Understanding sexual violence and the implications for practice

McMillan, Lesley

Published in:
Obstetrics, Gynaecology and Reproductive Medicine

DOI:
10.1016/j.ogrm.2023.09.001

Publication date:
2023

Document Version
Author accepted manuscript

Understanding Sexual Violence & Implications for Practice

McMillan, Lesley

Published in:
Obstetrics, Gynaecology and Reproductive Medicine

Publication date:
2023

Understanding Sexual Violence & Implications for Practice
Obstetrics, Gynaecology and Reproductive Medicine

Professor Lesley McMillan
Glasgow Caledonian University

Abstract
Sexual violence is a significant social problem and rates of victimisation are high. Women face a disproportionate risk of sexual violence, and the impacts and consequences are considerable. These consequences can be physical, psychological, emotional, social and interpersonal. Sexual violence is not commonly disclosed and many women presenting in gynaecologic, obstetric and reproductive medicine practice will have had experiences of sexual violence in their lifetime. These experiences can impact upon experiences of engagement with heath care. Clinicians should be aware of the forms, prevalence and impact of sexual violence in the lives of women and its potential consequences for health care. Sensitive and trauma-informed practices, particularly around intimate examinations, are vital.

Key Words
Sexual violence, sexual assault, rape, trauma, trauma-informed care

Introduction
Sexual violence is an immense social problem across the globe. It manifests in different ways in different contexts, and no space or place is immune. Forms sexual violence can take includes but is not limited to: rape; sexual assault; unwanted sexual touching; the use of inappropriate sexual language; non-consensual sharing of sexual images; indecent exposure; and child sexual abuse and exploitation. Sexual violence is also a common element of domestically abusive and coercively controlling relationships, where abusive and controlling partners may perpetrate sexual violence, and may also seek to exercise control over reproductive, contraceptive, gynaecological and obstetric choices. Pregnancy is also a known risk factor for the escalation of domestic abuse, which may include sexual violence. Patients with experience of sexual violence will present regularly in gynaecology and obstetric practice, though many will not disclose their experiences. It is vital that clinicians are sensitive to the likelihood of sexual violence experience in their patients, aware of the impact and physical and mental health sequalae associated with sexual violence, and be prepared to offer trauma-informed and sensitive care. This requires clinicians to challenge their own views about sexual violence and confront their own capacity for judgement. The health sector has a crucial role to play addressing the health implications of sexual violence, mitigating the barriers sexual violence may pose for access to healthcare, and signposting survivors to appropriate support and care.

Prevalence & Incidence of Sexual Violence
Measuring prevalence and incidence of sexual violence is notoriously difficult because the majority of sexual violence happens in private spaces, by known men, and without witnesses. It is also difficult to measure because many of those who experience sexual violence do not disclose it. For example, a study in the United States in the 1990s found 91% of women who were raped had told no one prior to taking part in the research. Sexual violence is notoriously under-reported to formal authorities, be that criminal justice, social work, health care professionals or other agencies, making estimates of prevalence difficult. Another study in the United States suggests that as few as 5% of rapes are reported to the police meaning prevalence estimates from formal authorities are not an accurate representation of the scale of the issue.

Self-report studies tend to show higher levels of prevalence that data recorded by state agencies. Diana Russell's studies in the early 1980s indicated 44% of US women in a randomly generated sample had experienced rape or attempted rape. We find lifetime prevalence rates tend to cluster closer together. UNICEF report lifetime prevalence rates for rape as between 1 in 5 and 1 in 7 women, and the World Health Organisation suggest that globally 1 in 3 women have been subjected to either physical and/or sexual intimate partner violence, or non-partner sexual violence in their lifetime. The Crime Survey of England and Wales for the year ending March 2020 suggests 773,000 adults aged 16-74 had experienced some form of sexual assault in the previous year. The same survey reports 5.9 million people in England and Wales had experienced sexual assault since the age of 16.

Sexual violence is a strongly gendered problem. The vast majority of those who are victimised are women, and the vast majority of those who perpetrate sexual violence are men. While it is not only women who experience sexual violence, men, trans-identified and non-binary people do also, the gendered pattern of victimization is striking. One study that examined gender differences showed rape victimisation of 9.2% for women, and molestation rates of 12.8%, compared to 0.7% and 2.8% respectively for men.

Myths and Realities

There are a great deal of myths, misinformation, and misunderstandings that surround sexual violence and we find these among both the general public, professionals who are involved in the investigation and prosecution of incidents of sexual violence, and those whose job it is to provide care and support, including among healthcare clinicians.

By way of example, a study conducted with the general public by Amnesty International in the United Kingdom in 2005 found that:

- 34% of people believe a woman is partly or wholly responsible for sexual violence if she flirts
- 1 in 4 think a woman is responsible for sexual violence if she is wearing 'sexy' clothing
- 1 in 5 think a woman is responsible for sexual violence if she has had many sexual partners
- 30% attribute some responsibility for sexual violence to a woman if she is drunk

There are other commonly held myths that sexual violence is committed by strangers in public places, who use high levels of violence causing significant injury. In fact, the majority of sexual violence survivors are assaulted by someone known to them, and most often there is no obvious physical injury. It is also commonly believed that if someone is 'truly' raped they would immediately report it to the authorities, however the reality is rather different and sexual violence remains one of the most under-reported crimes.

Who does what to whom?

A common misperception about sexual violence is that strangers pose the greatest threat, and those most likely to be assaulted somehow contributed to their assault by putting themselves in a risky situation. While stranger assaults do of course happen, and they are often widely reported in the media, the greatest risk is from known men. Further, the focus on women's behaviour and what they should or should not have done to prevent an assault, is a common form of victim-blaming that prevails in society and prevents perpetrators being held to account.

In an ESRC-funded study conducted in an area of England where one year's worth of reported rape cases was analysed, it was found that:

- 89.6% of victims knew the man who had assaulted them
- perpetrators included friends, relatives, parents, current and former partners, boyfriends, colleagues and family friends
- those who were raped were aged 2 to 64 years of age
- perpetrators were aged 9 to 74 years of age
- over one third of those who had reported had additional vulnerabilities including mental health issues and disability

In line with existing research, the study also found the majority of those assaulted had little or no physical injury. A small proportion of the sample – 17.1% - reported their assault within an hour, and a further 24.5% reported within 24 hours – and of the remainder, many took between several days and as long as 47 years to report the assault. Delayed, or indeed no, reporting is commonplace.

Disclosure and Non-Disclosure of Sexual Violence

More recently, research and criminal justice data, tells us that women may be more willing to disclose sexual violence to formal authorities than they were in the past as reporting rates have been increasing steadily. Police reporting data for England and Wales for the year ending September 2022 shows the highest rate of reporting yet, but when compared to prevalence data from self-report studies, disclosure remains the exception rather than the rule and many are still reluctant to disclose victimisation. Research on disclosure and reporting highlights a number of barriers and facilitators. Barriers to disclosure that have been identified in research include:

- not naming the incident as sexual violence at the time, or for a long time afterwards
- concerns whether an incident will be taken seriously or believed by those they disclose to
- fear of being blamed, shamed or embarrassed
- fear of retaliation by a perpetrator
- a lack of confidence in formal authorities
- fear of being treated unfairly, disrespectfully or unsympathetically
- fear of losing autonomy and agency

There is a wide body of research that has identified poor responses from formal authorities and communities to those who have experienced sexual violence. This is often referred to as secondary victimisation or as a ‘second rape’. These problematic responses can include making judgements about those who are victimised, questioning either explicitly or implicitly the person’s behaviour before, during or after an incident, and doubting the veracity of disclosures. The consequences of these responses are severe - a poor response to disclosure in one setting will make a further disclosure in a different setting less likely. This is likely to prevent survivors accessing appropriate healthcare, support, or criminal justice redress. On the other hand, an empathic, sensitive and non-judgemental response has the capacity to facilitate access to good healthcare and emotional support, and future help-seeking as required. The impacts of sexual violence are not only immediate, but may occur some time later, and for many years after an assault.

Research has also highlighted reasons why people do disclose and report. These include wanting to prevent a perpetrator harming them or somebody else again, to expose a perpetrator, to seek validation from their family, friends and community for the harm they have suffered, and for some it is a sense of civic duty or therapeutic reasons for the individual. Recent studies have suggested that few are motivated by punitive punishment for the perpetrator. Accountability for perpetrators in the criminal justice system is also a rarity. In England and Wales in 2021, only 1.6% of reported rapes ended in a charge, and the

conviction rate will be even lower. Criminal justice may not be the route for many survivors, and research suggests that healthcare settings may be the first point of disclosure of sexual violence so clinicians should be prepared to respond sympathetically and appropriately.

Impact of Sexual Violence

Sexual violence is both a cause and a consequence of gender inequality in society. As a culture we are not especially comfortable talking about sexual violence, which contributes to the low levels of reporting and disclosure outlined above. This is highly problematic, as we know if people receive a sensitive and supportive response following a disclosure, in whatever setting that occurs, it can ameliorate some of the harms that we know are common among those who are sexually violated.

Scholars have documented the negative impact of rape and sexual assault on survivors in a number of areas of their lives, including the physical, mental, social, and the interpersonal. The potential immediate, short-term and longer-term impacts of sexual violence are considerable. Survivors report physical and/or mental health symptoms in the immediate aftermath of a sexual assault, or many years after the event.

While many sexual assaults cause no identifiable physical injury – and a lack of injury is not indicative of no assault having taken place, as often rape and sexual violence is accomplished through coercion and fear, rather than force – where physical injury is present, this can include scrapes, bruising, and genital tears or trauma. Survivors may also contract sexually transmitted infections, and rapes may result in unwanted pregnancy. Where sexually transmitted infections are untreated it can lead to pelvic inflammatory disease. Other reported gynaecologic consequences include chronic pelvic pain, irregular bleeding and painful periods and urinary tract infections.

There are a range of psychological and emotional consequences of sexual violence. The World Health Organisation reports that sexual violence significantly increases the chances of depression, anxiety, psychosomatic disorders, and suicidal behaviour. Survivors often report fear, self-blame, anxiety, shame, difficulty sleeping, changes to eating habits, and difficulty in personal and intimate relationships. A number of factors increase the likelihood of longer-term psychological difficulties, and these include the extent to which a survivor feared for their life, a previous history of trauma, the duration of the assault, whether they received responses from communities or individuals that were unsympathetic, retraumatising, or unsupportive. Some survivors report challenges with intimate relationships, trust, and sexual difficulties. Survivors' sexual and reproductive health is also affected as they are less likely to access gynaecological services and contraceptive care, and more likely to experience recurring sexually transmitted infections.

Implications & Considerations for Gynaecological, Obstetric and Reproductive Healthcare

While some survivors will present immediately or a short time after the incident of sexual violence and seek medico-legal care in the form of a forensic medical examination, many will not. Some survivors may present immediately or a short time after in a healthcare setting seeking emergency contraception, or post-exposure prophylaxis, but without the collection of forensic samples. However as outlined above, this is a minority of sexual violence survivors, and many will not seek intervention of any form in the short term. Given the prevalence rates discussed, women presenting in gynaecology, obstetric and reproductive medicine settings may well have had an experience of sexual violence in their lifetime, and it is vital that clinicians are sensitive to the potential impacts this may have, and incorporate this understanding into their practice. Experiences of sexual violence can be a barrier for women

engaging with healthcare that involves pelvic examinations, for example at cervical smear tests, gynaecology and obstetrics appointments, and survivors report greater levels of pain, discomfort and re-traumatisation.

It is the case that informed consent, sensitive care that promotes agency and autonomy, and respectful interactions should be a central part of all healthcare however these features are particularly important when engaging with patients who may be survivors of sexual violence. Sexual violence experiences are characterised by having control taken from the survivor, who often feels humiliated, disempowered, violated and exposed and poorly delivered healthcare can reignite these feelings. Research conducted on barriers to cervical screening for sexual abuse survivors indicates that focussing on communication, safety, the development of trust, and sharing control, can improve the experience for women. Research on gynaecology and obstetrics settings suggests trauma-informed patient-centred care promotes opportunities for disclosure and the improvement of reproductive health overall. Conversely, research also shows that poor healthcare experiences in these settings can compound traumatic experiences and engender distrust of healthcare professionals. Some research has questioned the absence of routine screening for sexual violence experiences in healthcare settings, and the paucity of specific training for clinicians in handling sexual violence disclosures. Clinicians who are able to build and support trust, and who have the appropriate language and tools to engage with patients about sexual violence experiences will improve patient care, outcomes, and empower choice for women.

While patients with a history of sexual violence will be routinely presenting in gynaecology, obstetrics and reproductive medicine clinics, for some survivors their experiences and the manner in which healthcare is routinely delivered, prevent them from engaging. To address this some specialist services have been developed to facilitate access to care for survivors. One example is the *My Body Back* project. Entirely run by volunteers and working in collaboration with the NHS, it provides clinics and workshops for those who have experienced sexual violence. This specialist service offers cervical screening, contraceptive care, testing for sexually transmitted infections and maternity care in a trauma-informed way. Designed by survivors and specialist psychologists, the two clinics in London and Glasgow offer UK residents an alternative way to access healthcare that is sensitive to their sexual violence experience. Cervical screening can prove challenging, or be inaccessible for survivors of sexual violence through conventional routes, and research shows that those with a history of sexual abuse are less likely to attend. Survivors often report finding an intimate internal examination very difficult. A central aspect of the My Body Back project is allowing survivors to feel in control during their engagement with the services and the healthcare they offer. Having control taken away is a central aspect of sexual violence experience so returning it to survivors and supporting choice at a pace suitable to the individual can be very empowering. Appointments at My Body Back are for one hour and survivors can set their own timeframes, making as many appointments as are needed to engage with the healthcare they need, and promoting agency and choice for survivors is central to the ethos of the service.

Conclusion

Sexual violence experiences are commonplace in the lives of women, and many will experience some form throughout their life course. The majority of those who experience sexual violence do not report it to the police and criminal justice authorities and many women tell no one. When women do disclose it may be in a healthcare setting during consultation or treatment where the focus of the interaction is not the experience of sexual violence itself. Given this, clinicians must be aware of the commonality of sexual violence experience in their patient cohort, the impacts and consequences this can have in terms of physical, psychological and emotional health, social and interpersonal relationships. The effects of sexual violence can make it more difficult for women to engage in healthcare especially when intimate physical examinations are a likely part of that care. Clinicians

should ensure they are informed about sexual violence, that they reflect on and challenge their own views about it, and equip themselves to deliver sensitive, trauma-informed and patient-centred care, including onward referral to specialist services where necessary.

Practice Points

- Patients may have experiences of sexual violence they have never disclosed in a healthcare setting or to anyone
- Sexual violence is so commonplace that it is wise to assume patients may have had these experiences rather than assume they have not
- Communication with a patient prior to, and during, intimate examinations is vital, including asking patients directly if anything would make them feel more or less comfortable
- Sexual violence removes control and autonomy from an individual and poorly delivered healthcare has the capacity to recreate these dynamics so good clear communication, informed consent and promoting patient choice is vital
- Clinicians should ensure they are equipped to respond sensitively and non-judgementally to any disclosure of sexual violence and be able to offer appropriate signposting to support
- Patients may present with very recent experiences of sexual violence or with historical assaults that can impact individuals many years after the event
- Dialogue with patients without partners or family members present may increase the likelihood of disclosure and help-seeking especially in the context of an abusive or coercively controlling relationship
- Clinicians should reflect on their own views about sexual violence and ensure they are not subscribing to common myths, misperceptions and judgements as themes maybe explicitly or implicitly communicated to patients and compound the harm and impact of sexual violence

Further Reading

Basile, K.C. & Smith, S.G. (2011) Sexual Violence Victimization of Women: Prevalence, Characteristics, and the Role of Public Health and Prevention, American Journal of Lifestyle Medicine 5(5):

DeMaria, A.L., Meier, S., King, H., Sidorowicz, H., Seigfried-Spellar, K.C. & Schwab-Reese, L.M. (2023) The role of community healthcare professionals in discussing sexual assault experiences during obstetrics and gynecological healthcare appointments, *BMC Women's Health* 23: 263

McMillan, L. (2013) Sexual Violence: Disclosure, Responses and Impact, in Lombard, N. & McMillan, L. eds. (2013) *Violence Against Women*: *Current Theory and Practice for Working with Domestic Abuse, Sexual Violence and Exploitation*, Research Highlights in Social Work Series, Jessica Kingsley

The My Body Back Project Available at: https://mybodybackproject.com/

World Health Organisation (2013) *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*, World Health Organisation