Sexual Violence

www.wpanet.org

DEFINING TERMS

- **Sexual violence**: 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.
- **'Coercion'** as a spectrum of acts- apart from physical force, includes psychological intimidation, blackmail or other threats (eg: Threats of physical harm, being dismissed from job).

World Report on Violence and Health, WHO, 2002

DEFINING TERMS

- The WHO multi-country study operationalized sexual violence as acts through which a woman:
  - Was physically forced to have sexual intercourse when she did not want to.
  - Had sexual intercourse when she did not want to, because she was afraid of what her partner might do.
  - Was forced to do something sexual that she found degrading or humiliating.

- **Rape** is defined as 'Physically forced or otherwise coerced penetration – even if slight – of the vulva or anus, using a penis, other body parts or an object'.
  - Includes assault involving a sexual organ including coerced contact between the mouth and penis, vulva or anus.

WHO, 2012

- Coercive penetration of vagina, anus, mouth
- Attempted coercive penetration of orifice
- Sexual violence when the woman is under influence of a substance and cannot provide consent
- Sexual violence with threats to physical safety
- Unwanted sexual advances
- Sexual harassment
- Child sexual abuse including Incest

REASONS FOR UNDER REPORTING OF SEXUAL VIOLENCE

- Inadequate support systems
- Shame and stigma
- Risk/fear of retaliation
- Risk/fear being blamed
- Risk/fear of not being believed
- Risk/fear of being socially ostracized

MYTHS RELATED TO SEXUAL VIOLENCE

1. ‘No’ really means `yes’
2. Women love to be taken by force.
3. She was asking for it!
4. She provoked it (dress, location)
5. Women “cry rape” to punish men.

MYTH BUSTERS RELATED TO SEXUAL VIOLENCE

1. ‘No’ means ‘NO’. When women say No, they actually mean it.
2. Women do not like being forced for sexual activity and experience it as traumatic.
3. She never asked for it. You just wanted to blame her for the event.
4. People get raped in diverse attires & locations. Both aspects are not causative.
5. Survivors of sexual assault are often reluctant to speak up due to stigma and for fear that they will not be believed. Speaking about sexual assault requires courage.

ECOLOGICAL MODEL OF FACTORS ASSOCIATED WITH **PERPETRATION OF** SEXUAL VIOLENCE

WHO, 2002

INDIVIDUAL FACTORS IN PERPETRATORS

- Alcohol & drug use
- Coercive sexual fantasies.
- Impulsive and antisocial behaviors
- Preference for impersonal sex
- Hostility towards women
- History of sexual abuse as a child
- Witnessing family violence as a child

RELATIONSHIP FACTORS

- Perpetrator associating with sexually aggressive and delinquent peers
- Family environment characterized by physical violence
- Strongly patriarchal family environment

COMMUNITY FACTORS

- Poverty, unemployment mediated through forms of crisis of male identity
- Inadequate institutional support from police and judicial system for sexual assault crimes
- General tolerance of sexual assault within the community.
- Weak community sanctions against sexual violence.

SOCIETAL FACTORS

- Societal norms supportive of sexual violence, male superiority and sexual entitlement
- Weak laws related to sexual violence and low levels of conviction
- High levels of crime and weak/social sanctions especially in humanitarian crisis

TRAUMA INFORMED CARE

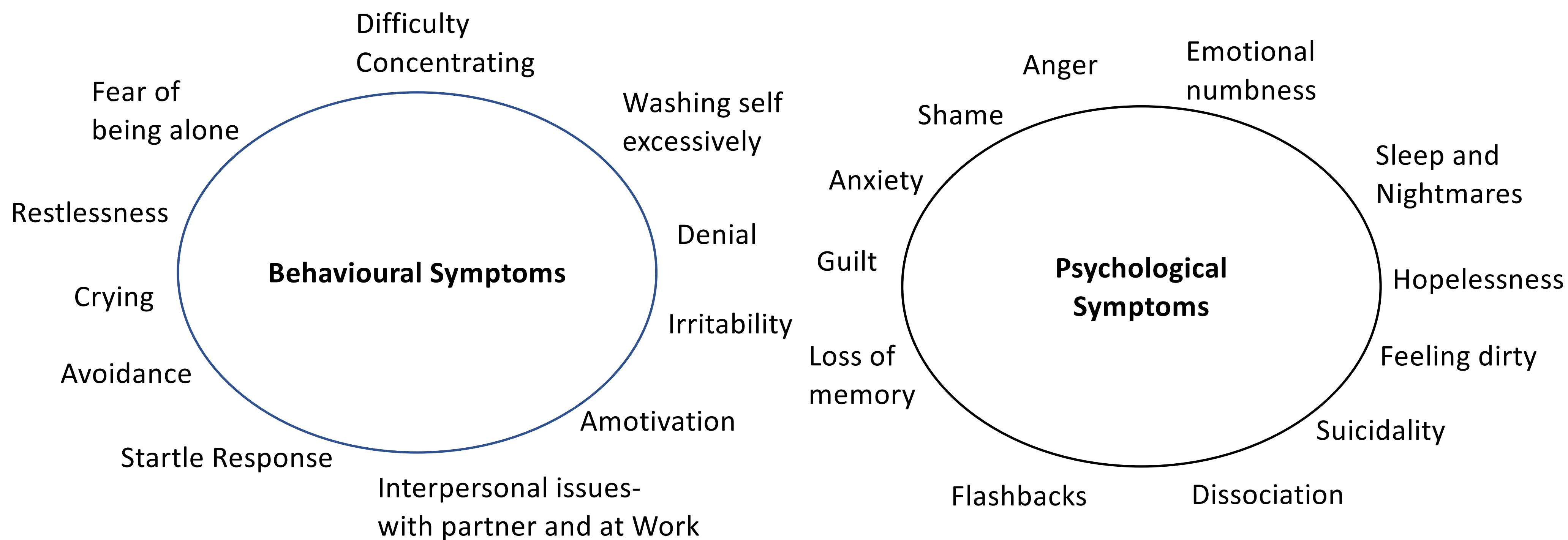
- A program, organization or system that…
- Realizes the widespread impact of trauma and…
- Understands the potential paths for recovery
- Recognizes the signs and symptoms of trauma…
- In clients, families, staff and others
- Responds by integrating knowledge about trauma…
- Intro policies, procedures and practices and
- Seeks to actively resit re-traumatization

SAMHSA 2014

FIRST LEVEL (IMMEDIATE) PSYCHOLOGICAL INTERVENTIONS FOR WOMEN WHO HAVE EXPERIENCED SEXUAL VIOLENCE

- Sexual Violence especially Sexual Assault is severely traumatic and associated with immediate psychological reactions and distress.
- Sensitive and supportive counselling received at the time of first contact may determine later coping
- Validating the survivor's experiences helps to prevent self-blame and shame

FIRST LINE PSYCHOLOGICAL INTERVENTIONS
WHAT TO LOOK FOR AT THIS STAGE?



- Validation and offering reassurance.
- Allowing expression of Emotions
- Gradual recounting of the experience keeping the woman's comfort and distress into account and at her own pace
- Explaining what to do during an emergency
- Conducting Risk Assessment for self harm
- Establishing no suicide and no self harm contract
- Teaching relaxation methods.
- Finding and practicing suitable grounding methods.

PREPARING FOR POLICE AND LEGAL PROCEDURES (if the woman decides to report)

- Educating the woman about ensuing legal events
- Helping to understand the legal process as aiding empowerment
- Discussing resources for support during the difficult phases in the process
- Reviewing relaxation and grounding methods that can be used if she is distressed
- Discussing possible flashbacks or anxiety during legal and police procedures

PREPARING FOR THE MEDICAL EXAMINATION

- Educating in detail about the purpose for medical examination (it is an important part of evidence if she decides to press charges).

- Discussing what constitutes the medical examination with explanation.

- Discussing expected responses of fear of touch, startle response to touch and helping using basic grounding methods.

FIRST LINE PSYCHOLOGICAL INTERVENTIONS

Identifying the Stage of Psychological Reaction to Sexual Assault:

- **The acute phase-** Starts immediately after the assault and may last for several weeks or months and may result in the complete disruption of the survivor's life.

- **The reorganization phase-** May continue for months or years, encompasses the survivor's process of reorganizing her disrupted life.

- **The restitution phase-** Rehabilitation occurs in this final stage.

Burgess & Holmstrom, 1974

FIRST LINE PSYCHOLOGICAL INTERVENTIONS

Role of the mental health professional in first line intervention:

Acute Phase

- Physical and Psychological Safety
- Information regarding medical examination and treatment
- Information about emergency contraception and STD/HIV prophylaxis
- Sensitive Discussion about medical and forensic examination
- Education and preparation for the police report

Reorganization and Restitution Phase

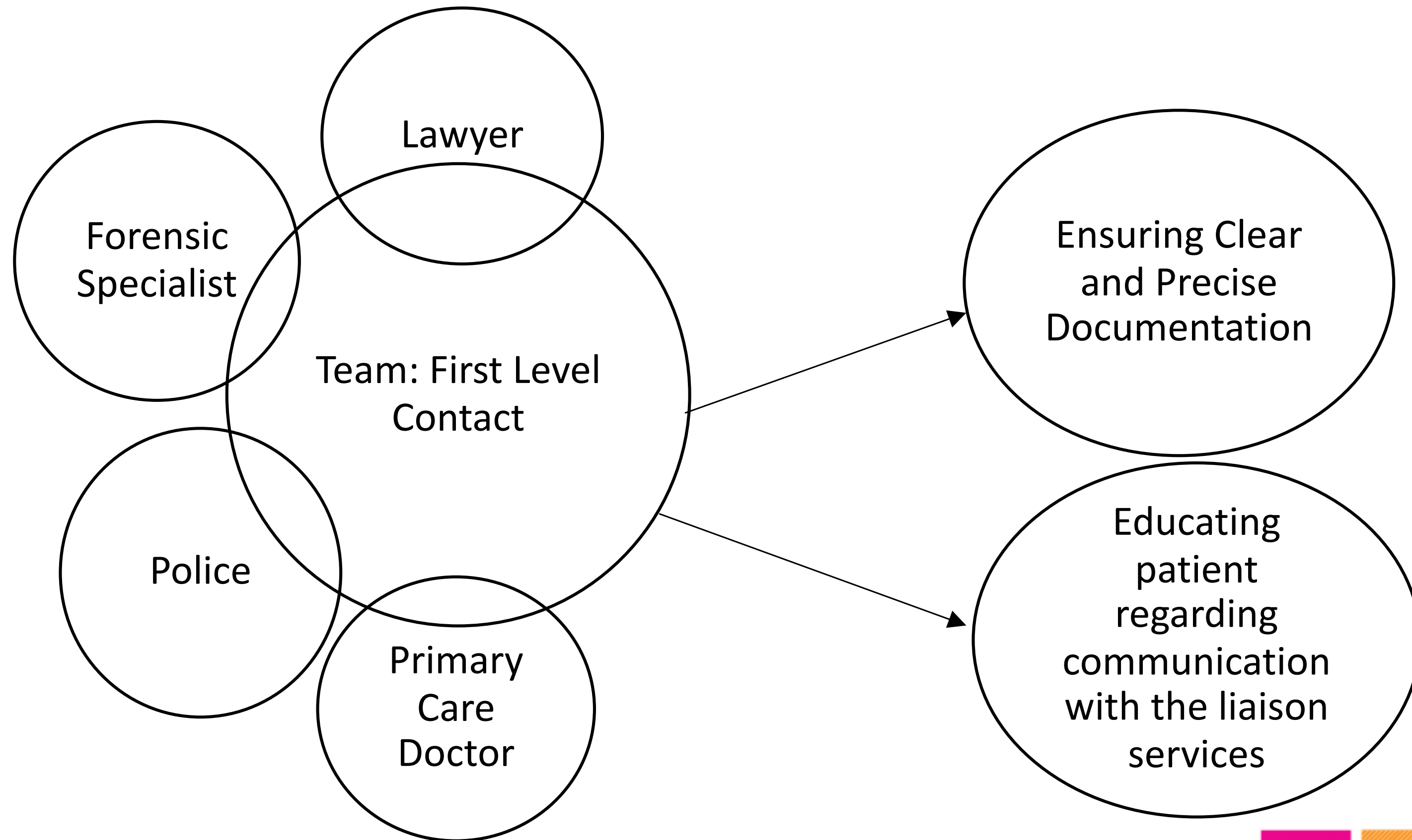
- Discussing triggers of re- experiencing trauma.
- Ongoing counselling support.
- Accepting body, addressing shame.
- Discussing interpersonal issues.
- Working with family or partner

WHEN SHOULD A WOMAN BE REFERRED TO A MENTAL HEALTH PROFESSIONAL?

- Suicidal risk or Self Harm
- Severe & persistent emotional dysregulation
- Substance use.
- PTSD and dissociative symptoms
- Past history of mental illness
- Intellectual disability and Neurodevelopmental Disorders
- Depression & anxiety symptoms.
- Psychotic Symptoms

FIRST LINE PSYCHOLOGICAL INTERVENTIONS

LIAISON WITH OTHER KEY SERVICES



FIRST LINE PSYCHOLOGICAL INTERVENTIONS

WOMEN WITH PHYSICAL OR DEVELOPMENTAL DISABILITIES AND/OR MENTAL ILLNESS

- High vulnerability to sexual violence and may have special needs.
- Difficulty in understanding the traumatic experience or reporting.
- Women reporting while in an episode of mental illness, may be 'not believed' or be dismissed casually.
- Awareness of additional help required to enable feeling safe and to communicate distress.
- Psychiatric assistance immediately after first level interventions should be arranged, if seen necessary.

LONG -TERM INTERVENTIONS FOR PSYCHOLOGICAL CONSEQUENCES OF TRAUMA FROM SEXUAL VIOLENCE

- Trauma-focused psychological intervention
- Exposure based intervention
- Interventions with moderate evidence
- Multicomponent intervention

TRAUMA-FOCUSED PSYCHOLOGICAL INTERVENTION

1. Trauma Focused Cognitive Behaviour Therapy (TF CBT)

- Evidence based intervention for adolescent and adult survivors of trauma.
- Follows a trauma informed format of CBT protocol.
- Designed to be delivered in 12 to 16 weekly sessions.
- Psycho-education, relaxation methods, in-vivo exposure, cognitive restructuring

Follette & Ruzek, 2007

EXPOSURE BASED INTERVENTION

1. Prolonged Exposure Therapy
   - Exposure corrects erroneous stimulus-stimulus and stimulus-response associations and mistaken evaluations.
   - 8-to-15-session protocol, typically provided in weekly or bi-weekly basis, 60-to-90 minute sessions.
   - Techniques used are relaxation, psychoeducation
   - Imaginal exposure progresses to In-Vivo exposure techniques.

Follette & Ruzek, 2007

1. Cognitive Processing Therapy
   - Uses methods such as Psychoeducation, Socratic questioning and Cognitive restructuring.
2. Narrative Exposure Therapy – NET
   - Reprocessing, meaning-making and integration is facilitated.
3. Eye Movement Desensitization and Reprocessing
   - Uses bilateral saccadic eye-movements while recounting events.
4. Antidepressants
   - Venlafaxine, paroxetine, fluoxetine

MULTICOMPONENT INTERVENTIONS

- Systematic review and component network meta-analysis with 94 RCTs, for a total of 6,158 participants, were included across the primary and secondary outcomes

- Evidence for efficacy of multimodal interventions for survivors of sexual violence.

- Multicomponent interventions that include cognitive restructuring and imaginal exposure were the most effective for reducing PTSD symptoms.

Coventry et al, 2020

TRAINING PSYCHIATRISTS

- Need for training psychiatrists and residents on discussing sexual well-being and sexual violence as a health care issue.

- Primary and Secondary prevention strategies:
  - Trauma focused training of professionals
  - Developing clinically integrated teams in psychiatric settings for women reporting sexual assault
  - Awareness about community resources
  - Addressing safety, lack of financial resources and homelessness.

Coverdale, 2019

THANK YOU

WPA Secretariat
Geneva University Psychiatric Hospital
HUG – Belle Idée – Bât.11 Les Voirons
2, ch. du Petit-Bel-Air,
1226 Thônex, Switzerland
T : +41 22 305 57 37
F : +41 22 305 57 35
E : wpasecretariat@wpanet.org
www.wpanet.org