Rape and Sexual Assault

NHS SCOTLAND

What health workers need to know about gender-based violence

The Scottish Government has introduced a national programme of work across NHS Scotland to improve the identification and management of gender-based violence. A national team has been established to support its implementation.

This guide is one of a series developed by the programme to support health staff. It has been written and compiled by Shirley Henderson (Shirley Henderson -writing, editing and consultancy, www.shirleyhenderson.co.uk) and Katie Cosgrove, Programme Manager (GBV Programme, NHS Scotland).

Thanks to the National GBV Reference group who also contributed to its development.

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Who is this guide for?

This guide is one of a series designed to support health workers to work effectively with the victims of gender-based violence in line with national guidance issued to health boards[a,b], and the Scottish Government's shared approach to tackling violence against women.[c]

As a health worker you are in a unique position to respond to such abuse. You are not expected to be an expert or to provide everything a patient needs, but you can play a crucial part in improving the immediate and long-term health impact on all those affected.

The series of practice guides covers the following aspects of gender-based violence:[d]

- **What health workers need to know about gender-based violence: an overview**
- **Domestic abuse**
- **Rape and sexual assault**
- **Childhood sexual abuse (adult survivors)**
- **Commercial sexual exploitation**
- **Stalking and harassment**
- **Harmful traditional practices (for example, forced marriage, female genital mutilation, and so-called 'honour' crimes)**

Note: Given prevalence statistics, the terminology used in this guide assumes victims are female and perpetrators are male. This is not always the case, however, and the principles of the healthcare response apply to both women and men.

[a] Gender-based violence encompasses a range of abuse most often perpetrated by men against women and girls. It includes domestic abuse, rape and sexual assault, childhood sexual abuse, commercial sexual exploitation, stalking and harassment and harmful traditional practices, such as forced marriage and female genital mutilation.
[b] SGHD Chief Executive's Letter to health boards on identifying and responding to gender-based violence www.sehd.scot.nhs.uk/mels/CEL2008_42.pdf
[c] 'Safer Lives: Changed Lives. A Shared Approach to Tackling Violence against Women in Scotland'' Scottish Government 2009 www.scotland.gov.uk/Publications/2009/06/02153519/0
[d] These are available at www.gbv.nhs.scot.uk

What are rape and sexual assault?

Rape and sexual assault are sexual acts which take place without someone's consent.

Such sexual violence can have a devastating effect on health and wellbeing. At present, rape is narrowly defined under the law as forced penetration of the vagina by the penis without consent. There is new legislation on sexual offences which will be implemented in 2010 which will broaden this definition to include vaginal, anal and oral penetration without consent.[1] Sexual assault covers other forms of frightening and distressing sexual violence including:

- Being forced to have oral/anal sex
- Penetration by objects
- Being forcibly touched in a sexual manner
- Sexual harassment

Rape or sexual assault can be one-off or repeated. Some women are violated over years, for example by an abusive partner. Others may be raped or sexually assaulted by different people at different times in their lives. Humiliation and degradation are often an intrinsic part of ongoing sexual violence, for example being forced to watch or act out pornography. Asylum seekers and refugees may have been sexually violated as victims of war or torture.

There is a misconception that rape and sexual assault are usually carried out by strangers and involve force, yet in most cases, assaults are carried out by someone known to the victim. This includes sexual partners, casual acquaintances, family members, colleagues and others. Most rapes are committed indoors, usually in the home.

Unlike other crimes, victims are often held responsible for sexual violence. Recent surveys have shown high levels of blame relating to alcohol intake, style of dress, flirting and sexual history.[2]

The many myths about sexual violence, combined with the low prosecution rate, means that women often minimise what has happened or think they may be blamed or that they are to blame for the assault. They may try to conceal it and be reluctant to disclose through shame or fear.

7% of women and 0.4% of men experience rape[3]

23% of women and 3% of men experience sexual assault as adults[4]

In 54% of cases, the perpetrator is the current (45%) or ex (9%) partner of the victim[5]

One in seven women experiences rape in marriage[6]

Who is at risk?

The key risk factor for experiencing sexual violence is being female.

There is a higher prevalence of sexual violence amongst young women but it can happen to anyone of any age. Since gender-based violence is so common, many women experience more than one form of abuse during their lifetime.

Sexual victimisation in childhood or adolescence increases the risk of both physical and sexual abuse in adulthood. Within the context of commercial sexual exploitation, women report repeat victimisation.[7]

Male victims of sexual violence

Although fewer men than women are sexually assaulted, the health and emotional effects are just as severe. It may be very difficult for men to talk about what has happened because of a commonly held view that men should be 'strong' and able to protect themselves or (in the case of men who are straight) because they think the assault has 'made them gay'.

Since sexual assault of men is less common, they may not come forward because they think they will not be believed. But men are affected and it is vital that they get help.

How rape and sexual assault affect health

Rape and sexual assault can have a serious effect on short and long-term physical and mental health.

This may vary according to the nature of the assault, when it took place, previous history of abuse (sexual or otherwise) and the other circumstances of an individual's life.

Experiencing sexual violence as an adult can trigger intense reactions for those who experienced sexual abuse as a child and is linked to significantly elevated levels of post-traumatic stress disorder (PTSD) and depression.[8] Research on the health impact of sexual violence within intimate relationships identifies higher levels of depression and anxiety, PTSD and gynaecological disorders than those associated with physical violence alone.[9] Cumulative experiences of repeat victimisation can lead to what is described as complex post-traumatic stress disorder.[10]

For healthcare staff, there are implications beyond immediate crisis intervention. A quarter of adult rape victims experience severe and long-term impacts.[11] Repeated abuse exacerbates these impacts. Women might present with the following health problems:

Physical

- **Shock, injury and trauma**
- **Possible pregnancy**
- **STIs and urinary tract infections**
- **Lower abdominal pain and lower back pain**
- **Headaches**
- **Difficulty in defecating and bowel disorders**
- **Sexual dysfunction**
- **Gynaecological problems**

Mental

- **Self-harming**
- **Depression, anxiety**
- **Addiction issues**
- **Sleep and eating disturbances**
- **Panic attacks**
- **Flashbacks**
- **Suicidal feelings**
- **Post traumatic stress disorder**

Your role as a health worker

Health staff, particularly those working specifically in women's health, are in a unique position to identify sexual violence.

No matter how much time has passed since an assault, it is never too late to offer treatment and support. Unresolved sexual trauma is more likely to occur when the victim

- Has had little support
- Has not disclosed to anyone or had a poor reaction to disclosure and
- Is unable to settle her reactions to the experience

For women sexually abused as children, sexual assault in adulthood can re-awaken memories of previous assault and their reaction may be all the more intense.[12]

Disclosure of any form of sexual violence is difficult, sometimes distressing, for victims, whether it is a recent or historical experience. Violation, particularly sexual violation, can leave victims feeling dirty, ashamed and often vulnerable.

In all encounters with patients, you bring your own beliefs, value systems and cultural experiences. Being aware of these and of how you understand sexual violence is crucial in detecting and responding to victims of sexual violence.

Identifying rape and sexual assault

Women who have been raped or sexually assaulted could present in any primary or acute care setting.

This may be in the immediate aftermath of an assault, in the context of ongoing abuse after weeks, months or even years. They may have been assaulted once or repeatedly. Be aware of how they might present in your setting and that this may be for recent, ongoing or historical assault. It may not be immediately apparent that a woman has been raped or sexually assaulted especially if the abuse is historical or within an intimate relationship; women often go to great lengths to conceal it.

There are some signs, clinical and behavioural, which may make you suspicious, in addition to the health problems noted earlier. The effects of sexual violence can be varied and significant. Immediately following rape or sexual assault some women will be visibly distressed while others may appear very calm. Acute and long-term reactions are shown opposite.

Barriers to disclosure

There are also barriers which deter women from seeking help, including:

- **Fear of being disbelieved and judged –** women are likely to be very sensitive to any indication that they are not being believed given the self-blame and feelings of shame which often accompany sexual violation. Some situations intensify this fear, for example drug assisted rape, if alcohol is involved, or if women think they will be seen as 'contributing' in some way to what happened

- **Not conceptualising the experience as sexual violence –** given the general myths and stereotypes that exist, women may have a particular idea of sexual violence, e.g. that it is committed by a stranger out of doors. Depending on the circumstances, they may find it difficult to talk about being raped or sexually assaulted for example:

  – women who are sexually abused by their partners may believe, or think others believe, that they cannot be violated by someone with whom they have, or had,

a sexual relationship. In the context of ongoing abuse, this view may be more entrenched. There may be additional cultural beliefs that a man cannot rape his wife[13]

- In some cultures, woman may be considered responsible for bringing dishonour on the family

- Women raped or sexually assaulted in prostitution may think it will be dismissed as an 'occupational hazard' or that people will not consider rape possible within prostitution or the 'sex industry'

- **Not seeing connections with presenting problem or symptoms –** often the health impact of rape and sexual assault endures after the initial injuries or shock. Women may therefore not associate health problems with the trauma they experienced or they may think that it will be dismissed or they will be told *"it's in the past, you have to get over it"*

- **Language and cultural barriers –** there may be communication barriers, for example for women whose first language is not English or women with learning disabilities. These may make it difficult for them to understand unfamiliar terminology or concepts. They may need additional support to access services, for example, advocates or interpreters

Fear of being intrusive makes many healthcare professionals reluctant to ask about sexual violence, yet research indicates that women want to be asked about abuse. It gives them the chance to speak about their experience and to receive help.

Reactions to rape and sexual assault

Acute

- **Shock and disbelief which can be controlled or expressed**
- **Physical pain, which can be generalised or in a specific area traumatised by the assault**
- **Sleep and eating disturbances and emotional reactions**

Long-term

- **Physical problems such as gynaecological and menstrual disorders**
- **Musco-skeletal pain, general malaise, disruption to sleep and eating**
- **Psychological problems, including dreams and phobias e.g. fear of going out**
- **Sexual problems such as fear of, or loss of interest in, sex**

Other indicators include

- **Minor health procedures triggering symptoms of rape trauma, for example pap test, gynaecological examinations, dental treatment**
- **Silence, anger or difficulty discussing the assault e.g. displaced anger, refusing medical treatment**

What every health professional can do

All health workers should

- Be aware that rape and sexual assault, recent or historical, are a possibility
- Recognise signs and symptoms; initiate discussion
- Listen and make time
- Give correct information about sources of help

Sexual violence is a serious health issue and you have a duty to those affected. If you intervene sensitively and appropriately, you could improve long-term health and well-being. Rarely would your actions make things worse.

Although a minority of men experience sexual violation, they may face additional barriers in disclosing an experience that they may feel has emasculated them or made them look 'weak'. It is also important to be aware that this abuse may also have been in the context of domestic abuse, particularly in same sex relationships.

Support disclosure

Routine enquiry of domestic abuse is being introduced into mental health, sexual and reproductive health, A&E, addictions, community nursing and maternity settings. For all settings, if you suspect that someone may be affected by rape and sexual assault, it is your responsibility to introduce the subject sensitively and ask. If rape or sexual assault is disclosed, your intervention will be partly determined by the setting you work in, whether this is a one-off or ongoing contact, and by the circumstances of the assault, that is, if it is recent, ongoing or historical sexual violence.

Whatever the situation, however, it is essential to create an atmosphere which is conducive to disclosure and which will provide appropriate care. In cases of drug-assisted rape a woman may have little memory left. She may have other evidence to suggest something has happened, such as bruises or bleeding or may find herself somewhere or with someone she does not know. For attacks which happened some time ago, she may have started recalling fragments of memory. This can be very distressing.

- **Provide a safe, quiet and confidential space –** ensuring privacy and confidentiality is essential for protecting women who have been raped or sexually assaulted. Reassure her about confidentiality but tell her about the limits to this. Go at the woman's pace – it may take some time

- **Ask non-threatening and open questions –** enquire gently if you think there might be problems, for example, *'Has anyone ever touched you sexually when you did not want them to or forced you to do something sexual?'*

  The effect of shock and trauma may mean that a woman's recollection of what has happened is hazy. If alcohol/drugs were involved (including drug-assisted rape/sexual asault), the woman may remember very little

- **Treat the patient with respect and dignity –** it is not easy to disclose sexual violence and she may feel embarrassed, humiliated and distressed. Listen and be sensitive, for example *'I'm sorry that this has happened to you. It takes a lot of courage to talk about something like this.'* Be non-judgemental, supportive and sympathetic

- **Validate her experience by telling her that you believe her and reassure her that she is not to blame –** do not suggest by word or attitude that you hold her responsible in

Women who are able to talk about sexual violence and who receive responses which are supportive, empathic and non-judgemental experience fewer trauma-related symptoms and are more likely to recover

any way for the attack. Discussion with colleagues and unguarded telephone calls within earshot of the patient may be particularly distressing and remembered long after the incident

- **Validate her feelings and acknowledge the impact of the abuse –** reassure her that her response to the assault is a normal reaction to an abnormal experience

- **Check whether she wants to speak to a male or female health worker**

- **Ensure access –** for example to interpreting services. If necessary, provide an interpreter for hearing impaired patients or those whose first language is not English, or an advocate for someone with a learning disability. The interpreter must be professional. Do not use family or friends. It is also important to check that key issues such as confidentiality are explained carefully since these may be unfamiliar to people who have immigrated to the UK

Be aware of barriers such as age, poverty, language and disability which can increase vulnerability and limit access to help and services. You may need to provide specific support, for example interpreters or assistance with transport

Adult support and protection

Consider vulnerability and whether the patient is an adult who is *"unable to safeguard their own interests though disability, mental disorder, illness or physical or mental infirmity, and who are at risk of harm or self harm, including neglect"* as defined by the Adult Support and Protection Act, (October 2008) and therefore in need of more directive intervention.

It is important to be aware that sexual violence may also have been in the context of domestic abuse

Recent and/or ongoing abuse

Assessment and treatment

Providing an accessible, non-stigmatising response will potentially have a stabilising influence on the subsequent, longer-term impact of rape and sexual assault. If someone presents to your service after a **recent** rape or sexual assault, you should:

- Treat any immediate physical or medical conditions requiring attention or make necessary arrangements
- Never 'interrogate' the patient about the incident. If she seems distressed, ask her if she would prefer you to ask questions to which she only needs to reply 'yes' or 'no'. Only ask questions about symptoms, injuries or relevant past medical history but allow the patient to talk as little or as much as she wishes, noting down carefully - as far as possible verbatim - what she says
- Check whether she wants to report to the police. If so, contact them. Do not examine the patient. If the police are involved, an examination by a forensic specialist will be arranged. Follow local protocols
- Ensure that no items of clothing and so on are discarded. Explain that it is important that she does not wash. Try to make her as comfortable as possible while waiting for the police and forensic examination
- If the assault may have been 'drug assisted' and the woman wants to involve the police, is important to do this as soon as possible as traces of the drugs can leave the system very quickly, along with other forensic evidence. This varies depending on the drug. Some leave no trace after 12 hours

Whether the abuse is recent, ongoing, or past will be important in determining your intervention

If she does not want the police to be involved

- Address any immediate concerns
- Do not attempt any form of pelvic examination. The patient may later wish to report the matter to the police after the shock of the crisis, so it is important that evidence is available if required later since this may be retrievable for up to seven days[14]
- Evaluate the risk of pregnancy either to prescribe emergency contraception or to ensure appropriate management
- Assess wish/need for referral for further assessment and screening, particularly for sexually transmitted infections, and counselling
- Depending on the setting, consider admission as a 'haven' to help recovery

Safety and referral

- Discuss safety concerns for the woman and any children. If the perpetrator is known to her, check how this affects both her feelings about the assault and the options available
- If the sexual violence is in the context of domestic abuse, check whether she feels safe about returning home and if not help her find a safe alternative
- For women abused in prostitution, give details of any specialist local support services (Rape Crisis can provide details of these)
- Tell her how she can get information about legal rights and criminal prosecution

- Give her correct information about local support agencies including the **Rape Crisis Scotland Helpline 08088 01 03 02** and the **Domestic Abuse Helpline 0800 027 1234 (24 hours)**
- Give supporting literature in a format she can use
- If appropriate, provide aftercare and follow up. Always consider the woman's safety and how any approach you make might affect this
- Stress that she can ask the NHS for help at any time
- If the woman is in need of protection as defined by the Adult Support and Protection Act, follow local procedures to provide appropriate support

Whatever the woman decides to do next, you should support her and help her plan for her safety.

Child protection

If sexual violence has occurred within the context of an intimate relationship, it may be part of a systematic pattern of domestic abuse and this should significantly increase your suspicion that any children in the family may be at risk.

While the existence of domestic abuse does not require you to automatically instigate child protection procedures, your risk assessment of the woman should include risks to any children in the family.

Documenting and recording

Keep detailed records as this may build up a picture over time if there is a pattern of sexual violence within an intimate relationship. This is important health information which will enable continuity of care. It may also help in any future legal proceedings.

Women may be anxious about the confidentiality of medical records. Reassure them about this but explain that if someone, especially a child, is at risk of significant harm, this overrides confidentiality requirements. Explain the benefits of keeping a record. The following should be included:

- Exact time of any examination
- General state and demeanour of the patient
- State of clothing and make-up
- Any bruises, scratches or other injuries
- Note of what the victim has said about the assault and assailant, as far as possible in her own words
- Outcome of risk assessment
- Action taken

Sharing information

You may need to share information about a particular case. It may be required by law, for example, as required in the Adult Support and Protection Act, or it may be necessary to share information with support agencies to make sure that the woman and any children are safe and properly supported. Discuss with the woman about notifying her GP to allow for continuity of care.

Key elements of a health response in the aftermath of a recent sexual assault or rape

- **Treatment and documentation of injuries**
- **Collection of medico-legal evidence and maintaining chain of evidence**
- **Treatment and evaluation of STIs**
- **Pregnancy risk evaluation and prevention**
- **Crisis intervention and arrangement of follow up counselling**

Historical rape and sexual assault

A disclosure of sexual victimisation may come months or years after the abuse has occurred.

There may not be issues about immediate danger, but about unresolved physical or emotional trauma such as pelvic pain. Sometimes the significance of past events may be appreciated by the patient, but not always.

The setting within which sexual violence is disclosed and the timing of the disclosure may be very significant. Do not assume that any unresolved issues about sexual violence always require counselling or mental health interventions. For example, a woman may disclose sexual violence to a midwife because she is anxious about childbirth and the invasiveness of clinical procedures. She may need to be able to talk through the options and consider how best she can control the situation. Similarly, a woman seeking dental treatment who has previous experience of oral assault may need to be able to discuss strategies for coping with her fear about dental treatment with the staff providing her care.

Assessment and treatment

- Check the meaning of the experience(s) for the woman and the reason for her disclosure
- If relevant, ask how she thinks this has affected her life
- Discuss the impact on her health, and whether it is still affecting her physically, sexually and/or emotionally
- Discuss with her what she thinks she needs from your service
- Offer to refer her to further specialist services if she thinks this would be helpful

Support and information

- Give the woman correct information about local support agencies including the **Rape Crisis Scotland Helpline 08088 01 03 02** and **the Domestic Abuse Helpline 0800 027 1234**
- Give supporting literature in a format she can use

Documenting and recording

Any disclosure of sexual violence should be recorded since it is important health information which will enable continuity of care. It may also help in any future legal proceedings, for example if she decides to report at a future date. Include:

- What the woman says occurred
- The nature of the consultation and significance of the experience of sexual assault to this
- Action taken and note of any referral

**Sometimes the significance of past events may be appreciated by the patient, but not always.
The setting within which sexual violence is disclosed and the timing of the disclosure may be very significant. Do not assume that any unresolved issues about sexual violence always require counselling or mental health interventions**

Support for staff

Supporting someone who is experiencing, or has experienced, sexual violence can be stressful. At times it can be distressing to hear accounts of trauma and abuse, and you may be worried that you might be overwhelmed by it. It is also common to feel frustrated or helpless if you cannot 'solve' the problem for someone. In these situations it is important to be able to acknowledge how you feel and seek support or guidance from a supervisor or colleague.

Given the prevalence of sexual violence, and the number of people employed in the NHS, this may directly affect you or a colleague. If you have experienced sexual violence, it is important to recognise how this may be affecting you. If you are being sexually abused by a current or former partner, there should be a local employee policy on domestic abuse within your health board that provides guidance on how you can be supported at work, and of any help available, for example occupational health or employee counselling. The latter may also be able to offer support if you have been raped or sexually assaulted by someone other than a partner.

You may find it helpful to contact the Rape Crisis Helpline for support and information. Women's Aid and the Domestic Abuse Helpline can also provide advice.

Further information

Rape Crisis Scotland:
Information about rape and sexual assault and main contact for network of local centres
www.rapecrisisscotland.org.uk
Helpline **08088 01 03 02** (daily, 6pm-midnight)

Survivors UK National Helpline:
information, support and counselling for men who have been raped or sexually abused
www.survivorsuk.org
0845 122 1201
Tuesday and Thursday 7pm-10pm

Domestic Abuse Helpline 0800 027 1234 (24 hours)
www.domesticabuse.co.uk

www.scotland.gov.uk/Publications/2008/04/16112631/0 information and help after rape and sexual assault

Survivor Scotland
Scottish Government information and education resource on childhood sexual abuse
www.survivorscotland.org.uk

Women's Support Project
information, support and training on violence against women and children
www.womenssupportproject.co.uk

Role of local health boards

As part of the implementation of the CEL on gender-based violence and the Public Sector Duty for Gender, your health board should have an identified lead to help staff address gender-based violence and direct you towards training and further information.

Your health board should also be represented on its local Violence Against Women Training Consortium. Training for health staff may also be available through the consortium.

References

[1] The Sexual Offences (Scotland) Act 2009.

[2] Amnesty International research and domestic abuse evaluation (2007). www.scotland.gov.uk/publications/2007/08/01142941/0

[3] Walby, S. & Allen, J. (2004) 'Domestic violence, sexual assault and stalking:findings from the British Crime Survey'. Home Office Research Study 276. London.

[4] Ibid.

[5] Myhill, A. & Allen, J. (2002) 'Rape and sexual assault of women: the extent and nature of the problem'. Home Office research Study 237. London.

[6] Painter, K. (1991) 'Wife rape, marriage and the law'. Manchester: University of Manchester, Faculty of Economic and Social Studies.

[7] Three in four women who sought help from the Council for Prostitution Alternatives in 1991 reported being raped an average of 16 times a year by pimps, and 33 times a year by clients. Council for Prostitution Alternatives, Annual Report, 1991, Portland, Oregon.

[8] Campbell, R (2001), 'Mental health issues for rape survivors: current issues in therapeutic practice'. Violence against Women online resources. www.vaw.umn.edu.

[9] Ibid.

[10] Herman, J. (1992) 'Trauma and recovery'. New York: Basic Books.

[11] Hanson, (1990) 'The Psychological Impact of Sexual Assault on Women and Children: A Review' Annuls of Sex Research, 187-232.

[12] Burgess, A.W. & Holmstrom, L (1974) 'Rape trauma syndrome'. American Journal of Psychiatry, 131 981-986.

[13] In Scotland, rape in marriage has only been a crime since 1989.

[14] If the woman lives in Greater Glasgow area, she can be referred to ARCHWAY (Sexual Assault Referral Centre) which will undertake the examination and store the forensic evidence in case she decides to report the assault to the police at a later date. It will also offer medical and social support.

Local information and notes

This page is for you to record any local information or services for your area

You can download this guide online at: www.gbv.scot.nhs.uk