship + Living with a partner + Married + Other.

*** D = University qualification (degree) + Postgraduate qualification; ND = Junior Certificate + Leaving Certificate + Post Leaving Cert. /RTC + Other.

Appendix 28: Table showing the eight combinations/groups for Stage Three participant selection.

Table A28: Table illustrating the dichotomous levels of the three control variables, and the eight groups generated as a result used in the selection of participants for the in-depth interviews in Stage Three.

Stage Three: Control variables and groups					
	*Marital Status		**Age		***Education
<i>Group 1</i>	IR	+	-40	+	ND
<i>Group 2</i>	IR	+	+40	+	ND
<i>Group 3</i>	IR	+	+40	+	D
<i>Group 4</i>	IR	+	-40	+	D
<i>Group 5</i>	NIR	+	+40	+	ND
<i>Group 6</i>	NIR	+	-40	+	ND
<i>Group 7</i>	NIR	+	-40	+	D
<i>Group 8</i>	NIR	+	+40	+	D

* Marital status: IR = In a relationship; NIR = Not in a relationship
 ** Age: -40 = Less than 40 years old; +40 = More than 40 years old
 *** Education: ND = No degree; D = Degree

Appendix 29: Stage Three Participant Interview Schedule (PINS)

Stage Three: Participant Interview Schedule

Experience of sexual violence

1. Can you tell me a little about what actually happened to you and when it took place?
2. Did you report this incident to the Gardai immediately or at any stage after? If not why not?
3. Did you attend a Sexual Assault Treatment Unit (SATU) or have a forensic medical examination done? If not why not?
4. If Yes to 3 or 4. How did you feel you were treated by the Gardai, medical personnel etc. that you encountered after the incident?

Impact of the experience of sexual violence

5. How did you feel immediately after the incident?
6. In the days and weeks after the incident, what kind of things did you do to cope with what had happened?
 - a. Did you speak to someone or several people,
 - b. try to forget it had happened by getting back to normal as quickly as possible,
 - c. or use drugs or alcohol more than you normally would?
 - d. or all three
7. Can you tell a little about how you feel this experience has impacted on:
 - a. your health both physical and mental?
 - b. your ability to work?
 - c. your daily functioning?
 - d. your relationships with people close to you (partner, immediate family, children, close friends)?
 - e. your ability to form new relationships/friendships?
 - f. sexual and/or physical intimacy?
8. For you, which has been the hardest aspect to deal with?

Experience of disclosure and services

9. The first person that you did tell – what was their reaction?
10. Outside of family and friends did you speak or attempt to speak to anybody else about what had happened and how you were feeling either in person or by phone? (e.g. RCC, Samaritans, G.P. local counselling service, priest, any other helpline)
11. Did you ever attend (or are you currently attending) professional counselling/RCC counselling as a result of what happened to you?
 - If yes, with whom and for how long?
 - If not, why not?
12. About the services or support you received either from personal or professional services – what helped you the most?
13. What services, not available to you at the time, do you feel would have helped you deal more effectively with what happened?
14. If this was to happen to another woman, what are the most important things you feel she needs to know about what has happened to her, how she is feeling and how she is going to cope?

Research feedback

1. What prompted you to take part in this research?
2. Would you do something like this again?
3. What would you like to happen with the findings of this research i.e. what should they be used for?

Appendix 30: Stage 3 participant results for impact of SV

Table A30: Employment status at the time of assault for both the interview sub-sample (n=14) and the larger SV group (n=51)

Variable	Stage 3 sub-sample n (%)	SV sample n (%)
<i>Attending secondary school</i>	1 (7)	10 (20)
<i>Attending college/post- Leaving Cert. training</i>	5 (36)	10 (20)
<i>Employed</i>	5 (36)	20 (39)
<i>Unemployed</i>	3 (21)	11 (21)

Note. SV = Sexual violence sample.

Table A30: The results for both the Stage Three sub-sample (n=14) and the SVS sample (n=51), on their subjective ratings of the impact of their experience of SV on their close relationships, and ability to form close friendships and intimate relationships.

Impact on relationships	Stage 3 sub-sample n (%)	SVS sample n (%)
<i>Impact on close relationships (e.g. parents, children, partner)</i>		
Not at all	2 (14)	1 (2)
A little	3 (21)	12 (24)
A fair amount	1 (7)	10 (20)
A lot	8 (58)	28 (55)
<i>Impact on ability to form close friendships</i>		
Not at all	5 (36)	9 (18)
A little	1 (7)	9 (18)
A fair amount	1 (7)	9 (18)
A lot	7 (50)	24 (47)
<i>Impact on ability to form intimate relationships</i>		
Not at all	1 (7)	2 (4)
A little	1 (7)	7 (14)
A fair amount	2 (14)	12 (24)
A lot	10 (72)	30 (59)

Note. SVS = Sexual violence sample; SV = Sexual violence.

Table A30: Showing the subjective ratings given by the women in this sub-sample (n=14) of the impact of SV on ten areas of their lives. They figures are presented in rank order from the area that received the most negative ratings to the area that received the least.

Area of life	Positive/No impact ratings (n)	Slightly negative (n)	Moderately negative (n)	Very negative (n)
<i>Sexual relationships</i>	0	3	2	9
<i>Mental health</i>	0	3	5	6
<i>Self-esteem/confidence</i>	1	1	5	7
<i>Physical health</i>	1	4	4	5
<i>Personal relationships</i>	2	2	4	6
<i>Social life</i>	4	3	4	3
<i>Everyday life</i>	4	4	3	3
<i>Education</i>	7	2	1	4
<i>Work life</i>	8	2	2	2
<i>Personal finances</i>	8	1	2	3

Note. SV = Sexual violence.

Appendix 31: Selection of participant quotes on common reactions to experience of SV

Text Box 31: Theme 1: Participants comments on their immediate reactions to SV

'...denial really...when it did come into my head...I couldn't bring myself to use the word rape cos I was afraid to and also I was afraid he'd go [the perpetrator was a current boyfriend] that didn't happen and then I'd feel even worse.' (A 36-year-old women raped by her boyfriend)

'I kind of went into denial...like I wouldn't even let myself think about it. Not that I pushed it out of my head cos it was there like...but every time it would even start to come into my head I'd be like [sharp intake of breath]...I'd jump and get on with something else...' (A 30-year-old woman raped by a stranger)

'I think I just blocked it out as it happened...I didn't know I had actually been raped...' (A 30-year-old woman raped by an acquaintance)

'Immediately when I thought about it the next morning...what did I do to lead him on. I still thought whatever I've done, whatever's happened here it must have been my fault...I must have done something wrong.' (A 40-year-old woman raped by a family friend)

'You always blame yourself...you always think what if I didn't do this...I must have looked the easiest...I must have looked like a slapper.' (A 42-year-old woman raped by a stranger)

'I think there's huge shame in it...and I think self-loathing is probably not too strong a description.' (A 47-year-old woman sexually assaulted by someone she was on a date with)

'The blame and shame was because of the fact that, yes, I had become pregnant rather than what had happened to me [i.e. the rape]...nobody wanted to know what had happened to me.' (A 53-year-old woman raped by her boyfriend)

'I entirely felt it was my fault...I fully believed it was my fault...I was just so ashamed and humiliated...I felt I got exactly what I deserved in a way.' (A 36-year-old woman raped by someone at a party she was attending)

Appendix 32: Selection of participant quotes on immediate reactions to their experience of SV

Text Box 32: Theme 1: Participants feelings and reactions at the time of, and immediately after the rape/sexual assault

'I was really embarrassed...I didn't want them [other people at the party] to know that he had raped me.' (A 32-year-old woman raped by someone she was on a date with)

'In my head I was like screaming like but nothing was coming out...I just was completely blank. I was frightened but I was also stunned into thinking this is this person that I respect and know.' (A 40-year-old woman raped by a family friend)

'I felt cheap...I was ashamed that it happened...very, very confused [and] I remember walking from the car and I remember that feeling very well...the lowness of that feeling...I still can't put words on how bad that was...it was just the bottom.' (A 53-year-old woman raped by someone she was on a date with)

'It's the terror that goes with it...the pure terror and the primitive survival things that kicks in...that you'll do anything to survive...it's only after you realise that you don't want to survive and you wish you hadn't survived...' (A 42-year-old woman raped by a stranger)

'I just couldn't get away from him...I could not get out...and I couldn't scream...when I opened my mouth nothing came out.' (A 47-year-old woman sexually assaulted by someone she was on a date with)

'I don't even know how long it went on...I actually really left my body at that stage...I just kind of completely switched off like...I don't think I could even feel what was happening anymore.' (A 30-year-old woman raped by a stranger)

Appendix 33: Selection of participant quotes on effects on mental health.

Text Box 33: Theme 2: Participants reported mental health consequences

'...I mean constantly crying... and the insomnia again came back... like I was going to bed at 10 and 11 o'clock at night and I was still awake at nine the next morning... absolutely horrific nightmares... like it got to the point then that even though I was exhausted and I wanted to sleep that I was afraid of sleeping because the nightmares were that disturbing... and I just got to the point where I just felt like I couldn't function...I couldn't cope.' (A 38-year-old woman raped by her boyfriend)

'I often remember I'd have panic attacks afterwards in supermarkets where I would just have to get home...I'd just abandon the trolley and just drive home and just sit there and cry...' (A 46-year-old woman raped by her ex-spouse)

'My mental health disintegrated dramatically last year...I mean it was terrible, just really horrible...all I could do was get up and bring my daughter to school and make her meals and the rest of the time I was in that bed...not even asleep just going how am I going to get through this day..' (A 36-year-old woman raped by her boyfriend)

'At times I couldn't even sit at the dinner table when it was dinnertime with the family...I just wanted to sit in the room on my own...I probably had post-natal depression [as a result of a rape-related pregnancy] but it wasn't acknowledged...' (A 53-year-old woman raped by her boyfriend)

'I think it was more like a depression...I literally just couldn't pull myself out of bed in the morning. I locked myself in the bedroom for probably like eight months [and] I didn't leave the house.' (A 30-year-old woman raped by a stranger)

'...the flashbacks really started then and the nightmares...and I really thought this is it like I am losing my mind...I am going crazy...cos I was hearing voices and I was seeing things...just like crazy stuff...' (A 30-year-old woman raped by a stranger)

'It's cost me every single thing. I came out a nutcase in the end...I lost the plot completely...I had to go back home...I just ended up right back at the bottom. I was hearing voices at the time that I didn't even tell anybody about...the voices told me not to tell anybody...' (A 30-year-old woman raped by an acquaintance)

'...One day again I cut myself...I'll never forget the release and the joy of going 'There it is...there it all is, you know...there's the rape, there's the bulimia!' (A 36-year-old woman raped by someone at a party she was attending)

'I think the struggle to hold onto myself...I think that was the hardest part...holding onto my sanity...it was such a struggle...' (A 38-year-old woman raped by her boyfriend)

'I think the hardest bit for me was being that emotionally ill...the PTSD was the hardest...I think being mentally ill because of what happened was definitely the hardest for me.' (A 36-year-old woman raped by her boyfriend)

Appendix 34: Selection of participant quotes on suicidal ideation

Text Box 34: Theme 2: Participants comments on thoughts of suicide and suicide attempts

'...it's only in my early 30s that I stopped being suicidal ...even after being raped (and) I thought 'Oh God, I can't even breathe anymore...it's too hard to breathe, I just want to die...I just want to do something and kill myself and get it over with...I need to die because I can't stay alive anymore...I cant take it...' (A 38-year-old woman raped by her boyfriend)

'It got to the point where I didn't even really want to be here anymore. I'd pray to God that I wouldn't wake up tomorrow...I really, really would pray that I wouldn't wake up...I just didn't want to be here...really did not want to be here. I didn't think I could do it...I didn't think I could get through anymore.' (A 46-year-old woman raped by her ex-spouse)

'...I would say most days [thoughts of suicide came into her head]...not something I thought I would ever consciously go out and do but I used to really want to get hit by a bus...I really just would be craving that...I just wanted it...to passively have it happen to me.' (A 29-year-old woman raped by an acquaintance)

'When I was away first [this participant travelled for nine months after her rape] I used to just want to die...I used to want to swim out somewhere and not come back but I never did anything...I never tried anything...lots of thoughts about it but I never put them into action...' (A 42-year-old woman raped by a stranger)

'I was crossing a canal one day and I remember looking into the canal and I remember thinking if things don't improve I'd be better off dead. And what I would have done it...and when you think about like how crazy this is...I would have brought home a drip, an insulin drip and I would have made damn sure to do it properly if I was going to do it.' (A 47-year-old woman sexually assaulted by someone she was on a date with)

'...in and around the time when I was pregnant [as a result of being raped] and sent away...there was a little child in the house and I use to take her out for a walk and I used to say if I walked out in front of a lorry now and I was gone...' (A 53-year-old woman raped by her boyfriend)

'I was on the verge of suicide...I thought about it all the time...I used to be like how can I do it? I wanted to do it in a way that it wouldn't look like suicide...so I'd be like right...if I drove the car...and if I just drove really fast I'd hit a wall like...' (A 30-year-old woman raped by a stranger)

'I've had loads of suicide attempts...[I've] taken overdoses...I did cut my wrists before...and I tried choking myself...it's hard to describe but it's like you're in a bubble and there's one way out and like the time I cut my wrists I was clear that that was the only way out...' (A 30-year-old woman raped by an acquaintance)

'I felt like...20 times a day...will I drive into the wall or will I go off the pier, will I take these tablets, will I walk in front of the bus? It was continual...like thoughts [of suicide] all the time. I prayed for accidents to happen so that I'd end up crushed and in a wheelchair or something...surely that would be better to this hell...' (A 36-year-old woman raped by someone at a party she was attending)

Appendix 35: Selection of participant quotes on negative effects on relationships

Text Box 35: Theme 2: Participants comments on the impact of SV on their family relationships and friendships

'I've never really forgiven my parents for the fact that I felt I couldn't open up to them...I felt they wouldn't believe me.' (A 40-year-old woman raped by a family friend)

'It did affect my relationship with my family...for a long period...[and] that takes time to rebuild all that trust...' (A 46-year-old woman raped by her ex-spouse)

'My son has never seen me happy...I went out with a man for six months and he would look at me strangely because I was light in myself...and he asked me once... 'What's wrong with you, you're not giving out to me?' (A 53-year-old woman raped by someone she was on a date with)

'...he's 14 [her son]...I want him to think life is good and enjoy it. You know that you're never ok and trying to reconcile that with having a son...with bringing up a child and not passing on fear...not passing on...ideas about men...' (A 42-year-old woman raped by a stranger)

'I think my own family were too traumatised to be helpful and sometimes they were unhelpful. I think one of my sisters would have liked me to have taken a case against him [her childhood abuser]...and I think that she just felt terribly guilty that she was older than me and that she hadn't seen it...' (A 47-year-old woman sexually assaulted by someone she was on a date with)

'My brother was driving the car and I think I resented my brother for the best part of my life over this because...the only words he spoke in the whole lot of it was 'Ah you'll get over it.' (A 53-year-old woman raped by her boyfriend)

This participant had just had her baby taken from her for adoption after falling pregnant as a result of being raped.

'I kind of was like... 'Why did they [her parents] never know?' I went away this one person and I came back this completely [different person]...I was really angry cos they

never copped it. I cut away from my family a lot...I was very angry at my family at the time...[and] my mother only said after I moved out... 'The best thing you ever did was move out...I don't think I had a conversation with ya for two years...' (A 30-year-old woman raped by a stranger)

'My relationship with my mother...I think I'm starting to realise how messed up it is...I hate going home...I find it really hard to be around my family cos it brings up memories for me so its easier for me to cut myself off from them and I just send them the odd message, the odd phonecall.' (A 30-year-old woman raped by an acquaintance)

Well I fell out with one of them in particular...she would have been quite a close friend of mine...d'you know I just fell out on some level or scale with everybody when I had PTSD.' (A 36-year-old woman raped by her boyfriend)

'Even my friend who was with me on holidays [when the rape occurred]...we were so close and we stopped speaking completely after about four or five months...and then as soon as she [another friend] found out I started pushing her away too...' (A 30-year-old woman raped by a stranger)

'I mean it impacted even my friendships because then people didn't quite understand [her behaviour]...my view of life was so negative that it began to wear people down and they didn't know how to help...and I began to resent them for it...' (A 36-year-old woman raped by someone at a party she was attending)

Appendix 36: Kelleher & McGilloway, 2008 - Eisteach article

The views of counselling therapists and other service providers working with women who have experienced sexual violence: An Irish perspective

by **Caroline Kelleher** and **Sinéad McGilloway**

Department of Psychology, NUI Maynooth, Ireland

Abstract

This article describes the findings from the first stage of a study designed to describe and explore the widespread impact of sexual violence on Irish women's lives. This initial stage of the research involved face-to-face interviews with a range of stakeholders offering services to women (and men) who have experienced sexual violence. The findings may be of interest to all those keen to inform and develop policy and practice in the area of sexual violence services in Ireland, including counselling therapists, many of whom work with this client group. It is hoped that, once completed, the study findings will help to raise

public awareness of the 'hidden' costs of this crime and increase access to, and availability of, information and services for many women who have suffered sexual violence, but who may have difficulty in accessing appropriate services.

"What was she wearing?...Why was she there?...Why did she go with him?...that's a natural thing [to ask those questions] but in some ways it's a societal thing....it has to be seen that...nobody ever chooses this [rape]"

RCC service provider (12 years' experience)

Background

Current research suggests that one in every three women has been assaulted, coerced, or been a victim of some form of sexual abuse during her lifetime (Heise et al., 1999; Krug et al., 2003; Spanish, 2004). However, it is now widely accepted that official statistics underestimate the true scope of the problem and rape is now considered to be one of the most under-reported of all crimes (Crowell & Burgess, 1996; Tjaden & Thoennes

2006). The full impact of sexual violence on the lives of young women living in Ireland is relatively unknown, despite the substantial increase in reported sexual offences in Ireland since 1950 (Young et al., 2001). Results from the SAVI Report (*Sexual Abuse and Violence in Ireland*) (n=3118), which was the first prevalence study on sexual violence in Ireland, found that one in five women (20.4 per cent) had experienced contact sexual assault as an adult (i.e.

after the age of 17) (McGee et al., 2002). Furthermore, 42% who had reported experiencing sexual violence had never told anyone prior to taking part in the study. Whilst these estimates are broadly consistent with those from elsewhere in Europe - which range from one in ten to one in four (Kelly & Regan, 1999; Regan & Kelly, 2003) - Ireland has the lowest conviction rate (1-2% during 1993-2000) for rape and sexual assault in Europe (Regan & Kelly, 2003).

Support services: Rape Crisis Centres

In Ireland, the Rape Crisis Network of Ireland (RCNI) is the national umbrella organisation for the 16 Rape Crisis Centres (RCCs) that respond to the needs of women (and in many cases men) who have experienced sexual violence (SV) (RCNI, 2005). Each centre offers a range of services including: one-to-one crisis counselling, long-term counselling, attending Sexual Assault Treatment Units (SATUs) and court appearances, and advocacy and information. Several centres also provide outreach services, education and training, and community awareness-raising initiatives. All centres engage in fundraising in order to sustain and develop their services in the face of very little, if any, public sector funding. They vary widely with regard to the total number of staff (both paid and voluntary), their opening hours and phone-line operating hours. The Dublin RCC, which is the largest in Ireland, also operates the only 24-hour help-line available to men and women who have experienced sexual violence. Recent statistics (May 2007) released by the Dublin RCC, indicate that their 24-hour help-line received 15,871 calls in 2006, 77 per cent of which were genuine counselling calls (DRCC, 2006). Eighty-four per cent of calls were from women and the largest proportion of callers (39.9 per cent) was in the 18-29 years age bracket (DRCC, 2006). In 2006, DRCC counselling therapists delivered 3,585 individual client sessions, 35 per cent (1,242) of which were crisis appointments

for men and women who had experienced rape and sexual assault during the previous 12 months (DRCC, 2006). More recently the DRCC reported accompanying 30 people to the Rotunda Sexual Assault Treatment Unit (SATU) during the month of December 2007 (Press release, DRCC 2/01/08).

The current study

Little work has been conducted on the impact of sexual violence on Irish women. The study reported here forms part of a larger multi-method investigation designed to describe and explore the impact of sexual violence on the lives of Irish women. The objectives of this first part of the study were to: (1) obtain detailed information on the extent and nature of current service provision; (2) identify the key issues and challenges for therapists and other service providers working with these vulnerable women; and (3) to seek the advice of service providers on the most effective and sensitive way of accessing women for the purposes of conducting research.

Participants and research methodology

A series of one-to-one interviews was conducted with a range of key stakeholders (n=18) working at the 'frontline' of service provision in the sexual violence (SV) sector. After identifying suitable organisations and prospective participants, staff from 24 organisations throughout Ireland were contacted, 18 of whom agreed to participate in interviews. These included individuals of varying experience, who were working in, and/or providing

counselling in, a number of both urban and rural settings including rape crisis centres (RCCs) or other SV services (n = 14), SATUs (n=3), and domestic violence agencies (n=1). The backgrounds of these professionals included: counselling therapists (n=10), nurses (n=2), doctor / consultant (n=1), and management / administration posts (n=5).

Following an extensive review of the literature, a number of open-ended questions were devised to explore: the nature and extent of services currently provided by each organisation; the main challenges and difficulties women face during the immediate and long-term post-assault period; the obstacles and barriers they need to overcome in accessing services; and the current gaps in service provision. Participants also completed a brief *Background Questionnaire* eliciting information such as age range, number of years' experience, and the responsibilities/duties associated with their current role. Prior to meeting with the researcher (CK), participants were provided with an Information Sheet about the research and, in many cases, a sample of the topics to be covered during the interview (this was provided upon request). Interviews varied in length from 45 minutes to two hours. All interviews were audio-recorded with the exception of four participants who declined; these were then transcribed in preparation for a thematic analysis. This involved identifying a number of key themes and sub-themes relevant to the study objectives (Hayes, 2000). Those

A powerful and recurring theme throughout the interviews...related to the shame and guilt felt by many women after being raped or sexually assaulted and the fact that this poses one of the most significant obstacles in accessing appropriate support

interviews that were not recorded were set aside and examined only after the 14 transcriptions had been analysed; any new material was then included in the final analysis.

Results

Participant profile

All of the participants (n=18) were female, ranging in age from 30 to 59 years and had been working in the sexual violence sector, in a range of capacities, for an average of 8.5 years. Half rated current service supports for women who have experienced SV as only 'fair' to 'poor' and 90 per cent indicated that the amount of stigma associated with this crime is considerable (i.e. 'a lot').

Key themes and issues

Each of the key themes and their main sub-themes are described here in brief with selected illustrative quotes presented in Boxes 1 and 2.

1. Barriers to service provision

1.1 Shame and guilt

A powerful and recurring theme throughout the interviews – and one mentioned by all of the participants – related to the shame and guilt felt by many women after being raped or sexually assaulted and the fact that this poses one of the most

significant obstacles in accessing appropriate support. Participants also alluded to the negative experiences of disclosure amongst some women and how this may compound existing levels of guilt, sometimes resulting in their never telling someone again, much less identifying themselves as a likely recipient of some of the services available to survivors of SV. These kinds of issues intensify these women's difficulties in accessing both formal and informal support and pose a significant barrier to service provision. The comments in Box One clearly highlight some of the sentiments expressed by participants here.

1.2 Naming/acknowledgement of the incident

This sub-theme was recurrent throughout the course of the interviews. In order for women to see themselves in need of, or suitable for, the services provided by RCCs or SATUs, they first have to recognise that what they have experienced is sexual violence or rape or a crime. This commonly reported reluctance by women to name what has happened to them, often has the undesired effect of causing them to maintain their silence while they struggle with the emotions that typically arise after an incident of SV. This may also have

more far-reaching implications in terms of agencies effectively informing and promoting their services to women in this situation. A key message emanating from the interviews was that service providers must balance their desire to inform women of their services through the use of carefully selected language, images and media, whilst ensuring that they do not alienate an already marginalised and vulnerable population

1.3 Societal myths around rape

Several participants mentioned the many myths that still persist in today's society around rape and, in particular, prevailing stereotypes relating to who is a 'victim' and who is a 'perpetrator'. The consequences of experiencing SV outside of these societally ascribed parameters tend to lead to a high degree of self-blame amongst women. As a result, they tend not to feel entitled to access support services, or to bring the perpetrator to justice. As mentioned earlier, the woman's fear that she will not be believed by those closest to her is a significant barrier to disclosure and to the subsequent accessing of services. Nowhere perhaps, is this more salient than when the rape or sexual assault occurs

within the context of an intimate partnership or marriage. Negative or unsupportive responses to disclosure of sexual violence (often fuelled by ill-informed yet relatively commonplace myths and biases), such as blaming the woman for what has happened, are not unique to a woman's immediate family and friends. The impact of these myths and misconceptions may have more far-reaching consequences in many other areas (e.g. in the courtroom). The selected comments in Box One illustrate some of the points raised here.

2. Current gaps in service provision

All of the participants were asked to identify, in their experience, the current gaps in service provision. The following sub-themes were identified from their responses.

2.1 Education and awareness

Participants repeatedly stressed the need for, and the importance of, education and awareness-raising both for women, and broader society. Some commented that several women they had encountered either directly through their service, or external to it, had been unaware of the services in their local area (see Box 2 for related comments). Several mentioned the conflict between promoting their service and making people aware of their existence while at the same time ensuring a safe, confidential and therapeutic 'space' for women. Nonetheless, all were aware of the necessity to educate the public both young and old. Many felt that a widespread societal awareness and acceptance that SV was a

crime did not exist in contemporary Ireland and required urgent attention.

2.1 The Criminal Justice System

A number of the interviewees expressed disappointment and frustration with the Irish Criminal Justice System (CJS), particularly with the manner in which women are treated if they decide to proceed with a case. It would appear from the findings reported here that the experience for women who intend to prosecute the alleged perpetrator is at best stressful, and at worst re-victimising. Participants expressed particular frustration with the length of waiting time for a case to come to court and the appallingly poor attrition rates in these cases. These sentiments are clearly illustrated by the selection of comments in Box 2.

2.2 Availability of Sexual Assault Treatment Units

An urgent need for an increase in the number of SATUs in suitable and accessible locations was highlighted throughout the interviews. Additionally, participants emphasised that these units need to offer a true 24-hour service aimed at meeting women's medical and forensic needs as opposed to a service which can only operate if there is a sufficient supply of specifically trained doctors who in many cases donate their time voluntarily. In addition, the services of some of the SATUs are only available to women who are prepared to proceed with a legal prosecution. Several participants spoke about women having to remain in the same clothes they had been

wearing at the time of the assault for up to two and three days afterwards while waiting for a suitably qualified medical professional to perform the forensic medical examination (FME). However, this experience appeared to be determined largely by the women's proximity to a SATU.

2.3 Specialised services for vulnerable sub-groups

Several participants commented on the need for a range of services to meet the unique needs of a range of vulnerable sub-groups (e.g. Traveller women, immigrants, disabled women and teens). One participant remarked that is not sufficient for a service to be available in one fixed location and to expect the clients to come to that location (e.g. Traveller women). She felt that attempts should be made to meet these women on their territory and that the service was not complete otherwise (see Box 2 for related comments). According to respondents, the Irish government's policy of the decentralisation of refugees and immigrants has meant that the client profile of many of these organisations has changed dramatically in the last few years. For many of these women, the desire or need to deal with the SV-related issues is overshadowed by the pressing uncertainty of their living conditions and status. It was argued by several respondents that cultural differences may also render our traditional Western methods of counselling inappropriate for these women, effectively leaving them with limited, if any, options.

Another respondent indicated that many of the RCCs were not wheelchair accessible, nor had they basic facilities for women with disabilities. This indicates a significant gap in existing services.

Many of the organisations in which interviewees were based, had a lower age limit of 18 years for their services. In some cases, younger girls of 16 and 14, with their parent's permission, had attended for counselling, although it was stated that this would not be the norm. Work in the community and talks in local schools given by staff, in addition to almost weekly direct contact (in some places) from young girls reporting experiences of SV, had alerted many of the interviewees to a serious lack of services specifically for teenage girls.

Discussion and implications for practice

Barriers to service provision

Many of the themes and sub-themes in this study have been identified in the small pool of research conducted elsewhere. For example, guilt and self-blame have been identified as strong reasons for not reporting the incident in female victims of acquaintance rape (n=236) (Bachman, 1998). More recently, Sable et al. (2006) found that women's concerns are still dominated by shame, guilt and embarrassment, despite 30 years of legal reforms and public education campaigns and rape awareness activities on college campuses, all of which are designed to reduce the psychological and service system barriers to reporting a crime and accessing support.

As recently as 2005, a telephone survey conducted on behalf of Amnesty International UK revealed some worrying trends in public views and understanding of rape and sexual assault. Thirty per cent of respondents felt that if a woman was intoxicated, she was in some way responsible for being raped (Amnesty International UK, 2005). While 69 per cent agreed that a woman walking alone in a dangerous or deserted area was not responsible if she was raped, more than one in five felt that a woman in this situation would be 'partially' or 'totally' responsible (Amnesty International UK, 2005). These pervasive societal myths about rape (e.g. 'Women are only raped down dark alleys by strangers') stands in stark contrast to the statistics which indicate that only a minority of Irish women are assaulted in a public place or outdoors (24 per cent) and more often than not, that the assault is carried out by someone who is already known to them (79 per cent) (McGee et al., 2002). The impact of these rape myths mean that women have difficulty defining what has happened to them in terms of sexual violence, thereby considering themselves 'ineligible' for appropriate support services. This delay in accessing support can, in turn, impact upon their recovery from the effects of the assault and the knock-on consequences on their lives (Herman, 2001); these are being examined in the second stage of this study.

Current gaps in service provision

The participants in this study referred to a number of important

and persistent gaps in services. Our findings support those of Leane et al. (2001) who identified several inadequacies within the Irish criminal justice system based on interviews with 15 support personnel. For example, they cited the delay in rape cases coming to trial and Ireland's low rate of conviction in rape cases as 'a disincentive to victim engagement in the legal process' (Leane et al., 2001: 99). The average delay of two to three years in these cases coming to trial was also cited as impacting negatively upon victim recovery (Leane et al., 2001). Whilst our findings suggest that there has been little progress in the provision of an effective legal response to victims of sexual violence, a study commissioned by the RCNI is currently underway to quantify and explain why Ireland has the worst attrition rate in Europe. It is hoped that this work, coupled with the findings from the current study, will help to inform the development of appropriate supports and services to enable these women to have more positive experiences of the CJS. Furthermore, the Cork Sexual Violence Centre has just recently (December 2007) launched a step-by-step guide to the legal system for professionals and clients alike, in order to guide them through the process of proceeding with a case against a perpetrator (Crilly, 2007).

Participants in this study consistently emphasised an urgent need for education and awareness raising initiatives to overcome the pervasive negative stereotypes and rape myths in Irish society; these

Participants in this study consistently emphasised an urgent need for education and awareness raising initiatives to overcome the pervasive negative stereotypes and rape myths in Irish society

can pose significant obstacles to women accessing services in the aftermath of a rape or sexual assault. Furthermore, a number of marginalised sub-groups (e.g. Travellers, immigrants/asylum seekers) must overcome several additional obstacles, such as embedded cultural norms and customs, in order to avail of existing services. Some participants also expressed frustration with the government and society at large for not recognising sexual violence as a serious and widespread problem.

Six of the eight recommendations proposed by the SAVI Report were concerned with the need for public awareness campaigns and the development of educational materials, both for professional and public use, in order to effectively address the issue of sexual violence in our society today (McGee et al., 2002). One of these recommendations also highlighted the particular needs of marginalised groups when encountering health-related or law enforcement services (McGee et al., 2002). While sexually violent crimes continue to be perpetrated, the call for 'a comprehensive campaign on sexual violence [to] be developed, delivered and evaluated in Ireland' appears to have gone unanswered (McGee et al.,

2002:291). A similar recommendation was proposed both in Leane et al.'s study (2001) and again, almost 10 years ago, in a Government report on the Task Force on Violence against Women. According to the SAVI study, this campaign should be the responsibility of the Health Promotion Unit at the Department of Health and Children and they posit that 'the role of the media is crucial in developing an accurate and comprehensive understanding of sexual violence among the general public' (McGee et al., 2002:290). While some of the RCCs do run some external education and training courses, these are, for the most part, not funded. Arguably, the need for funding for more trained counselling therapists should not be at the expense of attempts, through education and public awareness raising initiatives, to prevent the problem occurring in the first place. A growing body of literature strongly supports the finding that rape prevention education can elicit a cognitive, emotional, and behavioural shift, thereby prompting the development of a 'rape consciousness' in participants (Klaw et al., 2005; Lonsway et al., 1998). The authors assert that 'intensive, sustained **rape education** efforts play a vital role

in dismantling **rape** supportive culture' (Klaw et al., 2005: 61).

Feedback from participants in the current study highlighted a clear and important need to improve the availability of support services and, in particular, SATUs. In fact, since the beginning of this research, plans have been announced for the establishment of two further SATUs in the Midland Regional Hospital in Mullingar and the University College Hospital, Galway. In addition, the HSE has announced funding for SATUs of €1.5m for the remainder of 2007 and €2.5m for every year after that (HSE, 2007). This expansion of services will also include 'sponsored specialist training for medical and nursing staff to provide post-assault and forensic care' in addition to similar sponsored training for GPs and other physicians who are interested in working in this area (HSE, 2007:1). These developments have come in timely response to a national review of sexual assault treatment services in Ireland, published in 2006 by the National Steering Committee on Violence Against Women (O' Shea, 2006). Amongst other things, this report recommended the expansion of SATU services in the HSE Western region (i.e. Galway) and

in the HSE Midland region (O'Shea, 2006). While this is a welcome development, the findings reported here suggest that there is considerable scope for progress on the implementation of several other recommendations including: the standardisation of existing services; addressing the gaps in the legal system (e.g. dedicated interview room for sexual crime victims in Garda Stations in each HSE region); the promotion of networking and the sharing of information between agencies; and the commissioning of research to clearly identify needs in the area of rape and sexual assault (O' Shea, 2006).

Findings in context

The issues and challenges in providing services to women who have experienced sexual violence that have been identified in this study are not new. However, they are extremely complex in nature and require a well-defined, multi-faceted resolution. Comparable challenges have also been revealed in the sexual violence service provision sector in the UK. The UK has quite a similar structure to Ireland with a total of 116 voluntary/third sector sexual violence and abuse services (these include RCCs and Survivor groups) as well as 19 Sexual Assault Referral Centres (SARCs - the equivalent of our SATUs) which respond to victims of sexual violence (Coy et al., 2007). However, Coy et al. (2007) report that only one in four local authorities have a specialised sexual violence support service. Again, the

geographical location of services and the unstable statutory funding means that many regions are severely under-served (Coy et al., 2007). For example, closer to home, Northern Ireland does not have a SARC and the only RCC operating there lost its government funding in July 2006 (Coy et al., 2007).

Sexual violence against women needs to be strategically positioned on the national radar. A recent Irish report looking at the health consequences of violence against women recommends that this *'devastating social problem...needs an integrated sector response...which addresses violence within all its aspects of policy and service provision'* (Women's Health Council (WHC) 2007:31). Encouragingly, an executive agency, *The National Office for the Prevention of Domestic, Sexual and Gender-based Violence*, also known as COSC, has just been set up to combat violence against women (WHC, 2007). Hopefully, this office will begin to address the inadequacies in our nationwide response to this crime and the distinct lack of public awareness and understanding of its devastating impact on the lives of a significant proportion of Irish women.

Conclusion

In conclusion, there are a number of areas that merit further research, but which are beyond the scope of the present study. For example, these include the need to examine the prevalence and impact of sexual

violence in men, as well as sexual violence within the context of marriage and/or intimate relationships. However, the findings have been used to inform the subsequent stages of the study. The second stage, which is currently underway, involves a questionnaire-based survey of a sample of women (n@100) who have experienced sexual violence (i.e. rape/sexual assault), in order to assess a range of outcomes relating to: mental health, stress and trauma; Quality of Life (QoL); general physical health and well being; social support; life events; and service needs. In the third and final stage of this research, a series of in-depth interviews will be conducted with a smaller sample of Irish women with a view to exploring in detail their experience of sexual trauma and its impact on their lives. It is hoped that the collective findings from all stages of this research will enhance our understanding of the impact of this trauma on the lives of women both in Ireland and further afield.

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We would like to thank all those who took time out of their busy schedules to participate in this research. We also offer our thanks to the Irish Research Council for Humanities and Social Sciences (IRCHSS) who kindly funded this study.

Box 1: A representative selection of service providers' comments on the barriers to services often experienced by women in the aftermath of an experience of sexual violence

Client's shame and guilt

- ◁ "I think the main difficulty...that everybody has, is the whole stigma and shame...It's a combination of stigma and shame and a lack of awareness among women of what sexual assault actually is..."
- RCC service provider (4 years' experience)
- ◁ "Quite a lot of clients will self-blame...that is definitely predominant...the clients that come in here still feel that they are to blame for what has happened even though they know...part of their brain is telling them... 'No, he was wrong'."
- SATU service provider (2 years' experience)
- ◁ "They definitely have a huge guilt thing that you know... 'God, was it something I did?'"
- SATU service provider (5 years' experience)

Naming/acknowledgement of the incident

- ◁ "...for a lot of women who have experienced unwanted sexual contact or, coercion into having sex...they may not name that as rape..."
- Domestic violence service provider (12 years' experience)
- ◁ "...an awful lot of people won't...don't identify with that word [rape] because they see it as 'Well rape means someone dragging you down an alleyway, sticking a knife to your throat and beating the crap outta ya!'"
- RCC service provider (2 years' experience)
- ◁ "...I have a client and she was describing what had happened to her...an absolute awful rape...it was named as rape [by the therapist]...and it was like 'Yeah I was raped'...but I think if it hadn't been named that this is what it is and you've survived it...that girl found it really hard for me to call it rape..."
- RCC service provider (6 years' experience)

Societal myths around rape

- ◁ "We have a notion in this society that rape is a stranger who jumps out of a bush when a woman is walking home. Certainly she doesn't know him, she doesn't go on a date with him, she never kissed him and she's NOT married to him...so that makes it much more difficult for women who are raped in those circumstances..."
- RCC service provider (13 years' experience)
- ◁ "...Well, you're in the relationship with him so you must have said something then to provoke this'...It's really difficult for women to feel that they're going to be taken seriously and that they're going to be believed..."
- Domestic violence service provider (12 years' experience)
- ◁ "...I've had loads of women who have said to me...'Oh the judge said I don't look like a victim'...like you may not fit the judge's idea of the traumatised victim because you're having to survive on a daily basis..."
- RCC service provider (3 years' experience)

Box 2: A representative selection of service providers' comments on the current gaps in service provision

Education and awareness

- ◁ "...One of the biggest things (is) education and information...I think that teaching young people about consent is absolutely essential...'What does consent mean?...How do you know if someone is consenting?...Do they have to say 'Yes or 'No'?..."
- RCC service provider (12 years' experience)
- ◁ "...I mean people say to me, when I say to them I work in the Rape Crisis Centre...they say I didn't know it even existed...there has to be an awareness around counselling...that it works, that people need counselling...there wouldn't be awareness with a lot of people..."
- RCC service provider (5 years' experience)

Box 2: A representative selection of service providers' comments on the current gaps in service provision (cont.)

- ◇ "...there's a huge gap in services...how is it that people know first of all that sexual violence is wrong 'cause we [society] don't hand out that message...and if you've experienced sexual violence how do you know that the services are accessible to you?..."
- RCC service provider (13 years' experience)

The Criminal Justice System

- ◇ "...You do hear things from people...that's where I'd see the biggest gap in the service...not so much at this level [SATU] but I think from here on in, it's horrendous...like maybe the fortunate ones are the ones that don't go to court..."
- SATU service provider (5 years' experience)
- ◇ "...the fourth (court accompaniment by an RCC volunteer) one was just not a guilty plea...and just how that girl was treated by the judge, by the guards...you're kind of going 'Is this still the Dark Ages?'"
- RCC service provider (12 years' experience)
- ◇ "...the biggest stumbling block in rape cases is the justice side of it from what I can gather...like they're [rape victims] only witnesses so they're not even allowed to give evidence."
- SATU service provider (2 years' experience)

Availability of Sexual Assault Treatment Units (SATUs)

- ◇ "...I think if you look at the [SATU] services...in general in the West of Ireland, in the Midlands and in the Northern part of the country, the border part of the country...they are a scandal..."
- SATU service provider (13 years' experience)
- ◇ "...I think the biggest [gap in services]...obviously the fact that the [SATU] services aren't available 24 hours...what I would like to see is that the SATUs were more available..."
- RCC service provider (18 years' experience)
- ◇ "...the SATU...we're quite far away from Dublin and that fact that we don't have the personnel to offer a 24-hour service...there's four social workers who are really keen for a SATU unit to be put in XX...that's not going to happen for a very long time..."
- RCC service provider (6 years' experience)

Box 3: Specialised services for vulnerable sub-groups

- ◇ "...we've had young girls on the phone who were raped and never told a sinner and they were absolutely at their wits end trying to do their Leaving Cert..."
- RCC service provider (5 years' experience)
- ◇ "...about asylum seekers...the traumatisation is just not recognised at all...you know, they'll be coming to us and they'll have seen solicitors, they'll have seen psychiatrists and nobody has picked up that they're traumatised..."
- RCC service provider (12 years' experience)
- ◇ "Gaps in services are around meeting the needs of the whole range of sexual violence survivors...Traveller women use refuges way more than they use Rape Crisis Centres...but part of that is...we have this notion that here's this centre or women's support service and you have to come to our centre to get services...that's not really...you don't have a choice [if you want our services]..." - RCC service provider (13 years' experience)

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Caroline Kelleher is a postgraduate student of psychology at the National University of Ireland, Maynooth. Her main area of interest is the impact of trauma on people and her current research, which is funded by the Irish Research Council for Humanities and Social Sciences (IRCHSS), focuses on the psychosocial impact of sexual violence on Irish women.

Correspondance

Caroline Kelleher
Department of Psychology
NUI Maynooth,
Maynooth, Co. Kildare, Ireland
Email: caroline.kelleher@nuim.ie



Dr Sinéad McGilloway is a Senior Lecturer based in the Department of Psychology at the National University of Ireland, Maynooth. She is a public health/community psychologist with considerable experience in undertaking applied, policy-relevant health and social care research, particularly with vulnerable populations.

Appendix 37: Kelleher & McGilloy, 2009 - HSCC article

'Nobody ever chooses this ...': a qualitative study of service providers working in the sexual violence sector – key issues and challenges

Caroline Kelleher BA and Sinéad McGilloway BSSc, PhD, CPsychol, CSci, AFBPS
Department of Psychology, National University of Ireland Maynooth, Ireland

Correspondence

Caroline Kelleher
Department of Psychology
NUI Maynooth
Maynooth
Co. Kildare, Ireland
E-mail: caroline.kelleher@nuim.ie

Abstract

This paper describes the findings from the first stage of a study designed to assess the impact of sexual violence (SV) on the lives of Irish women. Stakeholder interviews ($n = 18$) were undertaken to explore experiences of delivering services to people who have experienced SV, in rural and urban settings in Ireland. A range of themes and sub-themes were identified through a thematic analysis, and interrelationships between two of the main themes (barriers to services and current gaps in service provision) are discussed. Sub-themes include: survivor guilt and shame, difficulties in naming the incident as SV, problems with the Criminal Justice System and the availability of Sexual Assault Treatment Units. Participants identified an urgent need for a co-ordinated national strategy in the form of a public awareness and education campaign in order to undermine commonly held rape myths and stereotypes. The findings will be of interest to all health and social care professionals who are in contact with women who have experienced SV. They will also help to raise an awareness of the 'hidden' costs of SV, and inform appropriate policies and community-based responses to this important social problem.

Keywords: rape, service providers, service provision, sexual violence

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Introduction

Research suggests that one in every three women has been assaulted, coerced or been a victim of some form of sexual abuse during their lifetime (Heise *et al.* 1999, Krug *et al.* 2003, Tavara 2006, p. 397). However, it is widely acknowledged that rape is one of the most under-reported of all crimes (Crowell & Burgess 1996, Tjaden & Thoennes 2006). The impact of sexual violence (SV) on the lives of young women in Ireland is unknown, despite the substantial increase in reported sexual offences in Ireland since 1950 (Young *et al.* 2001). Results from the Sexual Abuse and Violence in Ireland (SAVI) report – the first prevalence study on SV conducted in Ireland – found that 42% of women have experienced sexual abuse or assault in their lifetime (McGee *et al.* 2002, p. 120). Furthermore, 47% had never told anyone *prior* to participating in the study (McGee *et al.* 2002, p. 121). While these figures are broadly consistent with those from elsewhere, Ireland has the lowest conviction

rate (1–2% during 1993–2000) for rape and sexual assault in Europe (Regan & Kelly 2003, p. 10).

Victims, or survivors, of SV (both terms are used interchangeably here) experience numerous negative effects on their lives including: resource disruption (e.g. unemployment, divorce) (Monnier *et al.* 2002); deterioration in interpersonal functioning (Schumm *et al.* 2004); elevated risk of suicide (Ullman 2004); and an increased utilization of medical services (Stein *et al.* 2004). These findings have important implications for health and social services, and for informing the development of effective treatments and interventions. In Ireland, the Rape Crisis Network of Ireland (RCNI) is the national umbrella organization for the 16 community-based Rape Crisis Centres (RCCs) that respond to the needs of those who have experienced SV (RCNI 2005). Each centre operates independently and offers a range of services including: one-to-one crisis counselling, long-term counselling, accompaniment to Sexual Assault Treatment Units (SATUs) and court appearances and advocacy

and information. Several centres also provide community outreach services, education and training and community awareness-raising initiatives. All RCCs rely heavily on fundraising in order to sustain and develop their services. They vary with regard to number of staff, opening hours and phone line operating hours (where applicable). The staff that work in RCCs typically include a director of the service, counselling therapists and various administration staff. In smaller centres, one person, often the director, frequently fills multiple roles. With regard to the SATUs, four currently operate in Ireland – in Dublin (east), Cork (south), Waterford (south-east) and Letterkenny (north-west). They offer forensic and/or medical services within local or national hospitals, but vary widely with respect to funding, management, staffing and scope of service provision (O'Shea 2006). The Cork-based SATU is the only one currently in receipt of statutory funding.

The Dublin Rape Crisis Centre (DRCC) (the largest in Ireland) operates the only available 24-hour help line in the country; almost 16 000 calls were received in 2006, approximately three-quarters of which were genuine counselling calls (DRCC 2007, p. 11). Most callers were female (84%) and over half (55%) involved adult rape and sexual assault, representing an increase of 3.5% since 2005 (2007, pp. 6, 14). In 60% of cases the perpetrator was known to the victim. During 2007, DRCC volunteers accompanied 315 victims to the Dublin-based SATU (an increase of 20% since 2005) (p. 6). Additionally, DRCC therapists delivered 3585 individual client sessions, 35% of which involved crisis appointments for men and women who had experienced rape and sexual assault during the previous 12 months (DRCC 2007, p. 14).

The present study forms part of a larger, multistage, mixed method investigation designed to describe and explore the impact of SV on the lives of Irish women. As far as we are aware, no peer-reviewed qualitative studies of service providers in this area have been conducted within Europe, while few have been conducted farther afield. The qualitative methodology used here is well suited to the topic under investigation in view of its sensitive and relatively novel nature (Patton 2002). The key objectives of this study were to: (1) identify key service providers from national representative organizations; (2) obtain detailed information on the extent and nature of current service provision; and (3) ascertain the key issues and challenges in this area from the perspective of service providers.

Subjects and methods

An initial scoping survey was conducted to identify key stakeholders throughout Ireland who were working in

the SV sector. Individual staff from 24 organizations were contacted, 18 of whom agreed to participate in one-to-one interviews. All of the interviews were conducted on a face-to-face basis by the first author (C.K.). Participants had variable levels of experience and worked in a range of urban and rural services including RCCs, or other SV services ($n = 14$), SATUs ($n = 3$) and domestic violence agencies ($n = 1$).

A semistructured interview schedule was devised following an extensive review of the literature. The items, some of which were organization specific, inquired about services provided, staffing arrangements, routinely available data, perceived gaps in current service provision and the requirements for high-quality services. The interview schedule was piloted with the first few participants, with only minimal modifications. Prior to the interview, participants received an information sheet and, upon request, a sample of the interview topics. They also completed a brief background questionnaire. Interviews lasted from 45 minutes to 2 hours, and all were audio-recorded with consent (excluding four who declined) and transcribed (by C.K.) in preparation for a thematic analysis (Hayes 2000). The transcripts were judged to accurately reflect the content of the interviews. Each interview was read and re-read several times, after which all items of interest were noted and colour coded by hand, and organised into proto-themes which were carefully examined and defined. The interview schedule was used as an initial 'theme guide' to organizing this material. A secondary examination of the transcripts was then conducted, and material relevant to each theme was identified, colour coded and organised into a systematic coding scheme. It was then possible to construct each theme in its final form which consisted of a name, definition and supporting data. The four interviews that were not recorded were examined only after the 14 other transcriptions had been analysed; any new material was included in the final analysis in the same iterative fashion. A random sample of the transcripts was checked by an independent researcher for purposes of validating the key themes and sub-themes.

Results

Participant profile

All participants ($n = 18$) were women ranging in age from 30 to 59 years, and had worked in the SV sector for an average of 8.5 years. They included counselling therapists ($n = 10$), nurses ($n = 2$), a doctor/consultant ($n = 1$) and managers/administrators ($n = 5$). Half of the sample rated current service supports for women who have experienced SV as only 'fair' to 'poor', while 90% reported the amount of stigma associated with this

Table 1 List of themes and sub-themes including descriptions

Theme name	Description of sub-theme
Theme 1: Barriers to Services	
1.1 Survivors' shame and guilt	Feelings of guilt and shame post-assault act as a barrier to survivors in accessing services
1.2 Naming/Acknowledgement of the incident	Victim reluctance to name the incident as sexual violence (SV) means they fail to identify themselves as eligible for services
1.3 Societal myths around rape	Persistent societal myths around rape facilitate further self-blame in victims
Theme 2: Current Gaps in Service Provision	
2.1 Education and awareness	Lack of awareness around services, and the prevalence and effects of SV
2.2 The Criminal Justice System (CJS)	Gaps exist in the CJS which can affect the likelihood of a woman proceeding with a case
2.3 Availability of Sexual Assault Treatment Units (SATUs)	Issues around the geographic spread of SATU services and the operation of a 'true' 24-hour service

crime to be considerable. Two key themes were identified and/or emerged from the analysis, within which a further six sub-themes were identified. These are described and summarised in Table 1.

Barriers to service provision

Survivors' shame and guilt. A powerful and recurring theme – and one mentioned by all participants – related to the shame and guilt felt by many women after being raped or sexually assaulted; this appears to pose one of the most significant barriers to accessing appropriate support and reporting to the police. For example, one participant commented:

... I think the main difficulty ... is the whole stigma and shame ... It's a combination of stigma and shame, and a lack of awareness among women of what sexual assault actually is ... (RCC service provider, 4 years of experience)

Participants also alluded to the negative experiences of disclosure among some women and how this may compound existing levels of guilt. If women feel a sense of responsibility for the incident, the effects of disclosing to someone who reinforces these beliefs, may prevent them from disclosing in the future, or from identifying themselves as in need of support services. Two participants commented:

... Quite a lot of clients will self-blame ... the clients that come in here still feel that they are to blame for what has happened even though they know ... part of their brain is telling them ... 'No, he was wrong' ... (SATU service provider, 2 years of experience)

... They definitely have a huge guilt thing that you know ... 'God, was it something I did?' ... (SATU service provider, 5 years of experience)

Feelings of shame, guilt and self-blame are common following an experience of SV and frequently give victims some sense of control over their world (Petra

& Hedge 2002). Issues perceived by respondents to present important obstacles to women when accessing formal or informal support included: the shame related to their perceived responsibility for the attack; how much they resisted it; and concerns about the attitudes of friends and family. Unless these kinds of issues can be addressed at an individual and societal level, essential support services will remain underutilised and underfunded into the future.

Naming/Acknowledgement of the incident. In order for women to see themselves in need of, or suitable for, the services provided by RCCs or SATUs, they must first recognise that what they have experienced is SV and a crime. This naming or acknowledgement of the incident was another recurring sub-theme; for example, one participant reported:

... for a lot of women who have experienced unwanted sexual contact or, coercion into having sex ... they may not name that as rape ... (RCC service provider, 12 years of experience)

This reluctance to name what has happened to them often leads to a sustained silence during which women struggle with many negative emotions. This may have serious implications for service providers who are trying to reach out to vulnerable women. Thus, service providers need to balance their desire to inform women of their services (through the use of appropriate language, images and media) with their need to ensure that they do not alienate an already marginalised and vulnerable population.

Societal myths around rape. Several participants alluded to the numerous rape myths that still persist in today's society and, in particular, the prevailing stereotypes about who is a 'victim' and who is a 'perpetrator'. The stereotypical 'rape victim' is illustrated in the following:

... an awful lot of people won't ... don't identify with that word [rape] because they see it as... Well, rape means someone dragging you down an alleyway, sticking a knife to your throat and beating the crap outta ya! ... (Domestic violence service provider, 12 years of experience)

The consequences of experiencing SV outside of these parameters often lead to a high degree of self-blame among women; as a result, they tend to feel that they are not entitled to support services, or even justice. The following highlights some of the typical misconceptions that women must overcome in order to access services:

... We have a notion in this society that rape is a stranger who jumps out of a bush when a woman is walking home. Certainly, she doesn't know him, she doesn't go on a date with him, she never kissed him and she's NOT married to him ... so, that makes it much more difficult for women who are raped in those circumstances ... (RCC service provider, 13 years of experience)

The potential likelihood that a woman will not be believed by those around her is often a significant barrier to disclosure and subsequent service utilization, but this is perhaps no more salient than when the rape or sexual assault occurs within an intimate partnership or marriage:

... Well, you're in the relationship with him so you must have said something then to provoke this! ... It's really difficult for women to feel that they're going to be taken seriously and that they're going to be believed ... (RCC service provider, 2 years of experience)

This finding is consistent with quantitative research that suggests that marital rape is experienced by about 10–14% of all married women, and by about 40–50% of battered women (Martin *et al.* 2006, p. 337). These kinds of misinformed attitudes may extend beyond a woman's immediate family circle and close friendships, and may have consequences in many areas including the treatment of women within the Criminal Justice System (CJS). The potential difficulties with the CJS and its treatment of victims of SV are explored in more detail below.

Current gaps in service provision

Education and awareness. Participants repeatedly stressed the need for, and the importance of, education and awareness raising. Some commented that several women they had encountered either directly through their service, or external to it, had been unaware of their local services. One participant noted:

... I mean people say to me when I say to them I work in the Rape Crisis Centre ... they say I didn't know it even existed ... there has to be an awareness around counselling ... that it works, that people need counselling ... (RCC service provider, 5 years of experience)

Several participants mentioned the tensions inherent in promoting their service while ensuring a safe, confidential and therapeutic 'space' for women – in other words, providing a place of sanctuary where women felt sufficiently secure to confide in someone. For example, one RCC worker felt that, if more women were accessing the service, some might feel more easily identifiable when entering and exiting the RCC premises, thereby compromising their confidentiality. Nonetheless, a therapeutic 'space' that is safe physically, emotionally and psychologically was considered by most RCC workers to be essential to their clients' recovery. However, all were also aware of the need for public education initiatives:

... One of the biggest things is education and information ... I think that teaching young people about consent is absolutely essential ... What does consent mean? ... How do you know if someone is consenting? ... Do they have to say 'yes' or 'no'? ... (RCC service provider, 6 years of experience)

Participants were clear about the need to increase awareness of the seriousness and impact of SV, and an understanding of the difficulties faced by women when trying to access support. Common responses to victims of SV were seen by one participant as being particularly unhelpful:

... What was she wearing? ... Why was she there? ... Why did she go with him? ... that's a natural thing [to ask those questions] but in some ways, it's a societal thing... it has to be seen that ... nobody ever chooses this [rape] ... (RCC service provider, 12 years of experience)

Worryingly, wider society was considered by some participants to be characterised by a 'rape-supportive' culture. It was suggested that without effective national education and awareness raising programmes – similar to the 'Don't Drink and Drive' campaigns run by the Irish Road Safety Authority and the Department of Transport – women who experience SV will have to continue to decipher mixed messages and information before accessing services. One participant commented:

... there's a huge gap in services ... how is it that people know first of all that sexual violence is wrong because we [society] don't hand out that message ... (RCC service provider, 13 years of experience)

The CJS. Several interviewees expressed disappointment and frustration with the CJS and particularly the manner in which women are treated if they proceed with a case. Our findings suggest that the experience for women who intend to prosecute the alleged perpetrator is at best stressful, and at worst, re-victimizing. Participants expressed particular frustration with the length of waiting time for a case to come to court, and with the treatment of the victim as a 'state witness'. This can often mean that the victim is not always kept informed of developments in the case. As one participant reported:

... the biggest stumbling block in rape cases is the justice side of it from what I can gather ... like they're [rape victims] only witnesses ... (SATU service provider, 5 years of experience) (Note: The CJS is not legally obliged to keep a witness informed of progress in the case, although in many cases they try to.)

Another issue with the Irish CJS is the current Director of Public Prosecution's (DPP) policy, whereby there is no obligation to provide a reason for a decision to abandon a case. The decision by the victim to proceed with a case is, at best, a difficult one, but to have a case dropped for no reason must be even more frustrating. Remarkably, one participant whose job involved collecting the forensic evidence used in these cases, commented:

... You do hear things from people [about the CJS] ... that's where I'd see the biggest gap in the service ... not so much at this level [SATU], but I think from here on in, it's horrendous... maybe the fortunate ones are the ones that don't go to court ... (SATU service provider, 2 years of experience)

According to some participants, even when a case reaches court, the attitudes of CJS personnel may sometimes be far from understanding and supportive. Furthermore, the myths and stereotypes surrounding rape are not peculiar to the general public as illustrated by the following:

... the fourth one [court accompaniment by RCC volunteer] was just a 'not guilty' plea ... and just how that girl was treated by the judge, by the Guards [the Gardai – the Irish police force] ... you're kind of going 'Is this still the Dark Ages?' ... (RCC service provider, 8 years of experience)

Availability of SATUs. An urgent need for an increase in the number of appropriate and accessible SATUs was highlighted throughout the interviews, as was the need to offer a 24-hour service aimed at meeting women's medical and forensic needs:

... the biggest [gap in services] ... is obviously the fact that the [SATU] services aren't available 24 hours ... what I would like to see is that the SATUs were more available ... (RCC service provider, 18 years of experience)

Some SATUs only provide services to victims if they are willing to proceed with a case and have a forensic medical examination (FME). Funding issues and difficulties in securing and retaining qualified doctors to carry out the FMEs also affect service availability. Several service providers, particularly from rural areas, spoke about women having to remain in the same clothes they had been wearing at the time of the assault, for up to 2 and 3 days afterwards, while waiting for a suitably qualified FME. The likely occurrence of this appears to be determined largely by a woman's proximity to a SATU. As one participant commented:

... the SATU ... we're quite far away from Dublin and that fact that we don't have the personnel to offer a 24-hour service ... there are four social workers who are really keen for a SATU unit to be put in XX [name withheld] ... that's not going to happen for a very long time ... (RCC service provider, 6 years of experience)

Further comments were made about the uneven geographical spread of SATU services within Ireland. According to a national review, SATU services in Ireland 'have developed in a relatively fragmented way rather than as a co-ordinated strategy' (O'Shea 2006, p. 39). Consequently, a large portion of the population is under-served. One service provider remarked:

... I think if you look at the [SATU] services ... in general in the West of Ireland, in the Midlands and in the Northern part of the country, the border part of the country ... they are a scandal ... (SATU service provider, 16 years of experience)

Many of these issues require an urgent response, while others, such as public attitudes and behavioural change, will require a more carefully constructed and co-ordinated, inter-agency approach in the longer term. The findings are discussed in more detail as follows.

Discussion

A key strength of this study was its qualitative approach and its emphasis on service providers. Previous small-scale research undertaken in Ireland has identified some of the issues in the SV sector, but only within the context of victims' experiences of the judicial system and a national review of sexual assault services based largely on documentary data (Leane *et al.* 2001, O'Shea 2006). The use of qualitative methods in the current study provides useful insights into the key issues affecting victims and the experiences of service providers. The results suggest a distinct, yet subtle interplay between the themes and sub-themes. For example, is the shame and guilt that women feel after an experience of SV influenced by societal rape myths? Are the barriers identified here in some way related to the gaps in existing services? These and other questions require careful examination in the context of the present findings.

The role of rape myths

Rape myths have been defined as 'prejudicial, stereotyped or false beliefs about rape, rape victims and rapists' (Burt 1980, p. 1). Some examples of these – from both the current and other studies (Burt 1980) – include: 'women ask for it', 'all women secretly want to be raped' or 'women are only raped in dark alleys by a stranger'. A relatively recent UK telephone survey ($n = 1095$) (Amnesty International UK 2005) revealed some

worrying trends in public views and understanding of rape/sexual assault. Almost one-third felt that, if a woman was intoxicated, she was in some way responsible for being raped (p. 7), while more than one in five felt that a woman would be 'partially' or 'totally' responsible if she was walking alone in a dangerous or deserted area (Amnesty International UK 2005, p. 6). A recent attitude poll conducted in Ireland ($n = 1002$) reported similar results (Irish Examiner/Red C 2008). These societal myths and attitudes contrast sharply with official statistics which indicate that only a minority of Irish women are assaulted in a public place or outdoors (24%), and that the assault is more often carried out by someone they already know (79%) (McGee *et al.* 2002, pp. 98, 101). The impact of these rape myths means that many women have difficulty in defining what has happened to them. Thus, Kahn *et al.* (2003, p. 233) reported that at least half of women who have been raped 'do not label themselves as rape victims'. Our findings suggest that this can pose a significant barrier to accessing services.

Rape myths have also been found to compound the feelings of self-blame and guilt experienced by women in the aftermath of SV. Results from several studies indicate that the responsibility for the rape (in a hypothetical scenario) is often attributed to the woman (e.g. Acock & Ireland 1983, Renner *et al.* 1988). Furthermore, guilt and self-blame have been identified as strong reasons for non-reporting in female victims of acquaintance rape ($n = 236$) (Bachman 1998). Unsurprisingly, these feelings may affect a woman's decision to disclose, and it is interesting to note that 47% of the SAVI study sample had never told anyone about their experience of SV prior to taking part in the research (McGee *et al.* 2002, p. 121). Clearly, such internalised rape myths, in conjunction with a reluctance to name their experience as SV, may deter women from seeking help.

A small qualitative study ($n = 8$) by Ahrens (2002) found that some of the participants following negative interactions with service providers questioned whether they had actually experienced rape. Ahrens (2002) reported that these were rooted largely in rape myths and stereotypes. Participants who had initially disclosed their experience of SV to both formal (and informal) support providers proceeded to maintain their silence for some time after these interactions (Ahrens 2002). This delay in accessing support may, in turn, impact upon recovery from the effects of the assault and the knock-on consequences on their lives (Herman 2001). Interestingly, Sable *et al.* (2006) found that the concerns of women in the USA are still dominated by shame, guilt and embarrassment, despite 30 years of legal reforms and public education campaigns, and rape awareness activities on college campuses.

Gaps in our services and gaps in our society

Participants in this study referred to several important and persistent gaps, in the way society responds to victims of SV and in the inadequate provision of information/education and rape-related services. Some of the legal issues highlighted here and relating to the treatment of rape victims within the Irish CJS have been documented in some small-scale research within Ireland (e.g. Bacik *et al.* 1998, Leane *et al.* 2001), although much less is known about the adequacy of available support services across sectors generally. The findings also highlight an important need to increase the availability of support services including, in particular, the SATUs.

Leane *et al.* (2001) identified several inadequacies within the Irish CJS including delays in rape cases reaching trial, low rates in convictions and a lack of understanding of the psychological impact of rape. Our findings suggest that there has been little progress in providing an effective and a compassionate legal response to victims of SV. Our participants were very explicit about some of these legal barriers and the often-negative, stereotypical attitudes of CJS personnel. The key legal actors with whom victims engage include the Garda (police), prosecution and defence lawyers and judges. Training has been recommended for all of these personnel in relation to rape myths, rape trauma syndrome and sensitivity to victims (Leane *et al.* 2001). Notably, the Cork Sexual Violence Centre has just launched a step-by-step guide to the legal system for both professionals and clients proceeding with a rape case (Crilly 2007). A statutory agency, entitled The National Office for the Prevention of Domestic, Sexual and Gender-based Violence (known as 'Cosc'), has also been set up recently to combat violence against women (Women's Health Council 2007). Cosc has already expressed a strong interest in the current study, and it is hoped that our findings will be used to inform the development of appropriate and responsive services within the Irish CJS and perhaps farther afield.

All four SATUs in Ireland face several challenges including: the recruitment and retention of trained FMEs, the sometimes conflicting roles of nursing staff to provide appropriate out-of-hours cover (e.g. one of the SATUs relies on nurses from the gynaecological ward of the adjacent hospital) and the limited scope of service provision (e.g. Waterford SATU services are only available to victims who proceed to court) (O'Shea 2006). Comparable challenges exist within the UK. For instance, Coy *et al.* (2007) reported that fewer than one in four local authorities have a specialised SV support service (p. 33). Furthermore, Northern Ireland does not have a Sexual Assault Referral Centre, while its only RCC lost its government funding in July 2006 (Coy *et al.* 2007).

Thus, the geographical spread of services and unstable sources of funding, as in Ireland, mean that many regions are grossly under-served.

Since this study began, plans have been announced to establish two further SATUs in Ireland – one in the Midlands and a second in the west of the country (HSE 2007). The Irish government also announced funding of €1.5 million for SATUs for the remainder of 2007, and €2.5 million for every year thereafter (HSE 2007). These developments have come in timely response to a national review of sexual assault treatment services (O'Shea 2006). Nonetheless, our findings suggest that there is still considerable scope for improvement and for implementing some of the other key recommendations in the O'Shea report, such as standardizing existing services and commissioning needs-led research (O'Shea 2006). Unfortunately, the current downturn in the economy may pose an obstacle to implementing these recommendations and to ensuring that ring-fenced funding for the SV sector is provided into the future.

'Prevention is better than cure': education and awareness raising

Our findings are broadly consistent with the small pool of qualitative studies which have been conducted with counsellors/RCC staff in both the USA (O'Sullivan & Carlton 2001, Logan *et al.* 2005) and Australia (e.g. Carmody 1997). They represent a timely contribution to tackling the important issue of SV and provide some important cues to action. There is a cautious, but growing awareness of this crime in Ireland and of its impact on women, their families, neighbourhoods and communities, as well as the demands on health and social services. However, as long as the blame continues to be placed largely at the feet of victims, the societal problem of SV will remain unacknowledged. Our findings suggest that a substantial shift is required in our collective thinking about rape (e.g. who is a perpetrator; who is a victim).

Recently, the World Health Organization (WHO) highlighted an urgent need for the primary prevention of SV, including violence that occurs within intimate relationships (Harvey *et al.* 2007). The concept of primary prevention, in the context of SV, means 'reducing the number of new instances of intimate-partner violence (IPV) or sexual violence by intervening before any violence occurs' (Harvey *et al.* 2007, p. 5). A growing body of literature purports that rape prevention education can elicit the cognitive, emotional and behavioural changes required to develop a 'rape consciousness' (Lonsway *et al.* 1998, Klaw *et al.* 2005). Participants in our study repeatedly emphasised a pressing need for education and awareness-raising initiatives to address

negative stereotypes and rape myths; this is also underlined in six of the eight recommendations in the SAVI report (McGee *et al.* 2002). Recently, Fisher *et al.* (2008) examined the role of research in developing appropriate and effective rape prevention programmes and risk reduction interventions. They identified several key guiding concepts such as increasing awareness/knowledge about rape and reducing rape myths/rape supportive attitudes (Fisher *et al.* 2008). While some of the Irish RCCs run external education and training courses, these are, for the most part, not funded. Arguably, the need for more funding for extra staff should not be at the expense of explicit attempts at prevention, which should be funded solely by the Irish government (McGee *et al.* 2002).

Fortunately, this move towards primary prevention and awareness raising is already evident in certain service sectors both in Ireland and elsewhere. For example, the DRCC have just launched the first ever awareness-raising campaign (in conjunction with Cosc) and have commissioned a TV advertising and an outdoor poster campaign. Some of the issues in which Cosc has become involved include: ensuring the delivery of well-co-ordinated services for victims and raising awareness of the level and impact of these crimes and of local support services (<http://www.cosc.i.e.22/07/08>). These developments suggest the beginnings of a stirring in our collective consciousness that will hopefully increase our knowledge of this crime and begin to eradicate some well-known (and ultimately harmful) myths and stereotypes.

Education initiatives targeted at multilevels of society are clearly needed to create a less hostile environment and culture, where victims of SV can safely seek help, pursue and secure justice and heal from the trauma of their experiences. Klaw *et al.* (2005, p. 61) assert that 'intensive, sustained rape education efforts play a vital role in dismantling rape supportive culture'. Notably, however, the WHO indicates that the complex behaviours associated with SV may not be irrevocably changed using public information campaigns in isolation (Harvey *et al.* 2007). Thus, a longer-term, multi-pronged approach may be required in order to properly tackle this problem.

Conclusion

SV against women needs to be strategically positioned on the national and international radar. An evidence-based, co-ordinated and inter-agency response is required to address the issues raised here and, in particular, to dismantle the persistent societal rape myths and improve service provision. This may be achieved through ongoing school-, community- and media-based education and

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