THE HEALTH, MENTAL HEALTH AND WELL-BEING BENEFITS OF RAPE CRISIS COUNSELLING

Final report to Northern Rock Foundation

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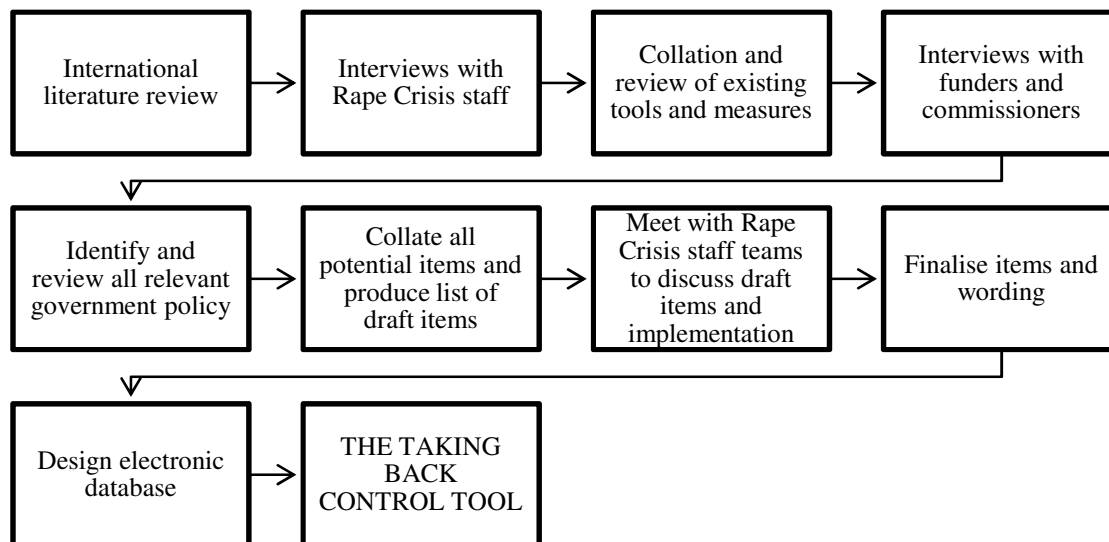Sue Alderson and Lizzy Kirkham.

Contents

Introduction

Rape Crisis Centres have provided support to survivors of rape and other forms of sexual violence in England and Wales since the late 1970s. However, as Brown et al. (2010) highlight, there is a dearth of longitudinal studies that look at the impact of such interventions. Continuous funding difficulties led to a marked decline in the number of these Rape Crisis Centres between the early 1990s and late 2000s. This has resulted in a pressing need to evidence the value of such services by demonstrating any impact they can have on women's health, mental health and well-being. This action research project developed and piloted a tool called the 'Taking Back Control' tool that measures such impact over time. An international literature review and interviews with practitioners and policy makers were conducted. This report describes the development of the tool, the results, and then discusses each of the measures in turn.

The lack of evaluation of community based support services for rape victim survivors has been noted both in the UK (Brown et al., 2010) and the USA (Campbell and Martin, 2001; Campbell and Wasco, 2005; Lonsway, Archambault and Lisak, 2009). This has begun to shift with a series of studies about advocates in the USA by Rebecca Campbell, Sarah Ullman and their colleagues on responses in the US, and a series of evaluations of SARCs in the UK (Lovett et al, 2004; Robinson, 2009; Schonbucher et al, 2009; Robinson, Hudson & Brookman, 2009; Robinson & Hudson, 2011), however these are limited in their scope and none have tracked longitudinally the outcomes associated with Rape Crisis support. Campbell and Raja (1999) found that women who had access to a sexual violence advocate experienced less distress than those who did not have this support, especially in cases where the perpetrator was known to the victim. Similarly, Campbell (2006) showed that the presence and interventions of these specialist advocates led to improved outcomes for victims, including reducing the number of negative responses from the police and health professionals, and buffering against the distress caused by the legal process. In the UK, the introduction of Independent Sexual Violence Advisors has received scant research attention, with only one evaluation to date which focuses primarily on process rather than impact or outcomes (Robinson, 2009). As far as we can tell, this is the first study of its type that has been conducted.

The development of the Taking Back Control Tool

Figure 1 (below) summarises how the tool was developed. This is then described in more detail below.

Figure 1. Taking back control tool - stages of development

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┌──────────────┐    ┌──────────────┐    ┌──────────────┐    ┌──────────────┐
│International  │ →  │Interviews with│ → │Collation and │ →  │Interviews with│
│literature    │    │Rape Crisis staff│  │review of     │    │funders and   │
│review        │    │              │    │existing tools│    │commissioners │
│              │    │              │    │and measures  │    │              │
└──────────────┘    └──────────────┘    └──────────────┘    └──────────────┘
        │                                                          │
        ▽                                                          │
┌──────────────┐    ┌──────────────┐    ┌──────────────┐    ┌──────────────┐
│Identify and  │ →  │Collate all   │ →  │Meet with Rape│ →  │Finalise items│
│review all    │    │potential items│   │Crisis staff  │    │and wording   │
│relevant      │    │and produce   │    │teams to      │    │              │
│government    │    │list of draft │    │discuss draft │    │              │
│policy        │    │items         │    │items and     │    │              │
│              │    │              │    │implementation│    │              │
└──────────────┘    └──────────────┘    └──────────────┘    └──────────────┘
        │
        ▽
┌──────────────┐    ┌──────────────┐
│Design        │ →  │THE TAKING    │
│electronic    │    │BACK          │
│database      │    │CONTROL TOOL  │
└──────────────┘    └──────────────┘
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The international literature review focused on what is currently known about the impact of rape and other forms of sexual violence on health, mental health and well being. It included both traditional academic literature and 'grey' literature. Literature on current tools in use, for example, on depression, anxiety and well-being were also reviewed. Interviews were then conducted with the manager/coordinator of each of the five Rape Crisis Centres[1] who we hoped would agree to use the tool[2]. These interviews focused on what the main impacts were of rape and other forms of sexual violence on health, mental health and well being from their experience. Although we had already examined the international literature on this topic, it was felt also important to ask front line project workers about the impacts, to include a 'bottom-up' approach. Rape Crisis Centre managers/coordinators were also asked about if/how they currently measured the impact of their work in terms of improvements on health, mental health and well-being.

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[1] Three of the centres were official Rape Crisis Centres in that they were members of Rape Crisis England and Wales. A fourth was a feminist rape service which was not at the time a member but has since joined. The fifth was a generic counselling service with a specialist women-centred rape support project attached to it. For ease of reference we refer to them all as Rape Crisis Centres.

[2] Two further centres were invited to take part, one declined and one started to participate but then withdrew following a major incident in the geographical area in which they were based.

Existing tools and measures identified through the literature review and through the interviews with Rape Crisis Centre managers/coordinators were collated and reviewed. It was found that the existing generic tools and measures (on depression, etc.) were overly detailed and lengthy for use in Rape Crisis Centres. In addition, none of them fully covered the very wide range of impacts identified through the literature review and interviews with Rape Crisis Centre managers/coordinators. Of the five Rape Crisis Centres, two did not collect any outcome data at all, one used a generic statutory healthcare outcome monitoring tool, and one collected only a handful of outcome measures within a longer evaluation of the service overall. Only one Rape Crisis Centre had designed their own health, mental health and well-being outcome monitoring tool, and had been collecting data using it for the previous two years. We found this, and the other tools, a useful starting point for the development of the 'Taking back control' tool.

Three local funders and commissioners were also interviewed. These were an important group to include in the development of the tool, since one of the intended consequences of the tool was to increase the level of Rape Crisis funding through demonstrating the outcomes funders were interested in. Similarly, a review of current government policy was conducted, since it is important from a funding perspective for Rape Crisis Centres to show that they fit into these policies (since funding is often attached to them). As well as the Sexual Violence and Abuse Action Plan, more generic policies were reviewed. While some of this may sound rather cynical, and state rather than women-centred, it is important to recognise the environment and severe funding crisis that the Rape Crisis Centre has faced over the last decade, as described earlier. It is also important to consider this in view of the overall 'statutorisation of the voluntary sector' that has been happening in England and Wales. The funders, commissioners, and policy priorities did not replace the themes found in the literature review and interviews with Rape Crisis Centre managers/coordinators. Rather, they added a further two perspectives to be taken into consideration.

All of the themes that had been pulled out of the literature review, interviews and policies were collated and printed out. This resulted in a list of 63 preliminary measures. These were reviewed initially by ourselves, and 21 of the themes were highlighted as the draft items based on the number of times they were mentioned and the importance accorded to them from the different perspectives (literature, interviews, policy). The full list, with the 21 highlighted draft items, was taken to the five Rape Crisis Centres. At this stage we met with

both the manager/coordinator and also the counsellors who would actually be administering the tool. A total of 16 Rape Crisis staff reviewed our draft items, and suggested amendments. Generally, they wanted to include far more items that the 21 we had chosen, but simultaneously stated that 21 items was the maximum number they felt it was possible to collect data on, but preferably less in order to reduce the burden on clients. Following these meetings some changes were made to the items we had initially selected and the tool was reduced to 15 measures.

Once the items were agreed, the statements to be used were written. These were written as clearly and simplistically as possible. A web based data collection system was designed to manage the data, and the 15 items were entered ready for data to be inputted.

Administration of the 'taking back control' tool

The Taking Back Control tool consisted of 15 statements (e.g. I use self harm to help me cope with my feelings), which the Rape Crisis client was asked to state how much they agree or disagree with. A standard Likert scale was used with five response categories.

After our meetings with the five Rape Crisis Centres, all agreed to start using the 'taking back control' tool with all new clients. We were pleasantly surprised with this, in particular that the centres already using outcome tools were willing to move over to the new tool. Some of these Rape Crisis Centres had previously been quite reluctant to collect any data at all from their clients, and we were pleased that they wholeheartedly supported the use of the tool and recognised its necessity. It was agreed that the tool would be used with all new clients attending the five Rape Crisis Centres.

The tool was designed to be administered by the client's counsellor, either on week one or two, and then repeated every six weeks if appropriate. It was decided to do it this way rather than using a pre-post intervention design so that clients who do not have a defined and pre-agreed end point to their counselling could still be included. In addition, it allowed for Rape Crisis Centres to use it as a client management tool. After the client had completed the paper based tool, assisted by the counsellor if necessary, the Rape Crisis Centre logged onto the web based database to enter the client's data. The Rape Crisis Centre could then choose to view individual clients' progress or look at all of their clients on any particular item. The research team could view the data from individual clients, individual Rape Crisis Centres or all five Rape Crisis Centres. It was very important to allow the Rape Crisis Centres to have

ownership over their own data and be able to access it whenever they chose to (for example, for funding bids or presentations). During the research period, clients were be given a participant information sheet and asked to sign a consent form. It was made clear that non-participation in the study would not affect their access to counselling in any way. No clients' names or other identifiable data was entered onto the database or passed to the research team.

Data analysis

The qualitative data collected consisted of: interviews with Rape Crisis managers and counsellors at the beginning, middle and end of the pilot period and interviews with funders and commissioners at the beginning of the period. These interviews were recorded and transcribed. Group discussions about the measures were not transcribed, but extensive notes were taken. The qualitative data were analysed thematically and used in the following ways: a) to feed into the development of the tool, b) to feed into the evaluation of the pilot and c) as examples of the rationale for the selection of the measures and displayed below in the discussion.

The quantitative data were more complicated to analyse. This was partly because of varying sample sizes at each of the stages of data collection. There were far more clients who completed an initial data collection point than there were subsequent points, and this is reflected in the sample sizes shown in the findings. A number of attempts were made to analyse and display the data in a meaningful way. In the presentation organised by the Northern Rock Foundation the data were presented in terms of a) incremental improvements (how many clients had moved at least one improvement position in the likert scale) and b) bubble graphs (where the bubble size represented the number of clients in any particular sample and the bubble position showed the average score). However, this was still quite difficult to interpret so the analysis was simplified. Two sets of results are therefore presented here: a) the initial responses (so presenting problems when accessing Rape Crisis support) with a sample size of 220 and b) the change responses (so only clients who completed a minimum of two data collection points).

When the data were analysed and results presented at a roundtable discussion with the Rape Crisis Centres involved in the study it was clear that some of the measures and data did not allow for meaningful conclusions to be drawn. This is because the quantitative data alone did not confirm whether the change was in a positive or negative direction. Because of this the

following measures were removed from the final version of the tool and are also excluded from the analysis below (though are available from the report authors if requested):

- The support I receive from this organisation meets my needs (more of a one off question than one to assess change, also difficult to answer when just accessing service for first time).
- I regularly use mental health services (unclear from quantitative data whether positive or negative).
- I regularly visit my GP (as above).
- I use non-prescribed drugs to help me cope (counsellors didn't like asking, they thought clients didn't like answering, but there was not agreement about this one so it is left in the results below and can be included as an optional measure).

Results

The following two tables summarise the results from the study. Following this results section is a more in-depth description of the measures, their rationales for inclusion, and a discussion of the results.

Table 1. Initial responses to Taking Back Control scale (n=260)

Taking Back Control measure	%	Number /sample size
I have 'flashbacks' about what happened	83%	215/260
I feel depressed	73%	190/260
I have panic attacks	64%	166/260
I over-eat, under-eat, or use food as a means of control	56%	145/260
I feel empowered and in control of my life (% disagree)	55%	143/260
I feel well enough to work or study (% disagree)	42%	108/260
I have thoughts about ending my life	41%	106/260
I do not feel responsible for what happened to me (% disagree)	38%	100/260
I have a fear or phobia that prevents me from doing everyday things	33%	86/260

I use alcohol to help me cope	24%	63/260
I use self harm to help me cope with my feelings	20%	51/260
I use non-prescribed drugs (such as heroin, cocaine, speed, cannabis) to help me cope	9%	19/216

This shows that the symptom most often presented at the first point of data collection is flashbacks, with 83% of clients strongly/agreeing with the statement 'I have 'flashbacks' about what happened'. Other statements with over 50% strongly/agreement were: 'I feel depressed', 'I have panic attacks', 'I over-eat, under-eat, or use food as a means of control', and strongly/disagreement with 'I feel empowered and in control of my life'. The least likely to be recorded as symptoms were 'I use non-prescribed drugs ... to help me cope' (although this may be related to a reluctance to admit to criminal behaviour) and I use self-harm to help me cope with my feelings (although at 20% - one in five – this is clearly still a much higher incidence than in the general population). These findings are discussed and contextualised further in the next part of the report.

Table 2 (below) shows, in descending order, the difference reported by clients measured by the number of clients who gave a negative response (i.e. they strongly/agreed with the statement if it was a negative statement or strongly/disagreed if it was a positive statement) on their first compared with their last data collection point. The sample size for this part of the study was 87 for each statement.

Table 2. Changed responses to Taking Back Control scale (n=87)

Taking Back Control measure	First	Last	Difference
I feel empowered and in control of my life (% disagree)	61%	31%	30%
I have 'flashbacks' about what happened.	84%	57%	26%
I have panic attacks	68%	43%	25%
I use alcohol to help me cope	28%	11%	16%
I feel depressed	72%	56%	16%
I have thoughts about ending my life.	39%	23%	16%
I feel well enough to work or study (% disagree)	45%	29%	16%
I have a fear or phobia that prevents me from doing everyday things	40%	29%	11%
I do not feel responsible for what happened to me (%	33%	22%	11%

disagree)			
I over-eat, under-eat, or use food as a means of control	57%	47%	10%
I use self harm to help me cope with my feelings	17%	7%	10%
I use non-prescribed drugs (such as heroin, cocaine, speed, cannabis) to help me cope.	6%	2%	3%

This shows that the most change was made in relation to the statement 'I feel empowered and in control of my life', where 61% strongly/disagreed at the first data collection point compared to 31% at the last data collection point. Hence, around half of the clients who initially strongly/disagreed no longer did so by the end of the data collection. In addition, more incremental changes could have happened for other clients (e.g. moved from strongly disagree to disagree, or moved from neither agree nor disagree to agree). Large shifts were also seen in relation to 'I have 'flashbacks' about what happened' and 'I have panic attacks'. Overall, some degree of positive change was seen for all measures, although this was small for 'I use non-prescribed drugs ... to help me cope' (which again may be linked to problems with the measure). The change for 'I use self harm to help me cope with my feelings' appears small on first sight (10%), however this is partly due to the small number initially reporting it as a symptom – at the first data collection point this was 15/87 and by the last this was down to just 6/87 – less than half reporting it as a symptom than did originally. The same cannot be said for the other statement with a 10% change: 'I over-eat, under-eat, or use food as a means of control went down from 57% to 47%, a difference of 50/87 to 41/87. These are all discussed in more depth and contextualised in the following discussion section.

Discussion

I feel empowered and in control of my life.

Some level of perceived control over one's life is an important factor of psychological wellbeing (Frazier et al., 2011). Consequently, traumatic events, especially those which involve a loss of control, can have serious implications for an individual's sense of self and mental health (Frazier et al., 2011). Rape in particular has been shown to threaten many assumptions and beliefs survivors have about themselves and the world around them (Koss, Heise and Russo, 1994). This was demonstrated within our study. At the first point of data collection, over half (55%, 143/260) of the clients did not feel empowered or in control of their life (they strongly/disagreed with the statement 'I feel empowered and in control of my

life'). As one of the Rape Crisis workers interviewed in our study explained, *'Sexual violence is a life changing experience, and from that moment on, that woman's life changes. She no longer recognises herself as the person she once was.'* This may be especially pertinent when a woman has been raped by someone known to her (e.g. Lawyer et al., 2006):

> *When a woman is raped within a relationship it touches the very core of who she is as a person. It's the same for someone who has been abused as a child. To be abused by someone you love and trust and who should be there to provide and care for you....well I don't think women are aware of why they are drinking too much or self harming.* (Rape Crisis worker)

Though it is impossible to remove the assault from an individual's past, studies have found that the more perceived control the person has over their present circumstances, the less distress they are likely to feel (Frazier et al., 2011). One particularly important aspect within this notion of present control is perceived control over the recovery process. Walsh and Bruce (2011) found that, among sexual assault survivors, those who had higher levels of perceived control over their recovery process were less depressed and had lower levels of posttraumatic stress. Similarly, Frazier et al. (2011) demonstrated that present control was associated with less binge drinking, less feelings of distress about the trauma, and lower levels of general distress. Indeed, in terms of reducing distress, perceived control over the recovery process appears to be even more helpful than the belief that future attacks are unlikely (Frazier, 2003). Therefore, empowerment was seen as central to the services that the Rape Crisis Centres were providing:

> *It's about independence, choice, regaining self confidence and assessing whether they are taking control back over their life.* (Rape Crisis worker)

> *[we hope the service will enable women to] regain strength, self esteem and self confidence. And feel healthier in order to live their lives to the full.* (Rape Crisis worker)

> *It's about her getting her life back to normal whether that be her social life or her work life or family life. It's about this feeling of being able to get on with her life. Like, I've moved on and I'm not a victim anymore.* (Rape Crisis worker)

A health commissioner gave her perception of an ideal outcome for women accessing rape support services:

> *I think it would be for that person to live confidently in society and feel safe and live as independently as possible. Help people to live independent and healthy lives but to know that support is there if needed.* (Commissioner)

This was the measure that saw the greatest amount of change in the longitudinal element of the research. A change was recorded from 61% (53/87) to 31% (27/87) for strongly/disagree with the statement 'I feel empowered and in control of my life'. Therefore, nearly half of those who strongly/disagreed with the statement at the first data collection point no longer strongly/disagreed at the last data collection point.

I feel well enough to work or study

The positive psychological benefits of returning to work after trauma, ill health or mental health problems have been well documented (Waddell and Burton, 2006; Grove, Secker, and Seebohm, 2005; Secker, Grove and Membrey, 2005). The trauma of rape can be particularly devastating. A study by Resick (1981) found that many women who have experienced sexual violence give up their job because they are unable to continue working in vulnerable settings (i.e. night shifts, in high crime areas, with men). The study also found that the day to day functioning of rape victims is impaired by up to eight months following assault, and that work is the area of functioning that is affected for the longest period of time after a sexual assault. In our study, 42% (108/260) of the participants felt unable to work or study at the first point of data collection (this is the %/number that strongly/disagreed with the statement 'I feel well enough to work or study'. This finding supports evidence from a recent survey of 35 rape crisis centres, which found that the support these centres provide can be instrumental

in helping women return to work (Women's Resource Centre & Rape Crisis, 2008). Without exception, service providers in this study felt that one of the indicators that a woman is on the road to recovery is when she can feel ok about doing everyday things such as going back to work or study. Rape Crisis staff were asked what they thought would be an ideal outcome for the women they worked with.

> *That she can return to how she was pre-rape, or that she can at least cope with her daily life, despite the rape or sexual assault.* (Rape Crisis worker)

> *Her life is getting back to normal. Whether that be her work life or her family life. It's about this feeling of being able to get on with her life. Like…I've moved on and I'm not a victim anymore.* (Rape Crisis worker)

Rape Crisis staff explained that returning to work or study after a long absence gives women a sense of 'their old self'. For example:

> *We can help women overcome their feelings of self blame which in turn have an impact on their health and relationships and their study or work.* (Rape Crisis worker)

It is well established that unemployment can be detrimental to mental health, while meaningful employment can help to reduce the amount of support required from mental health services (Secker and Membrey, 2003). A number of factors are important in ensuring that the working environment is beneficial and supportive. Seckey and Membrey 2003) found that positive relationships with colleagues, appropriate training, and a genuine interest in employees' welfare are all crucial elements in ensuring that the working environment is a positive place for those with mental health problems. Similarly, Bursztajn (2001) notes that although there are important differences between responses to individual trauma, recovery is facilitated by appropriate mental health care, combined with a quick return to an appropriate level of duty or work. He also states that any delay in the provision or availability of support is a prescription for enabling chronic work-related impairment and disability.

A change was recorded from 45% (39/87) to 29% (25/87) for strongly/disagree with the statement 'I feel well enough to work or study'. Therefore, nearly a third of those who

strongly/disagreed with the statement at the first data collection point no longer strongly/disagreed at the last data collection point.

I have a fear or phobia that prevents me from doing everyday things.

Most phobias and fears manifest as a disproportionate reaction to a place, situation, or object which does not necessarily present an objective danger (NHS, 2009; Mind, 2011). Phobias, which sometimes arise following traumatic experiences, create a sense of extreme anxiety which can shape a person's choices and severely restrict their quality of life (Mind, 2011). Such conditions are not uncommon, indeed it is thought that around 10 million people in the UK suffer from some form of phobia (NHS, 2009). Studies on the effects of sexual violence and childhood sexual abuse have consistently acknowledged the relationship between a history of sexual violence and long term mental health problems such as phobias (Glen-Landell et al., 2011; Chen et al., 2010; Ullman and Filipas 2001; Magee, 1999; Resnick, 1993; Burnam 1988). For example, there is a documented relationship between sexual abuse and social phobia (Walker and Stein, 2001), a condition in which people experience extreme anxiety in social situations, often leading to avoidance of everyday activities (Mind, 2011). Gren-Landell et al. (2011) found that women with social phobia were significantly more likely to have experienced sexual victimisation than those without social phobia. Another common phobia, agoraphobia, is four times more common among women than among men (Bekker and van Mens-Verhulst, 2007). Agoraphobia is a potentially debilitating condition which involves an extreme fear of situations from which escape could be difficult, such as being outside, being inside the home, or travelling in cars (Mind, 2011). Women who have experienced sexual abuse are more likely to fear childbirth (Soffer, 2011), and to experience extreme fear during labour (Eberhard-Gran, Slinning & Eskild, 2008). In our study, 33% (86/260) strongly/agreed with the statement 'I have a fear or phobia that prevents me from doing everyday things'.

Women who have been raped often experience a fear of something that reminds them of the violence. One Rape Crisis worker explained '*We had a woman who was afraid of cream. This reminded her of the perpetrator's semen*'. Workers gave examples of the wide range of fears and phobias their clients had, including: soap, the dark, the light, noises, certain sensations, animals, going outside, confined spaces, going to sleep and, perhaps the most obvious, fear of seeing the perpetrator.

In addition to the mental burden, phobias can lead to serious physical health consequences for those who have experienced sexual assault. Women who have been sexually abused are more than twice as likely to fear dental examinations as those who have not encountered sexual violence (Humphris and King, 2011). Indeed, dental treatment has been found to trigger memories of previous abuse for 28% of women who were sexually abused as children (Leeners et al., 2007). This fear of dental work can lead survivors of sexual abuse to avoid visiting the dentist and repeatedly cancel appointments (Dougall and Fiske, 2009), which in turn can have a detrimental effect upon their dental health. Fear and subsequent avoidance of vaginal examination (Soffer, 2011), a medical procedure which can also give rise to memories of sexual abuse (Lenners et al., 2007b), can have devastating effects for women who have been sexually assaulted. One service provider told us that many clients fear attending cervical smear tests due to the intimate nature of the examination. Failure to attend such routine examinations could lead to cervical abnormalities remaining undetected, potentially resulting in terminal illness. The Cross Government Action Plan on Sexual Violence and Abuse (HM Government, 2007) identified the development of phobias in some women as a direct health consequence of sexual violence, though the issue is not addressed in the more recent publication, Call to End Violence against Women and Girls (HM Government, 2010a).

A change was recorded from 40% (35/87) to 29% (25/87) for strongly/agree with the statement 'I have a fear or phobia that prevents me from doing everyday things'. Therefore, around a quarter of those who strongly/agreed with the statement at the first data collection point no longer strongly/agreed at the last data collection point.

I over-eat, under-eat, or use food as a means of control

Eating disorders such as anorexia nervosa, bulimia, and binge eating, affect many more females than males: of the 1.6 million people in the UK who have an eating disorder 90% are female (Mind, 2010). Eating disorders can often be trivialised within the mass media as a 'slimmer's disease' that only affects fashion conscious vacuous women (Schmidt, 2000). In reality, people with eating disorders experience extreme suffering and face an elevated risk of death, either from suicide or complications from their condition (Crow et al., 2009). Eating disorders were identified by Rape Crisis workers as being linked to sexual violence.

I suppose something that springs to mind initially is that I have quite a few clients who have responded to their trauma by developing an eating disorder. This obviously has a knock on effect for their health and well being. (Rape Crisis worker)

To have been abused by someone you love and trust and who should be there to provide and care for you is, (pause), well, I don't think women are aware of why they are drinking too much or why they are self harming. Particularly eating disorders – not linking the two. They find themselves accessing services but never really linking the two. This kind of sticking the plaster over things is not really getting to the real issue. (Rape Crisis worker)

Research has consistently highlighted links between sexual violence and eating disorders (Copeland et al., 2011; Chen et al., 2010; Wonderlich, Wilsnack, and Harris, 1996; Miller, McCluskey-Fawcett & Irving, 1993; Zlotnick et al., 1996). A history of child sexual abuse (CSA) is very common among women with anorexia nervosa. Carter et al. (2006) found that almost half (48%) of female in-patients with anorexia nervosa had a history of child sexual abuse. People who were sexually abused as children tended to show worse symptomology and were more likely to have other co-occurring mental health problems. In a study of the effects of adult sexual assault, Fischer et al. (2010) found a relationship between recent sexual assault and disordered eating which was independent of the effects of previous CSA. Even in comparison to other traumatic experiences, rape is particularly devastating for a woman's mental health. Faravelli et al. (2004) compared women who had been raped four to nine months previously with women who had experienced a different life threatening trauma in the previous nine months. It was found that 53% of the women who had been raped had developed an eating disorder, in comparison to 6% of those who experienced a different trauma. In line with previous research, our study demonstrated that many women who have experienced sexual violence have difficulties with food and eating: 56% (145/260) said they strongly/agreed with the statement 'I over-eat, under-eat, or use food as a means of control' at the first data collection point.

It is thought that some people who have been sexually abused develop eating disorders as a way of avoiding or regulating the negative emotions created by the assault (Fischer et al., 2010; Carter et al., 2006). Sexual assault can have a profound effect upon a woman's body

image and her sense of control, both of which can play a key role in the maintenance of eating disorders (Carter et al., 2006; Capitaine et al., 2011).

However, early disclosure of a sexual assault can facilitate more effective treatment for patients with eating disorders (Hall et al., 1989), and it is important that these patients are offered support in dealing with the abuse in addition to treatment for their eating disorder (Carter et al., 2006). In fact, a history of sexual abuse is so common among people with eating disorders, that it is advisable to screen for this when treating a patient with these conditions (Carter et al., 2006). Capitaine et al. (2011) suggest that depression acts as the link between sexual abuse and subsequent disordered eating. If this is indeed the case, then it is crucial that people who have been sexually assaulted receive appropriate support for their depression before it leads to further mental illness (Capitatine et al., 2011).

It used to be common in UK hospital settings to label women with anorexia nervosa as 'attention seekers', and treatment was administered through behaviour modification techniques that rewarded 'good' behaviour (eating), with privileges (Rowbotham, 2006). Rowbotham states that these types of programmes were 'oppressive' 'disempowering' and 'humiliating' and could lead to women who have experienced sexual violence to relive past traumas. Due to national guidelines developed by National Institute for Clinical Excellence (NICE, 2004) on the treatment of women with eating disorders, hospitals are now required to treat people with eating disorders at outpatients and through 'talking treatments'. However, with specialist eating disorder services in short supply, many local services often fail to meet these national standards (Mind, 2010). This lack of provision is at odds with the government's recognition of the 'critical' role of high quality care for those with eating disorders (HM Government, 2011), and suggests that objective 3 of the Cross Government Action Plan on Sexual Violence and Abuse (HM Government, 2007), which calls for a reduction in the number of people requiring treatment for eating disorders, may not have been met.

A change was recorded from 57% (50/87) to 47% (41/87) for strongly/agree with the statement 'I over-eat, under-eat, or use food as a means of control'. Therefore, around a fifth of those who strongly/agreed with the statement at the first data collection point no longer strongly/agreed at the last data collection point.

I use alcohol to help me cope

Life trauma has been shown to increase a person's consumption of alcohol (Rosenberg, 2011). Kendler et al. (2000) found that women who had been raped as children were at least 4 times more likely to develop an alcohol misuse disorder than those who had not been sexually abused. Similarly, Lown et al. (2011) found that women who had been sexually abused as children (with or without physical child abuse) were seven times more likely to be dependent on alcohol than those who had not been abused as children. In our study, 24% (63/260) said they strongly/agreed with the statement 'I use alcohol to help me cope'.

Research with women who have experienced the trauma of sexual violence has consistently found subsequent alcohol abuse (Kilpatrick et al., 1997; Resick 1993). In terms of prevalence, a study by Wilson (1998) found that 67-90% of women survivors of sexual violence had an alcohol or drug addiction problem, and Kilpatrick et al (1997) found that rape victims were 13.4 times more likely to have an alcohol problem than non victims. Furthermore, women who are addicted to alcohol are ten times more likely to have been raped than those who are not addicted (Copeland et al., 2011).

Women who have been sexually abused represent a distinct subgroup of those addicted to alcohol (Copeland et al., 2011). They are more severely impaired by their addiction, more likely to have co-morbid mental health conditions, and to access more treatment services such as inpatient rehabilitation (Schäfer et al., 2009). This pattern suggests that interventions for alcohol dependency are unlikely to lead to long lasting change unless the underlying issue of previous sexual violence is addressed. Treatment and support for women in this position is especially important, as addiction to alcohol increases the risk of sexual revictimisation, which in turn entrenches existing pathologies (Najdowski & Ullman, 2009).

The Department of Health (2004) have emphasised the importance of preventing dependence on, and addiction to alcohol, whilst the National Alcohol Strategy (2004) aims to encourage a more sensible drinking culture and reduce the burden of alcohol harm on society and the economy. The Cross Government Action Plan on Sexual Violence and Abuse (HM Government, 2007) and the Call to End Violence against Women and Girls strategy (HM Government, 2010a) both recognise that alcohol abuse can be a consequence of sexual violence. Acknowledgement of the role of sexual abuse in precipitating and fuelling alcohol dependence is particularly important at a time when a growing number of women (20%) are

consuming well above government guidelines, and alcohol abuse is costing the health service £2.7 billion each year (National Audit Office, 2008).

A change was recorded from 28% (24/87) to 11% (10/87) for strongly/agree with the statement 'I use alcohol to help me cope'. Therefore, less than half of those who strongly/agreed with the statement at the first data collection point no longer strongly/agreed at the last data collection point.

I use self harm to help me cope with my feelings

Self harm can take many forms, including repeatedly cutting the skin, burning, scalding, hitting, scratching, hair pulling or swallowing small amounts of toxic substances (Gill 1988; Hamilton 1998; Livingston 2004). The Cross Government Action Plan on Sexual Violence and Abuse (HM Government 2007) acknowledge self harm as one of the long term effects of sexual violence (see also Maniglio, 2011; Campbell et al., 2007; Itzin, 2006). The Mental Health Foundation and Camelot carried out an inquiry into self harm amongst 11-25 year olds and found that the risk factors associated with self-harm in younger populations seem to involve a number of common themes, including physical, emotional and sexual abuse (Mental Health Foundation and Camelot, 2006).

Without exception all service providers mentioned that self harm was used by many of their clients as a way of coping with their experiences. Some had seen an increase in the proportion of clients displaying self harm, but were sceptical of mainstream responses:

> *We are seeing more and more cases of women using self harm as a coping mechanism. We know that workers within the NHS have little understanding and often their response is one of impatience.* (Rape Crisis worker)

At the first point of data collection, one in five women in our study 20% (51/260) strongly/agreed with the statement 'I use self harm to help me cope with my feelings'. This supports research which has found that the rate of self harm has increased over the last two decades, giving the UK one of the highest rates in Europe (Royal College of Psychiatrists, 2010). Though self harm is often used as a coping mechanism (Santa Mina, 2010), research also shows a clear link to suicide – people who self harm are 66 times more likely than the general population to die by suicide in the subsequent year (Hawton et al., 2003).

As a response a range of problems in treating women who have self harmed, national guidelines (NICE 2004) have been issued to front line staff who come into contact with people who self harm. The Department of Health's (2011) consultation document on preventing suicide recognises that people who self harm are at increased risk of subsequent suicide, and suggests interventions which could reduce the number of suicides following self harm. The consultation acknowledges the importance of promoting the mental health of survivors and victims of abuse, including child sexual abuse. In 2004 the Mental Health Foundation and Camelot Foundation launched a National Inquiry into self harm calling on the Government to launch a UK-wide initiative to develop better and more appropriate responses to young people who self-harm (Mental Health Foundation and Camelot Foundation (2006).

A change was recorded from 17% (15/87) to 7% (6/87) for strongly/agree with the statement 'I use self harm to help me cope with my feelings'. Therefore, more than half of those who strongly/agreed with the statement at the first data collection point no longer strongly/agreed at the last data collection point.

I use non-prescribed drugs (such as heroin, cocaine, speed, cannabis) to help me cope.

As mentioned earlier, there was disagreement between Rape Crisis Centres as to the suitability of including this as a measure. This is because of a concern that women would not feel able to disclose illegal behaviour. In our study, 9% (19/216) strongly/agreed with the statement 'I use non-prescribed drugs (such as heroin, cocaine, speed, cannabis) to help me cope.'

Research has consistently documented associations between sexual violence and subsequent illegal substance abuse (Asgeirsdottir et al., 2011; Booth et al., 2011; Hayatbakhsh et al., 2009; Stewart 2000; Sharkansky 1999; Kilpatrick et al 1997; Bremner et al., 1996; Resick 1993). A study by Hayatbakhsh et al. (2009) found that, by the age of 21, women survivors of child sexual abuse were almost four times more likely than women who were not abused to be a frequent user of cannabis. Women who have been raped are twice as likely as those who have not been raped to have a substance use disorder (Booth et al., 2011). This likelihood of developing a substance use disorder increases with the number of times a woman is raped, with those who have been sexually assaulted four times in their lifetime being almost seven

times more likely to develop a substance use disorder than those who have never been raped (Booth et al., 2011). Kilpatrick (1997) found that rape victims are 26 times more likely to have two or more serious drug abuse problems than women who have not been raped. Other studies have found that rape victims are 3.4 times more likely to have used marijuana; 6 times more likely to have used cocaine and 10 times more likely to have used 'hard drugs' other than cocaine than non victims (Kilpatrick, Edmunds, and Seymour, 1992).

Rape support agencies were aware that many of their clients use non-prescription drugs to help them cope, although they did not always think their clients linked their drug use to the abuse they have suffered:

> *Over time their issues can become more complex. [The habit] becomes so deep rooted that many women think it is just the way they are rather than the direct result of the abuse.* (Rape Crisis worker)

> *I would think that around 80% of people who access drug services have suffered abuse.* (Rape Crisis worker)

The Cross Government Action Plan on Sexual Violence and Abuse (HM Government, 2007) recognises that drug abuse can be a consequence of sexual violence, with some people using illegal substances as coping mechanism in the aftermath of their assault. Consequently, the health service response to a woman's needs as a substance mis-user is unlikely to have long-term success unless her needs as a victim of sexual violence are also addressed. This has severe implications for the health service in terms of funding. The cost of treating people for the effects of alcohol and substance abuse is phenomenal, and is estimated to be £2.7 billion per annum for health services alone (Audit Office 2008).

A change was recorded from 6% (5/87) to 2% (2/87) for strongly/agree with the statement 'I use non-prescribed drugs (such as heroin, cocaine, speed, cannabis) to help me cope'. Therefore, more than half of those who strongly/agreed with the statement at the first data collection point no longer strongly/agreed at the last data collection point.

I have panic attacks

Panic attacks can be described as a sudden increase in anxiety accompanied by distressing physical sensations, such as nausea, sweating and trembling (NHS, 2010). Though panic attacks in themselves are not usually physically harmful, the symptoms are often so intense that the individual may feel as though they are going to die (Mind, 2008). The repeated experience of panic attacks over time, known as panic disorder, can give rise to depression and further anxiety disorders (Mind, 2008). The Cross Government Action Plan on Sexual Violence and Abuse (2007) recognised panic attacks as a potential consequence of sexual violence, whilst the mental health charity Mind (2008) notes that panic attacks are frequently seen among adult survivors of childhood abuse. The relationship between sexual abuse and panic attacks has also been documented within research findings (Bifulco, Brown, and Adler 1991; Foa and Riggs 1993; Resnick 1993; Ullman and Filipas 2001; Nixon, Resick, and Griffin 2004). Goodwin, Fergusson and Horwood (2005) found that young adults who had experienced childhood sexual abuse were more than four times as likely as those who had not been abused to experience panic attacks. It is possible that hypothesised that an appropriately extreme fear response to the initial abuse could predispose an individual to re-experiencing extreme feelings of panic later in life, after the abuse itself has ended (Goodwin et al., 2005).

At the first point of data collection, 64% (166/260) of women strongly/agreed with the statement 'I have panic attacks'. Interviews with Rape Crisis workers showed how panic attacks can affect rape victim survivors:

> *It's often different for each woman, they may be fearful of going out, or if it happened at home, afraid to stay in.* (Rape Crisis worker)

One service provider told us that many of their clients with anxiety disorders, including panic attacks have been in the mental health system prior to accessing rape support:

> *However, when sexual violence comes up…I don't think health professionals are not too keen on working with the client. They feel the need to refer to a specialist agency.* (Rape Crisis worker)

A change was recorded from 68% (59/87) to 43% (37/87) for strongly/agree with the statement 'I have panic attacks'. Therefore, around a third of those who strongly/agreed with the statement at the first data collection point no longer strongly/agreed at the last data collection point.

I feel depressed

Depression affects millions of people, and is set to be the second leading cause of global disability by 2020 (WHO, 2000). The disorder is twice as common in women as in men, a statistic which is strongly related to social factors (World Health Organisation, 2000). It has been well documented that depression in women is a common response to domestic violence, sexual violence and childhood sexual abuse (Cacardi, O'Leary and Schlee 1999; Green et al 2000; Krakow et al 2000; WHO 2000; Zimmerman et al 2003; Mind 2008; Heim et al., 2010; Chen et al., 2010). Walby and Allen (2004) report that 52% of women who have been subjected to serious sexual assault (including rape) suffer from depression, and a study by the Office for National Statistics (2001) states that up to 60% of women in the UK mental health service have been sexually abused in their lifetime. Chen et al. (2010)'s meta-analysis of 37 studies found that people who have been sexually abused are 2.7 times more likely to develop depression than those who have not been abused. The debilitating effects of depressive illness last for a long time after the attack itself. Machado et al. (2011) found that, after one month, 52% of women who had been sexually assaulted had moderate or severe depression. Even six months later, only 22% of the women were completely free of depressive symptoms. This was reflected in our study, with 73% (190/260) of the women strongly/agreeing with the statement 'I feel depressed'. One Rape Crisis worker told us how their feelings are often a mixture of anger and self-blame:

> *Sometimes the anger they feel is internalised and manifests itself into depression. We want women to feel they are not to blame so we challenge this feeling that they have.* (Rape Crisis worker)

Another told us that Rape Crisis services should be viewed as an alternative therapy to the traditional methods offered by health services:

> *Much of our work is with women who have depression and have been prescribed medication. Our therapy is an alternative to that.* (Rape Crisis worker)

There is evidence to suggest that sexual violence and childhood sexual abuse can have a negative effect upon brain chemistry and development (Heim et al., 2010), which can make them more vulnerable to future mental health problems (Weiss et al., 1999). A study by Heim

et al. (2000) found evidence to suggest that women with a history of sexual violence have an increased pituitary –adrenal response to stress which, when compared to a control group, was more than six times greater. Furthermore, child sexual abuse has been found to influence the physical properties of the brain itself. A study by Andersen et al. (2008) found that the age at which sexual abuse occurs influences the ways in which the brain is affected. Abuse at age 14-16 appeared to affect the development of the frontal cortex, a region which is important for decision making, whilst abuse at age 3-5 affected the development of the hippocampus, a region which lies in the middle of the brain and is important for memory processes.

A change was recorded from 72% (63/87) to 56% (49/87) for strongly/agree with the statement 'I feel depressed'. Therefore, around a quarter of those who strongly/agreed with the statement at the first data collection point no longer strongly/agreed at the last data collection point.

I have 'flashbacks' about what happened.

Research evidence has consistently documented a relationship between a history of sexual violence and the psychological distress of experiencing flashbacks (Arata 1999; Gold 1994; Resnick, Acierno and Kilpatrick 1997; Holstrom and Burgess 1978; Hellawell and Brewin, 2004). Flashbacks are different to ordinary memories in that they have very high levels of sensory content (Hellawell & Brewin, 2004), to the extent that the person often feels as though they are re-experiencing the traumatic event (Duke et al., 2008). Flashbacks occur in response to cues, both external, such as the smell of a perfume, and internal, such as a high level of anxiety (Milo, 1997). They can evoke a range of senses, and may involve images in the form of a video in one's mind, sounds, or even the feeling that someone or something is touching the individual (Milo, 1997). Survivors also experience intense emotions during and after a flashback, such as feelings of powerlessness, terror, and helplessness (Milo, 1997; Hellawell and Brewin, 2004). The frequency with which flashbacks occur varies considerably across individuals – some may only experience one flashback, while others experience daily intrusions (Milo, 1997). Research by Campbell (2001) suggests that women who have been raped re live the trauma, causing flashbacks, nightmares and thoughts that won't leave. A recent study found that, on average, the rate of flashbacks among a group of people who had been raped was 83 per year (Duke et al., 2008). Tyneside Rape Crisis Centre define flashbacks as:

... temporary states of remembering something painful or traumatic which has been hidden for quite some time in the subconscious mind and during a flashback you may feel as though aspects of the rape or sexual assault are actually happening to you now. The duration of a flashback differs and could last from a few seconds to a few hours. (Tyneside Rape Crisis Centre).

Rape Crisis staff told us that often survivors have flashbacks for many years after a sexual assault:

I don't think people understand that you can be affected even after a long time. Even after 25 years. (Rape Crisis worker)

The image may be visual and can also be accompanied by the feelings, smells and sounds associated with the assault. It's as if that person is right back in the experience, no matter how long ago it had taken place. (Rape Crisis worker)

Flashbacks can occur regardless of how the person is feeling. They can be triggered at any time and can happen anywhere. They can be triggered by anything that serves as a reminder of the sexual violence or just out of the blue. (Rape Crisis worker)

Our study supported previous findings regarding the high incidence of flashbacks among survivors of sexual violence – at the first point of data collection, 83% strongly/agreed with the statement 'I have flashbacks about what happened'. However, in spite of the research evidence documenting the frequency and invasiveness of flashbacks, and the knowledge gained by service providers in their work with women, there is no mention of flashbacks as a consequence of sexual violence in UK government health policy.

Whilst flashbacks are an extremely distressing consequence of trauma, appropriate support can alleviate their frequency (Hackmann et al., 2004). A change was recorded from 84%

(73/87) to 57% (50/87) for strongly/agree with the statement 'I have 'flashbacks' about what happened'. Therefore, around a third of those who strongly/agreed with the statement at the first data collection point no longer strongly/agreed at the last data collection point.

I have thoughts about ending my life.

In a recent meta analysis which included over three million participants, Chen et al. (2010) found that people who had been sexually abused were over 4 times more likely to attempt suicide than controls. This estimate is likely to be conservative owing to the under-reporting associated with sexual abuse (Chen et al.). Other studies have estimated the increased risk of suicide to be as high as 12 times the normal population for those who were sexually abused as children (Fellatti & Anda, 1998), and 13 times for those who have been raped (Kilpatrick et al., 1997). Bebbington et al. (2009) found significant differences between men and women in suicidal intent over the lifetime, with 17% of women reporting that they had explicitly considered suicide, in comparison to 12% of men. The relationship between gender and suicide attempts was no longer significant once sexual abuse was accounted for, suggesting that women's increased likelihood of suicidal phenomena may be explained by their increased likelihood of being sexually abused (5.2% of women reported sexual abuse, compared to 1.6% of men). It was found that, if sexual abuse were eliminated, the number of women who attempt suicide would fall by 28%. Furthermore, Bebbington et al. found that affect was a crucial factor in mediating the relationship between sexual abuse and suicidal behaviour, suggesting that positive levels of mental health could halve the number of suicide attempts following sexual abuse. This relationship between suicidal thoughts and behaviours and sexual abuse was reflected in our study. At the first time of data collection, 41% (106/260) women strongly/agreed with the statement 'I have thoughts about ending my life'. Furthermore, Rape Crisis staff told us that suicidal thoughts are a common response to sexual violence:

> *It's quite common for women to feel suicidal. There is a danger that we don't ask the things we should be asking. We shouldn't be afraid to ask these questions, they are really relevant.* (Rape Crisis worker)

The Suicide Prevention Strategy, published in 2003 by the National Institute for Mental Health England, (now disbanded and succeeded by the National Mental Health Development

Unit), aimed to reduce the suicide death rate by 20% by 2010. However, whilst the overall rate for 2007-09 was 14.2% lower than that of 1995-97 (HM Govt, 2011b), suicide levels have been increasing since 2007 (Samaritans, 2011), to 8.1 per 100,000 for the most recent 2009 figures (HM Govt, 2011b). This is some way from the Strategy's target of 7.3 per 100,000 for the 2009/10/11 period (National Mental Health Development Unit, 2009). As periods of economic instability and unemployment tend to correlate with an increase in the number of people choosing to take their own lives (National Mental Health Development Unit, 2009), it is likely that the rate will continue to rise.

Government publications have begun to recognise the role of sexual violence in suicide risk. The 2003 National Prevention Strategy included a specific objective of promoting the mental health of victims and survivors of abuse including child sexual abuse, whilst the more recent Consultation on Preventing Suicide (HM Govt., 2011b) notes the vulnerability of children who have been sexually abused, and the relationship between sexual violence and rates of depression. This Consultation also refers to the role of the cross governmental strategy Call to End Violence Against Women and Girls (HM Govt, 2010a) in reducing suicide rates, as well as the importance of funding agencies which specialise in supporting victims of sexual violence. A direct implementation of suicide prevention goals has been the issuing of a suicide prevention toolkit for mental health services (National Reporting and Learning Service, 2009). However, this toolkit does not mention the high risk group of sexual violence survivors, suggesting a potential lack of dissemination of crucial information to service providers.

Without this information, survivors will be unable to access high levels of support which could be crucial in helping them to escape suicidal feelings. Rape crisis support appears to have made a notable difference to respondents in our study. A change was recorded from 39% (34/87) to 23% (20/87) for strongly/agree with the statement 'I have a fear or phobia that prevents me from doing everyday things'. Therefore, more than a third of those who strongly/agreed with the statement at the first data collection point no longer strongly/agreed at the last data collection point.

I do not feel responsible for what happened to me.

Although victims may blame the rapist for the assault, they also blame themselves, which in turn harms their well being (Brascombe et al. 2003). There is a well documented relationship between self blame and lower self esteem and self worth (Katz & Burt, 1988; Miller et al. 2010). Miller et al. (2010) found that the more an individual blamed themselves for the assault, the more negative emotions they experienced. Self blame is linked to greater psychological distress (Koss, Figueredo and Prince, 2002), greater likelihood of PTSD (Ullman, Filipas, Townsend and Starzynski, 2007), higher levels of depression, and feelings of helplessness (Shaver and Drown, 1986; Abdullah et al., 2011). At the first point of data collection in our study, 38% (100/260) strongly/disagreed with the statement 'I do not feel responsible for what happened to me'.

The responsibility for rape always lies with the perpetrator, and as such, the common presence of self blame among survivors is unrelated to the objective facts of the assault. Instead, self blame is linked to the extreme emotions and pressures experienced by a survivor of sexual assault. This has been demonstrated by work by Miller et al. (2010), who found that the more distressed a woman was during the assault, the more likely she was to blame herself for its occurrence. One Rape Crisis worker described this relentless self blame:

> *Strangely enough even in these situations being threatened with a weapon, being dragged down an alleyway, somehow women still blame themselves. They say what is it about me, why me? I must have done something wrong. With rape by a stranger everything goes topsy turvey.* (Rape Crisis worker)

Koss et al. (2002) note that the criminal justice system is especially detrimental to rape survivors, as the process involves frequent attributions of blame upon the victim herself. This in turn encourages self blame, which is damaging to mental health and wellbeing (Koss et al., 2002). Unsurprisingly, the common feelings of self blame that victims already face can impact upon their decision to prosecute. This situation was noted by another Rape Crisis worker:

> *We also have to go the 1001 reasons why they think it's their fault. This is very common. They wonder what it was they did wrong. When you blame yourself it is impossible to seek justice.* (Rape Crisis worker)

The National Women's Study (Kilpatrick et al., 1997) found that rape victims are concerned about people blaming them for the rape. Their data revealed that 69% of rape victims worry about being blamed and 68% of rape victims are concerned about people outside of her family knowing about the rape. This concern is not unfounded. Findings from a 2005 Amnesty International UK (2005) poll of 1,000 people found that a third of people believe a woman is partially or completely responsible for being raped if she has behaved flirtatiously. It also found over 25% believe a rape victim is at least partly to blame if she has worn revealing clothing or been drunk. This practice of blaming the victim for her rape can be found across cultures (Grubb & Harrower, 2008) and across society, from the police, to healthcare providers, to providers of legal services (Suarez & Gadalla, 2010).

Schwartz and Leggett (1999) found that women who were too intoxicated to give consent tend to blame themselves and fail to label the attack as rape even when the incident clearly met the criteria of rape. This has a detrimental effect upon the already low rates of reporting. Kilpatrick et al. (2007) found that whilst 19.1% of female college students who had not consumed alcohol at the time of their rape reported the crime to the police, this was true of only 6% of those who had been drinking at the time. In drug facilitated sexual assaults, women are often hesitant to label the event as rape or to report the crime to the police due to memory impairment (Donovan 2000; Shwartz, Milteer, and LeBeau 2000; Fitzgerald & Riley, 2000). Wolitzky-Taylor et al., (2011) found that, when rape involved drugs or alcohol, only 2.7% of the women interviewed reported the assault to the police. One service provider however, said that regardless of whether alcohol was consumed or substances taken:

> *Society has a lot to say and perpetuates a stigma by saying things like you shouldn't have worn that skirt or gone out late at night. There is a perceived stigma to get over for all women who have suffered from sexual violence.* (Rape Crisis worker)

A change was recorded from 33% (29/87) to 22% (19/87) for strongly/disagree with the statement 'I do not feel responsible for what happened to me'. Therefore, around a third of those who strongly/disagreed with the statement at the first data collection point no longer strongly/disagreed at the last data collection point.

Moving on – conclusions from the pilot project

Interviews were conducted with managers and staff during and at the end of the pilot period. In addition, a workshop was organised by the research funder (Northern Rock Foundation) where the results were presented and discussed.

At the final interviews, only two of the five were still using an adapted version of the Taking Back Control tool. The others had either gone back to their original data collection tool or had started using the national Rape Crisis Data Management tool. Interestingly, one of the Rape Crisis Centres that was using an adapted version had continued its use because of recognition from the counsellors of the benefits of data collection. This is interesting since it is usually trustees, managers, and/or those responsible for finance/completing monitoring forms that push for data collection! It appears that by involving the whole organisation in the development and piloting of a tool can lead to ownership at all levels of the organisation. Even those who were going back to use their existing/planned to adopt the national data collection system saw the benefit of being involved in the pilot, and were able to describe how it had changed the data collection practices of their organisation. For example:

> *The choice of answers works better than the one to 10 scale we currently use. We also don't include regular monitoring of changes to eating, fears, flashbacks, panic attacks in our health outcomes form so it's on our 'things to do' list depending on how soon we can get the [national database].*(Rape Crisis worker)

Regardless of whether they were/planned to continue using the Taking Back Control tool, Rape Crisis Centres were able to give examples of how they had found it useful. Some talked about using it in funding applications or discussions with existing funders, others in training sessions.

Suggestions for change made in these interviews and in the roundtable event have been taken into consideration in the final draft of the measures, which are listed in Appendix 1. As well as the removal of the measures that did not give meaningful results (described earlier) these suggestions were to: simplify the reporting of results and to scale all measures the same way.

Appendix one. Revised Taking Back Control tool.

Please put a tick in the boxes that are most applicable to you.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Do not want to answer
1. I do not feel empowered and in control of my life.	☐	☐	☐	☐	☐	☐
2. I do not feel well enough to work or study.	☐	☐	☐	☐	☐	☐
3. I have a fear or phobia that prevents me from doing everyday things.	☐	☐	☐	☐	☐	☐
4. I over-eat, under-eat, or use food as a means of control.	☐	☐	☐	☐	☐	☐
5. I use alcohol to help me cope.	☐	☐	☐	☐	☐	☐
6. I use self-harm to help me cope with my feelings.	☐	☐	☐	☐	☐	☐
7. I have panic attacks.	☐	☐	☐	☐	☐	☐
8. I feel depressed.	☐	☐	☐	☐	☐	☐
9. I have 'flashbacks' about what happened.	☐	☐	☐	☐	☐	☐
10. I have thoughts about ending my life.	☐	☐	☐	☐	☐	☐
11. I feel responsible for what happened to me.	☐	☐	☐	☐	☐	☐
12. I use non-prescribed drugs (such as heroin, cocaine, speed or cannabis) to help me cope. [optional]	☐	☐	☐	☐	☐	☐

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