



CALCASA
CALIFORNIA COALITION
AGAINST SEXUAL ASSAULT

2014

SEXUAL VIOLENCE
RESEARCH REVIEW



ENVISIONING A WORLD FREE FROM SEXUAL VIOLENCE.

The mission of The California Coalition Against Sexual Assault (CALCASA) is to provide leadership, vision and resources to rape crisis centers, individuals and other entities committed to ending sexual violence.





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TABLE OF CONTENTS

EXECUTIVE SUMMARY

• Prevalence of Sexual Assault	6
• Consequences of Sexual Assault	6
• Supportive Interventions for Survivors of Sexual Assault	7
• Systems Response to Sexual Assault	7
• Sexual Assault Prevention	7
• Sexual Assault on College and University Campuses	7
• Sexual Assault in Military and Veteran Populations	7
• Sexual Assault in Prison and Detention Facilities	8
• Sexual Assault in the Context of Domestic Violence	8
• Population-Specific Sexual Assault Information	8
• References	9

PREVALENCE OF SEXUAL ASSAULT

• Assessing the Accuracy of Prevalence Estimates	12
• National Intimate Partner Sexual Violence Survey (NISVS)	12
• Other Prevalence Estimates	13
• Factors That are Related to Sexual Assault	13
• Perpetrators	14

CONSEQUENCES OF SEXUAL ASSAULT

• Mental Health Consequences of Sexual Assault	18
• Health Consequences of Sexual Assault	18
• Behavioral Consequences of Sexual Assault	18
• Cost of Sexual Assault to Individuals and Society	19
• Conceptual and Theoretical Frameworks for Thinking about Consequences of Sexual Assault	19
• Resilience and Protective Factors	19

SUPPORTIVE INTERVENTIONS FOR SURVIVORS OF SEXUAL ASSAULT

• Rape Crisis Center Services, Strengths, and Challenges	22
• Secondary Trauma Stress	23
• Survivor Help-seeking Experiences	23
• Mental Health Treatment Approaches for Trauma	23
• Religious Coping	23

SYSTEMS RESPONSE TO SEXUAL ASSAULT

• Health Care In General	26
• Benefits of Sexual Assault Nurse Examiners (SANEs)	26
• Effect of SANES on Prosecution	26
• CHALLENGES AND CRITIQUES OF SANES	26
• Police and Prosecutor Decision-Making	27
• Survivor Engagement with Criminal Justice	28
• Barriers to Reporting	28
• Secondary Victimization	28
• Critiques of Criminal Justice Goals	29
• Sexual Assault Response Teams (SARTs)	29
• Collaboration Across Systems	29

SEXUAL ASSAULT PREVENTION

• Prevention in Middle and High Schools	32
• Social Norms Approaches	32
• Engaging Men in Prevention	33
• Bystander Intervention	34
• Risk Reduction Approaches	35
• Theoretical and Conceptual Advances That Can Inform Prevention Work	35



SEXUAL ASSAULT ON UNIVERSITY + COLLEGE CAMPUSES

- Prevalence 38
- Characteristics and Risks of Campus Sexual Assault 39
- Campus Subcultures: Greek Life and Athletics 39
- Theoretical and Contextual Understandings of Campus Sexual Assault 40
- Help-seeking and Campus Resources 40
- Alcohol and Other Drugs as a Risk Factor for Campus Sexual Assault 41

SEXUAL ASSAULT IN MILITARY + VETERAN POPULATIONS

- Prevalence of Sexual Assault in Military and Veterans Populations 44
- Consequences of Sexual Assault in Military and Veteran Populations 46
- Services and Interventions in Military Contexts 47
- Theories about Sexual Assault in Military Contexts 47

SEXUAL ASSAULT IN PRISON + DETENTION FACILITIES

- Prevalence 50
- Pre-detention Sexual Assault Prevalence 51
- Reporting Barriers 51
- Perpetrators 51
- Survivors 51

SEXUAL ASSAULT IN THE CONTEXT OF DOMESTIC VIOLENCE

- Prevalence 54
- Characteristics and Risks 54
- Consequences 55
- Help-seeking 55

POPULATION-SPECIFIC SEXUAL ASSAULT INFORMATION

- Older Adult Survivors 58
- Male Survivors of Sexual Assault 59
 - Consequences
 - Help-seeking
 - Context
- Lesbian, Gay, Bisexual, Transgender Survivors 60
- Survivors with Disabilities 61
- Survivors in Rural Areas 61
- American Indian & Alaska Native Survivors 62
- Survivors of Human Trafficking 62

REFERENCES

63 - 73

EXECUTIVE SUMMARY

CALCASA is pleased to release this summary and compendium of research on sexual violence from 2005-2014 mostly from the United States. This document is both an update and a re-envisioning of the research reports last released by CALCASA in 2008. The 2008 CALCASA Report on Violence and Abuse can be found at www.calcasa.org/resources/publications. The current report focuses only on the most current research in order to reflect recent trends and advances in both the topics studied and methods used by researchers. We attempted to do a thorough review of the research literature, however this report is not meant to be an exhaustive detailing of every piece of research on sexual violence. Instead it is meant to be a concise summary of relevant research that can be used to support the work of CALCASA member agencies, rape crisis centers and rape prevention programs.

In order to enhance the usability of the document, we chose to focus on ten topics critical to the work of rape crisis centers: 1) Prevalence of Sexual Assault, 2) Consequences of Sexual Assault, 3) Supportive Interventions for Survivors of Sexual Assault, 4) Systems Response to Sexual Assault, 5) Sexual Assault Prevention, 6) Sexual Assault on University and College Campuses, 7) Sexual Assault in Military and Veteran Populations, 8) Sexual Assault in Prison and Detention Facilities, 9) Sexual Assault in the Context of Domestic Violence, and 10) Population-Specific Sexual Assault Information. The topics were chosen based on an initial review of the research literature and conversations among CALCASA staff.

When using research summarized in this document, users should cite the original study, not this document. Ideally, users should consult the original source prior to using the information for grants, community education and outreach, or other purposes. We have provided the full citation of all referenced articles in a bibliography to assist with locating the research included in this report. Users who do not have a way to access scholarly literature can contact CALCASA to obtain any needed research articles.

PREVALENCE OF SEXUAL ASSAULT

In 2011, the Center for Disease Control released a report detailing the findings of a large, methodologically rigorous research study on the prevalence and consequences of sexual assault, stalking, and intimate partner violence (Black et al., 2011). The study found:

- A lifetime sexual assault prevalence rate of 18.3% of women and 1.4% of men, meaning that almost 1 in 5 women and 1 in 71 men experiences rape in the span of their lifetime.
- 44.6% of women and 22.2% of men have experienced sexual violence other than rape in their lifetime (includes being made to penetrate someone, sexual coercion, unwanted sexual contact, and unwanted non-contact sexual experiences).
- Most rapes are committed by intimate partners (51.1% for women), acquaintances (40.8% for women, 52.4% for men).
- 79.6% of female victims of rape experienced their first rape before age 25, with 42.2% before the age of 18.
- 27.8% of male victims experienced their first rape by the age of 10.
- An estimated 1.3 million women were raped in the 12 months prior to the survey.

- State level estimates found that the lifetime prevalence of rape among women in California is 14.6% (or 2,024,000).
- California lifetime prevalence of sexual violence *other than* rape (including sexual coercion, unwanted sexual contact, sexual harassment among women is 40.7% (or 5,634,000).
- California lifetime prevalence of sexual violence *other than* rape among men is 22.1% (or 3,015,00).

CONSEQUENCES OF SEXUAL ASSAULT

- Sexual assault is consistently linked to increased rates of Post Traumatic Stress Disorder (PTSD) (Elklit & Christiansen, 2013; Masho & Ahmed, 2007; Zinzow et al., 2010), suicidal ideation (Basile et al., 2006; Behnken, Le, Temple, & Berenson, 2010; Bryan, McNaughton-Cassill, Osman, & Hernandez, 2013; Tomasula, Anderson, Littleton, & Riley-Tillman, 2012); and depression (Zinzow et al., 2010).
- McCollister, French & Fang (2010) calculate tangible and intangible losses and conclude that each rape costs \$240,000 (based on US context).

SUPPORTIVE INTERVENTIONS FOR SURVIVORS OF SEXUAL ASSAULT

- In an evaluation of STOP (Services, Training, Officers, and Prosecutors) funding and domestic and sexual assault programs, Zweig & Burt (2007) found that survivors found services helpful when they felt in control when working with staff, and when agencies interacted with the legal system and other community agencies. Also, when survivors entered the service system network by contacting rape crisis centers first, they rated agency helpfulness higher.
- Maier (2011) found that rape crisis centers struggle financially, and that when positions are eliminated, remaining staff and volunteers are overworked, services are reduced, and education and outreach activities are reduced. Administrators describe strategies for managing financial matters such as engaging in fundraising to diversify funding streams and coordinating and diversifying programming (including joining with domestic violence agencies) to tap into other funding sources.

SYSTEMS RESPONSE TO SEXUAL ASSAULT

- When victim has an exam, police collect more additional types of evidence which increases likelihood of prosecution. When Sexual Assault Nurse Examiners (SANE) conduct a suspect exam, police similarly more likely to collect additional types of evidence, interview the suspect, and refer the case for prosecution (Campbell, Bybee, Kelley, Dworkin, & Patterson, 2012).
- Beichner & Spohn (2012) found that legally relevant factors influenced prosecutor charging decisions in stranger rape cases, while legally irrelevant victim characteristics (victim prior criminal record, victim drinking behavior prior to assault, victim invited suspect to her residence) played a role in influencing charging decisions in nonstranger cases.
- Campbell (2006) also found that when a survivor has an advocate present, they are more likely to have a police report, less likely to be treated negatively by police and medical providers, report less distress as a result of interactions with legal and medical systems, and receive more medical services. Campbell cautions, however, that it's not clear whether the presence of the advocate itself accounts for the differences or whether communities that invite advocates into the response are also communities that do a better job of treating rape victims.

SEXUAL ASSAULT PREVENTION

- An evaluation of Shifting Boundaries found promising evidence that it increases knowledge and behavioral intentions and decreases actual violent behavior among middle school students (Taylor, Stein, Woods, & Mumford, 2011). The evaluation with 2700 students in 30 New York City middle schools included a school-level intervention (implementation of stay

away orders, better staff monitoring of "hot spots" and posters to increase awareness and reporting). Classroom sessions alone were not effective, but both the building intervention increased knowledge about laws and consequences, increased intentions to avoid perpetrating violence and to intervene. These components also reduced sexual harassment by 26-34% and peer sexual violence by 32-47%. The building intervention alone also reduced physical and sexual dating violence by 50%.

- Several reviews of the research on the effectiveness of sexual assault prevention programs and conclude that most programs improve student knowledge but fail to demonstrate lasting decreases in sexual victimization. They also review evidence that suggests that longer interventions, single gender audiences, and professional presenters may increase effectiveness of a prevention program (Anderson & Whiston, 2005; Daigle, Fisher, & Stewart, 2009; Vladutiu, Martin, & Macy, 2011).

SEXUAL ASSAULT ON COLLEGE AND UNIVERSITY CAMPUSES

- A study with 5446 undergraduate women found that nearly 20% of undergraduate women report attempted or completed sexual assault since entering college (Krebs, Lindquist, Warner, Fisher, & Martin, 2009).
- Smith & Freyd (2013) expand research on the role of betrayal in trauma by exploring institutional betrayal, or the belief that an institution failed to prevent sexual assault or respond in a supportive manner.
- Survivors who reported feeling institutional betrayal (mostly from their university/college) had higher anxiety and trauma-specific symptoms than those who did not feel betrayed by the institution.
- In a national sample of female college students, only 11.5% had reported their most recent rape to law enforcement and only 2.7% of rapes involving drugs or alcohol were reported. 18.7% of rape victims received medical care and 17.8% received assistance from a rape crisis center or other victim service program (Wolitzky-Taylor et al., 2011).

SEXUAL ASSAULT IN MILITARY AND VETERAN POPULATIONS

- The National Intimate Partner and Sexual Violence Survey, a large, nationally representative study, included two sub-samples drawn from military populations totaling 2836 women (the Department of Defense commissioned sub-samples only for females). 36.3% of active duty women and 32.8% of wives of active duty men had experienced sexual violence involving some sort of physical contact (Black & Merrick, 2013).
- 13% of male naval recruits in one study reported premilitary perpetration of sexual assault (Stander, Merrill, Thomsen, Crouch, & Milner, 2008). Among those men, 71% reported more than one incident of attempted or completed rape (McWhorter, Stander, Merrill, Thomsen, & Milner, 2009). They also reported

using substances to incapacitate victims more often than force, and targeting victims they knew rather than strangers. Those with a history of attempted or completed rape were more likely to perpetrate similar acts during military service.

SEXUAL ASSAULT IN PRISON AND DETENTION FACILITIES

- According to a Department of Justice report, 4% of prison inmates and 3.2% of jail inmates report experiencing sexual assault in a 12 month period. Gay, lesbian and bisexual (GLB) inmates had the highest rate of sexual victimization with 12.2% of GLB prisoners and 8.5% of GLB jail inmates reporting sexual victimization by another inmate, and 5.4% of prisoners and 4.3% of jail inmates reporting sexual victimization by staff (Beck, Berzofsky, Caspar, & Krebs, 2013).
- Male inmates in one study suggested that the most salient barriers to reporting rape were embarrassment, fear of harassment, and a fear of retaliation from the perpetrator (Levan, 2010).

SEXUAL ASSAULT IN THE CONTEXT OF DOMESTIC VIOLENCE

- The National Intimate Partner and Sexual Violence Survey (NISVS) found that 1 out of 10 women in the US (or about 11.1 million women) has been raped by an intimate partner in her lifetime. 1 in 6 women (or 19 million) have experienced sexual violence other than rape by an intimate partner. In the 12 months prior to the survey, an estimated 686,000 women were raped by an intimate partner and 2.7 million experienced sexual violence other than rape. 1 in 12 men (or about 9 million) have experienced sexual violence other than rape by an intimate partner in his lifetime (Black et al., 2011).
- Another study found that seeking help from social service and criminal justice agencies appears to be the most effective way to end sexual assault in the context of a violent relationship (Martin, Taft & Resick, 2007).

POPULATION-SPECIFIC SEXUAL ASSAULT INFORMATION

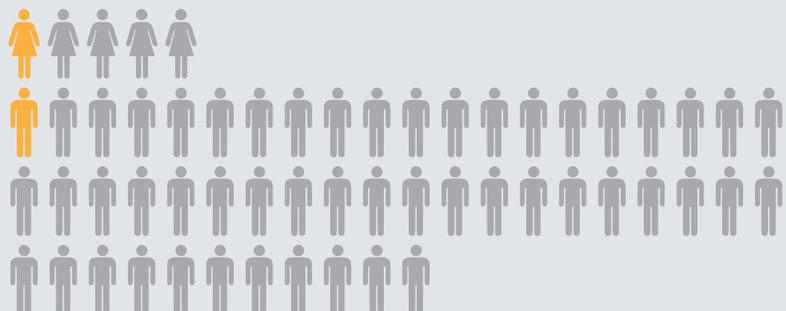
- A study by Cook, Dinnen & O'Donnell (2011) found that while older women report lower lifetime and past year physical and sexual assaults than younger women, those who have experienced sexual or physical violence report greater psychiatric distress (like PTSD or depression).
- In a review of the literature Tewksbury (2007) found that among male survivors of sexual assault, feelings of shame, stigma, fear that one's sexuality will be questioned are common, and anger or hostility are common. For male victims, sexual assault may be related to poor physical health, somatic complaints, sleep difficulties, depression, anxiety disorder, and substance abuse.
- A study using data from the National Youth Risk Behavior Survey found that female adolescents with physical disabilities were more likely to report having been physically forced to have sexual intercourse than those without disabilities (19.6% vs 9.4%) (Alriksson-Schmidt, Armour, & Thibadeau, 2010).
- NISVS found that 26.9% of American Indian and Alaska Native women reported rape in their lifetime and 49% reported sexual violence other than rape. 20.1% of American Indian or Alaska Native men reported sexual violence other than rape in their lifetime (Black et al., 2011).

The National Intimate Partner and Sexual Violence Survey, a large nationally representative survey (Walters, Chen, & Breiding, 2013), found that:

- Bisexual women had significantly higher lifetime prevalence of rape and sexual violence (46.1%) compared to lesbians (13.1%) and heterosexual women (17.4%). This was true when looking at rape by any perpetrator as well as when examining rape by intimate partners.
- Lifetime prevalence of sexual violence other than rape (being made to penetrate, sexual coercion, unwanted sexual contact, non-contact unwanted sexual experiences) was 46.4% for lesbians, 74.9% for bisexual women, 43.3% for heterosexual women, 40.2% for gay men, 47.4% for bisexual men, and 20.8% for heterosexual men.

A full report is available to CALCASA members. Please contact CALCASA to become a member.

1 in 5 women and 1 in 71 men experiences rape in the span of their lifetime.



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PREVALENCE OF SEXUAL ASSAULT



ASSESSING THE ACCURACY OF PREVALENCE ESTIMATES

Several researchers have investigated the accuracy of various means of assessing whether or not someone has experienced sexual assault. They consistently find that the way in which questions are asked alters the prevalence estimates produced (Abbey, Parkhill, & Koss, 2005; S. L. Cook, Gidycz, Koss, & Murphy, 2011; B. S. Fisher, 2009; C. Krebs, 2014). The National Intimate Partner and Sexual Violence Survey (detailed below) uses best practice survey wording and methodology to limit the problem of underreporting, but other sources of prevalence data may not. Some sources of data on prevalence of sexual assault rely on reports to the Federal Bureau of Investigation (Uniform Crime Reports) or otherwise, which systematically undercount the prevalence of sexual assault. When these figures are used, one should take care to highlight that the prevalence rate refers to reported rapes only.

California is home to over

2,000,000 

women who are survivors of rape

Approximately

8,500,000 

men and women are survivors of sexual violence other than rape over their lifetime

NATIONAL INTIMATE PARTNER SEXUAL VIOLENCE SURVEY (NISVS)

In 2011, the Center for Disease Control released a report detailing the findings of a large, methodologically rigorous research study on the prevalence and consequences of sexual assault, stalking, and intimate partner violence (M. C. Black et al., 2011). Using a large nationally representative sample of 16,507 men and women, the National Intimate Partner and Sexual Violence Survey provides some of the most robust and generalizable data on the frequency of sexual violence in the US. The study found:

- A lifetime sexual assault prevalence rate of 18.3% of women and 1.4% of men, meaning that almost 1 in 5 women and 1 in 71 men experiences rape in the span of their lifetime.
- 44.6% of women (almost 1 in 2) and 22.2% of men (1 in 5) have experienced sexual violence other than rape in their lifetime (includes being made to penetrate someone, sexual coercion, unwanted sexual contact, and unwanted non-contact sexual experiences).
- 13% of women and 6% of men have experienced sexual coercion (unwanted sexual penetration after being pressured in a nonphysical way).
- 27.2% of women and 11.7% of men have experienced unwanted sexual contact.
- Most rapes are committed by intimate partners (51.1% for women) or acquaintances (40.8% for women, 52.4% for men).
- 79.6% of female victims of rape experienced their first rape before age 25, with 42.2% before the age of 18.
- 27.8% of male victims experienced their first rape by the age of 10.
- An estimated 1.3 million women were raped in the 12 months prior to the survey.
- State level estimates found that the lifetime prevalence of rape among women in California is 14.6% (or 2,024,000).
- California lifetime prevalence of sexual violence *other than* rape (including sexual coercion, unwanted sexual contact, sexual harassment among women is 40.7% (or 5,634,000).
- California lifetime prevalence of sexual violence *other than* rape among men is 22.1% (or 3,015,000).

OTHER PREVALENCE ESTIMATES

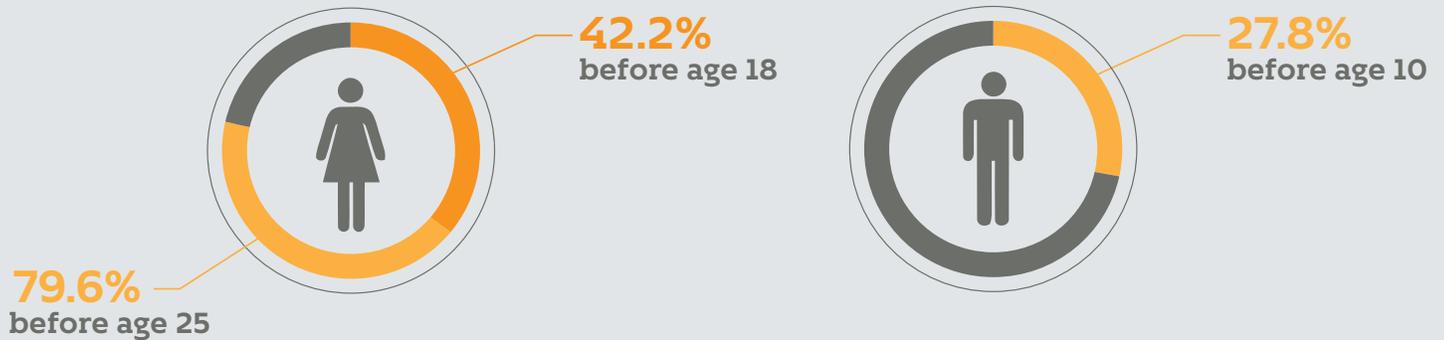
- The National Crime Victimization Survey (NCVS) is an annual, nationally representative survey administered to approximately 90,000 households in the US. According to this survey, in 2012 there were 346,830 sexual assaults, with 28% of assaults reported to police and 21.7% of victims receiving assistance from a victim service agency (Truman, Langton, & Planty, 2013). NCVS uses different survey wording than NISVS, which likely explains why it produces lower estimates of sexual assault prevalence.
- The Uniform Crime Report (UCR) data from the Federal Bureau of Investigations only reflects some crimes reported to law enforcement and, therefore, produces much lower estimates than other prevalence surveys. In 2012, 84,376 forcible rapes were reported to law enforcement agencies in the US and approximately 40% were cleared by arrest or other exceptional means. The FBI has recently changed the definition of rape used in the UCR to be gender neutral, include a wider variety of unwanted sexual acts, and to remove the word "forcible." The new definition went into effect in January 2013 and preliminary reports of 2013 data suggest an increase in reported rapes due to the broader definition being used to determine what law enforcement should count as a report of rape (www.fbi.gov/about-us/cjis/ucr).
- A nationally representative study focused on youth found that 8.9% of adolescents reported forced sex (about 1 in 8 females and 1 in 16 males) (Basile et al., 2006).
- A different nationally representative study of female adolescents found a lifetime prevalence rate of 12.2% for sexual assault (Elwood et al., 2011).
- A nationally representative survey of youth internet users (ages 10-17) found a decline in unwanted sexual solicitations online from 19% in 2000 to 13% in 2005 and 9% in 2010 (Mitchell, Jones, Finkelhor, & Wolak, 2013). Youth disclosed online sexual solicitations 53% of the time (compared to 39% in 2000), mostly to friends or parents. About 1 in 5 youth who experienced an online sexual solicitation said it made them feel very upset, afraid, and embarrassed.
- Ybarra & Mitchell (2008) found that 15% of youth experienced an unwanted sexual solicitation online and 4% of youth experienced such a solicitation on a social networking site. Instant messaging and chat rooms were the most common venues for solicitation.
- A study that examined prevalence of sexual assault among women, within various age cohorts, found that the lifetime prevalence rates appear relatively stable suggesting that the lifetime rate of sexual assault has remained constant (Casey & Nurius, 2006).

FACTORS THAT ARE RELATED TO SEXUAL ASSAULT

The following is a summary of research that suggests certain factors that might place people at higher risk for sexual assault victimization. However, it is important to note that researchers often cannot easily differentiate between cause and effect, especially if data was collected at only one time point. Even when researchers are able to determine chronological order (the risk factor pre-existed victimization), they may not have been able to control for all other possible explanations of the relationship. Therefore, these findings should be taken as suggestive of possible risk factors and should not be portrayed as certainties.

- An experimental study found that intoxicated women reported a decreased awareness of and discomfort with sexual assault risk clues in a hypothetical scenario, suggesting that alcohol might reduce perceptions of risk (Davis, Stoner, Norris, George, & Masters, 2009). Another study found various factors were associated with delayed assessment of threats and/or response to threats, including increased rape myth acceptance, prior coercive sex experiences, frequent pornography consumption, and prior victimization (Franklin, 2013).
- Another study found different variables were related to sexual assault victimization for intimate partner and non-intimate partner assaults. Prior IPV victimization, drug use, and low sexual refusal assertiveness were related to experiencing intimate partner sexual assault (M. Testa, VanZile-Tamsen, & Livingston, 2007).
- Other potential risk factors for sexual assault victimization include running away from home (Thrane, Yoder, & Chen, 2011), gang membership (Gover, Jennings, & Tewksbury, 2009), pre-existing PTSD (Elwood et al., 2011), child sexual abuse victimization (Elwood et al., 2011), and childhood exposure to domestic violence (Schewe, Riger, Howard, Staggs, & Mason, 2006).
- Homeless women with a history of child sexual abuse, substance abuse, lifetime sex trade activity, or previous incarceration are at increased risk of experiencing sexual assault (Hudson et al., 2010).

Victims of sexual violence experienced their first rape



Source: Statistics from 2010 National Intimate Partner & Sexual Violence Survey, Centers for Disease Control.

PERPETRATORS

Collecting accurate information about perpetration is challenging for a number of reasons. Some research on perpetrators has relied on non-representative samples (for example, only surveying convicted sex offenders). Survey question wording seems to influence whether or not perpetrators self-report their assaultive behaviors, with one study demonstrating that among the same sample of men, different questions designed to capture the same perpetration behaviors result in inconsistent findings (i.e. answer to one set of questions suggests that a person has perpetrated sexual assault, but the same person's answers on another set of questions would indicate a lack of perpetration) (Strang, Peterson, Hill, & Heiman, 2013). Those who perpetrate may not think of themselves as having perpetrated or might not want to admit it due to social desirability concerns. There is still a need for rigorous and accurate methods of assessing the rate of perpetration.

- A nationally representative survey found the self-reported prevalence of committing sexual assault was 0.15% (Hoertel, Strat, Schuster, & Limosin, 2012). The authors acknowledge that the rate of sexual assault is lower in this study than others, suggesting that the denial and minimization of abuse and the reluctance to disclose sexual assault behaviors might be a factor in the low rate. Those who did disclose committing sexual assault had lower levels of education; more antisocial behaviors, impulse control and related psychiatric diagnoses; and were more likely to have a cocaine use disorder.
- Tharp et al. (2013) systematically reviewed research and found consistent significant associations between 35 risk factors and sexual violence perpetration. The authors highlight two "constellations" of risk factors for sexual violence perpetration: 1) presence and

acceptance of violence at individual, family, and peer levels (includes risk factors like conflict in family of origin and peer support for sexual violence) and 2) unhealthy sexual behaviors, experiences or attitudes at individual or peer levels (includes things like having multiple sex partners, engaging in impersonal sex). Other consistent individual level risk factors include rape myth acceptance, hostility toward women, traditional gender role adherence, and hypermasculinity.

- A study of youth risky health behaviors found that 6.1% reported perpetrating sexual coercion. Factors like substance use, low social responsibility, family divorce, low parental monitoring, low social support, low school attachment, and low neighborhood monitoring were associated with self-reported perpetration of sexual coercion and dating violence. Gender and a history of victimization were the most significant predictors of perpetration (Banyard, Cross, & Modecki, 2006).
- Using a sample of male undergraduate students, one study found that 17.6% of participants reported perpetrating some form of sexual aggression since age 14, with 6.3% reporting sexually aggressive contact, 5.6% reporting sexual coercion, and 5.8% reporting attempted or completed rape. Over the three month period of the study, 10% reported perpetrating some form of sexual coercion, with 4.2% reporting sexually aggressive contact, 3.3% reporting sexual coercion, and 2.4% reporting attempted or completed rape (Gidycz, Warkentin, Orchowski, & Edwards, 2011).



1 IN 5



youth who experienced an online sexual solicitation said it made them feel very upset, afraid, and embarrassed.

Source: Mitchell, K. J., Jones, L. M., Finkelhor, D., & Wolak, J. (2013). Understanding the decline in unwanted online sexual solicitations for U.S. youth 2000–2010: Findings from three youth internet safety surveys. *Child Abuse & Neglect*.



CONSEQUENCES OF SEXUAL ASSAULT



MENTAL HEALTH CONSEQUENCES OF SEXUAL ASSAULT

- Sexual assault is consistently linked to increased rates of PTSD (Elklit & Christiansen, 2013; Masho & Ahmed, 2007; H. M. Zinzow et al., 2010), suicidal ideation (Basile et al., 2006; Behnken, Le, Temple, & Berenson, 2010; Bryan, McNaughton-Cassill, Osman, & Hernandez, 2013; Tomasula, Anderson, Littleton, & Riley-Tillman, 2012); and depression (Zinzow et al., 2010).
- Sexual assault can lead to feelings of disgust and mental contamination (feeling dirty and having the urge to wash) (Badour, Feldner, Babson, Blumenthal, & Dutton, 2013). This feeling, sometimes called mental pollution, appears to be significantly related to PTSD symptoms (Olatunji, Elwood, Williams, & Lohr, 2008).
- Revictimization (experiencing child sexual abuse and a subsequent adult sexual assault) is linked to higher levels of suicidality (Balsam, Lehavot, & Beadnell, 2011), PTSD (Filipas & Ullman, 2006), psychopathology, sexual functioning problems, adolescent pregnancy (Kaltman, Krupnick, Stockton, Hooper, & Green, 2005), and depression (Najdowski & Ullman, 2011).
- In one study, male and female victims of sexual assault display different patterns of response, with women displaying higher levels of guilt and men reporting higher anger directed inward (Galovski, Blain, Chappuis, & Fletcher, 2013).
- Females appear more likely than men to develop PTSD in response to trauma in general (Tolin & Foa, 2006).
- PTSD symptoms may be exacerbated by negative social reactions from others (Ullman, Townsend, Filipas, & Starzynski, 2007).

HEALTH CONSEQUENCES OF SEXUAL ASSAULT

- Rape, PTSD, and depression were all related to poor self-rated health (Amstadter, McCauley, Ruggiero, Resnick, & Kilpatrick, 2011).
- Of women seen in an emergency department sexual assault program, 62.8% had genital injuries (Baker & Sommers, 2008).
- Women with physical and sexual intimate partner violence reported poor/fair health, depression, and physical symptoms (Bonomi, Anderson, Rivara, & Thompson, 2007).
- Injury to victims was more likely when the offender was using substances (Brecklin & Ullman, 2010; Busch-Armendariz, DiNitto, Bell, & Bohman, 2010). Injuries led to time lost from work, school, and other activities (Busch-Armendariz, DiNitto, Bell, Bohman, 2010).

- Other health symptoms linked to sexual victimization include gynecological problems (Campbell, Lichty, Sturza, & Raja, 2006), greater intensity and frequency of health complaints (Conoscenti & McNally, 2006), and pain (McLean et al., 2012). PTSD was also linked to increased risk of health problems including diseases, endometriosis, fibromyalgia, and irritable bowel (Seng, Clark, McCarthy, & Ronis, 2006).

BEHAVIORAL CONSEQUENCES OF SEXUAL ASSAULT

- Several studies have found that having experienced sexual assault is associated with increases in alcohol and/or drug use (Balsam et al., 2011; Messman-Moore, Ward, & Zerubavel, 2013), including non-medical prescription drug use and abuse (Sturza & Campbell, 2005; Young, Grey, Boyd, & McCabe, 2011).
- Revictimization (experiencing both child sexual abuse and adult sexual assault) may increase the risk of various behavioral health concerns, like substance use and self-harm (Balsam, Lehavot, & Beadnell, 2011).
- Motives for drinking (for example, drinking to cope with negative emotions) may help explain the connection between sexual assault and negative drinking behaviors (Fossos, Kaysen, Neighbors, Lindgren, & Hove, 2011; Grayson & Nolen-Hoeksema, 2005; Lindgren, Neighbors, Blayney, Mullins, & Kaysen, 2012; Ullman, Filipas, Townsend, & Starzynski, 2005).
- Another study looked at drinking behavior at three time points, each one year apart, and also assessed for pre-existing sexual assault and assaults that occurred during the three year study period and concluded that heavy drinking was largely stable over time and not increased by sexual victimization (M. Testa, Livingston, & Hoffman, 2007).
- Adolescents with a history of forced sex were more likely to have used substances in the previous 30 days. Female victims were not as likely to have participated in team sports (Basile et al., 2006).
- Sexual assault experiences have also been associated with the following behavioral health concerns: smoking, activity limitations and poorer life satisfaction (Choudhary, Coben, & Bossarte, 2008); risky sexual behavior or increased sexual activity (Deliramich & Gray, 2008; Filipas & Ullman, 2006; Kaltman et al., 2005); withdrawal from others (Filipas & Ullman, 2006); eating disorders (Fischer, Stojek, & Hartzell, 2010; Forman-Hoffman, Mengeling, Booth, Torner, & Sadler, 2012); and sexual dysfunction (Postma, Bicanic, Vaart, & Laan, 2013; Sanjuan, Langenbucher, & Labouvie, 2009).

COST OF SEXUAL ASSAULT TO INDIVIDUALS AND SOCIETY

One way to make sense of the impact of sexual violence is to think of the costs to society and to individuals when rape occurs.

- McCollister, French & Fang (2010) calculate tangible and intangible losses and conclude that each rape costs \$240,000 (based on US context).
- Another method of accounting for the intangible costs of violent crimes (i.e. pain and suffering) involves estimating quality-adjusted life years that are lost as a result of the victimization. The authors conclude that rape results in the largest losses of all violent crimes of quality life years (based on UK context) (Dolan, Loomes, Peasgood, & Tsuchiya, 2005).

CONCEPTUAL AND THEORETICAL FRAMEWORKS FOR THINKING ABOUT CONSEQUENCES OF SEXUAL ASSAULT

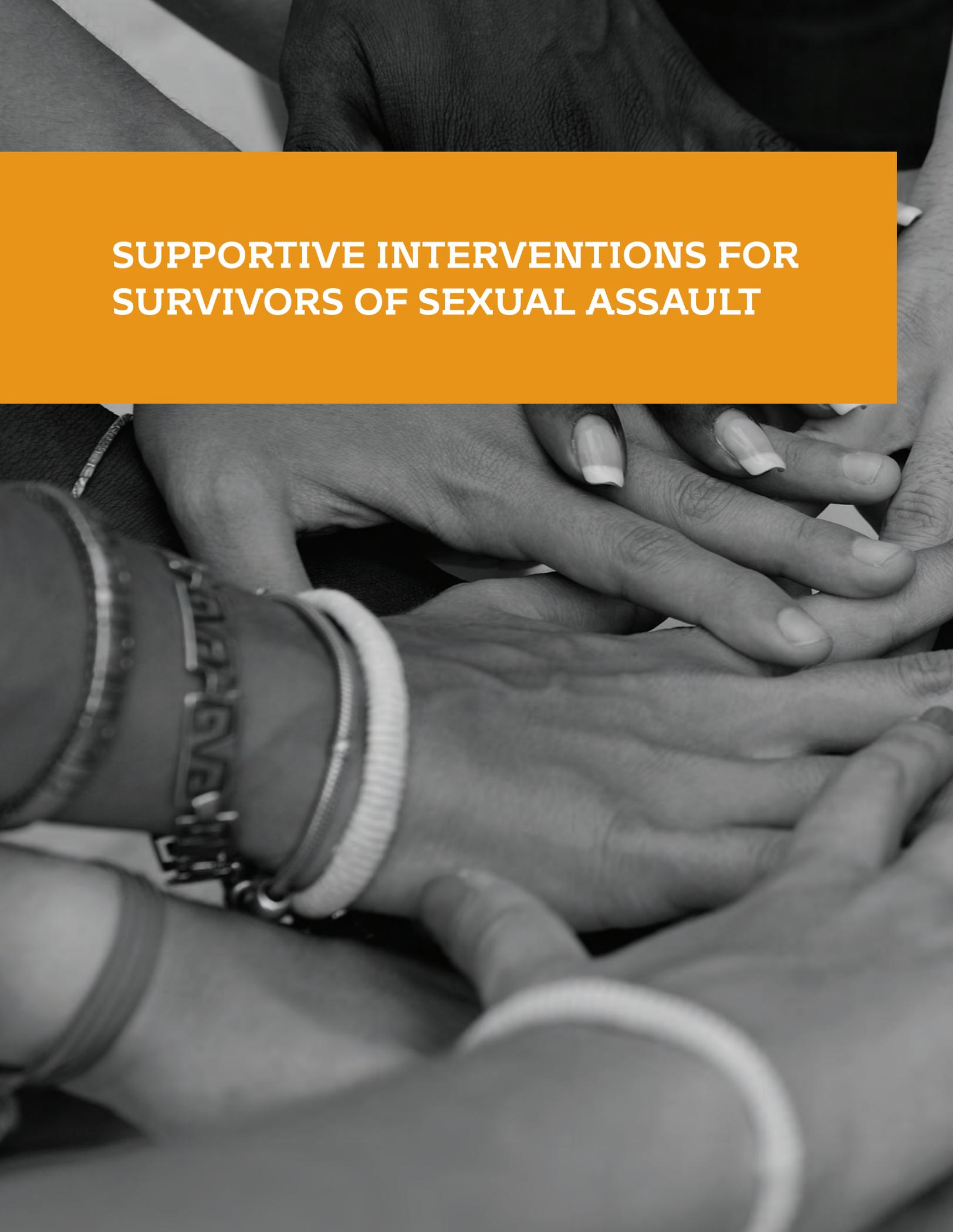
- Campbell, Dworkin & Cabral (2009) present an ecological model for understanding the impact of sexual assault on mental health, suggesting the importance of individual level factors (sociodemographics, biological/genetics), assault characteristics, informal support from friends and family, contact with formal systems, macrosystem factors (societal rape myth acceptance), and chronosystem factors (events over the life course).
- Bryant-Davis, Chung & Tillman (2009) argue for the need to consider interlocking experiences of racism, sexism, poverty, and intergenerational trauma when considering the mental health effects of sexual assault for African American, Asian American, Latina, and Native American survivors.
- Tillman, Bryant-Davis, Smith & Marks (2010) explore stigmatization of African American female sexuality and racism as barriers for African American survivors, again suggesting the need to contextualize survivors experiences in an understanding of interlocking experiences of oppression and a sociohistorical context. Mistrust and experiences of secondary victimization from service systems influences disclosure and utilization of formal supports.
- McKenzie-Mohr & Lafrance (2011) also highlight the role of patriarchy and discourses that individualize and depoliticize women's experiences of rape.

RESILIENCE AND PROTECTIVE FACTORS

Growing attention is being paid to the concept of resilience, or better understanding how and why some survivors seem to bounce back or recover more quickly than others.

- Certain personal characteristics might act as protective factors, for example one study found that having positive coping skills may make one resilient to coercive sexual assault (Walsh, Blaustein, Knight, Spinazzola, & Van, 2007).

- Perceived control over recovery from sexual assault was marginally associated with fewer suicide attempts and receiving aid and positive informational support was associated with less suicidal ideation (Ullman & Najdowski, 2009).
- Another study showed that perceived control over recovery was the only factor that predicted fewer PTSD symptoms (Ullman, Filipas, Townsend, & Starzynski, 2007).
- Steenkamp, Dickstein, Salters-Pedneault, & Hoffman (2013) suggest that recovery and resilience are different trajectories, distinguished by the amount of post-assault disruption. They argue that most survivors recover and adapt over a period of time, but that a gradual improvement over months should not be considered the same thing as resilience (which would show little disruption or a very quick return to stability).
- Survivors of childhood sexual abuse described healthy coping as involving seeking support, optimistic thinking, self-acceptance, and seeking meaning (Phanichrat & Townshend, 2010).
- A study with survivors of adult sexual assault suggests that healing from sexual violence may be a spiral pattern from breaking down, making meaning, and going beyond themselves (sharing their story, for example) (Murphy, Moynihan, & Banyard, 2009).
- Grubaugh & Resick (2007) explore post-traumatic growth among sexual assault survivors. The majority of participants described at least some degree of growth, although measures of PTSD and depression seemed unrelated to scores on a measure of growth.
- The degree to which survivors could attribute their victimization to situational circumstances external to themselves (rather than attributing the assault to their character, personality, or behaviors), the less distressed they felt by past experiences of sexual assault. Those with a personal belief in a just world were better able to adjust to sexual assault (Fetchenhauer, Jacobs, & Belschak, 2005).
- Adolescent sexual assault survivors who disclosed their assault to their mothers were at decreased risk for PTSD and delinquency (Broman-Fulks et al., 2007). Those who disclosed to someone within a month of the assault had a reduced risk of depression and delinquency.
- Ai & Park (2005) advocate for greater attention to resilience and recovery as a counterpoint to the almost exclusive focus on symptoms and pathology related to experiencing trauma. The authors highlight positive psychology, the role of spirituality and religion, and post-traumatic growth as areas for future research.



**SUPPORTIVE INTERVENTIONS FOR
SURVIVORS OF SEXUAL ASSAULT**



RAPE CRISIS CENTER SERVICES, STRENGTHS, AND CHALLENGES

There are a limited number of recent studies that evaluate the core services of rape crisis centers (RCCs). A slightly larger number of studies document the perspectives of staff and volunteers about strengths and challenges of RCC work in the current era.

- A thorough review of research and practice guidelines (for example, from state sexual assault coalitions) regarding sexual assault services identified best practices for rape crisis centers. Core sexual assault services include 24 hour crisis hotline, legal advocacy, medical advocacy, support groups and individual counseling. For each core service, the authors reviewed service goals, interventions, and practices. An example of a service goal is to enhance a survivor's capacity to cope. An intervention (or technique/ action) example is to normalize a survivor's reaction to rape. A practice example is that the service should be available 24 hours a day, 7 days a week, 365 days a year. The article contains a useful table outlining the full range of service goals, interventions and practices which are too plentiful to list here (Macy, Giattina, Sangster, Crosby, & Montijo, 2009).
- Maier (2011b) found that RCCs struggle financially, and that when positions are eliminated, remaining staff and volunteers are overworked, services are reduced, and education and outreach activities are reduced. Administrators describe strategies for managing financial matters such as engaging in fundraising to diversify funding streams and coordinating and diversifying programming (including joining with domestic violence agencies) to tap into other funding sources.
- Larsen, Tax & Botuck (2009) recount how engaging in evaluation at a victim service organization helped the organization meet strategic goals around standardizing practice.
- Macy, Giattina, Parish & Crosby (2010) outlined challenges faced by domestic and sexual assault service agencies in North Carolina. Challenges include insufficient funding, onerous funder requirements, sustainability, community norms, tension between grassroots and professional services, lack of attention to sexual assault, need for services that meet the needs of all survivors, and the need for services to help survivors with co-occurring substance abuse and mental health problems.
- Domestic violence and sexual assault agency directors in North Carolina indicated that the most important service goal was the provision of emotional support. Other goals highly rated included safety planning, provision of violence information, and social support (Macy, Johns, Rizo, Martin, & Giattina, 2011).
- Domestic violence and sexual assault service agency directors were asked their opinions about agency priorities. Directors consistently agreed that hotlines, medical and legal advocacy should be offered 24 hours a day, 7 days a week, but were less consistent in their opinion regarding whether these services should be provided by staff or volunteers. Directors also felt that support groups were most helpful when they were open and ongoing, but split in their opinions about whether group members should have similar experiences (Macy, Rizo, Johns, & Ermentrout, 2013).
- In a study interviewing rape crisis center directors and staff, Maier (2008b) found that the majority of directors identified their agencies as feminist, but that they and the staff downplay their feminism for fear of alienating members of their community or potential collaborators. 60% of advocates interviewed identified themselves as feminist, though many talked about the negative connotations that people have about feminism as "male bashing."
- Payne (Payne, 2008; Payne, Button, & Rapp, 2008; Payne, Ekhomu, & Carmody, 2009) explored challenges of community and campus based sexual assault advocates. Advocates named lack of community awareness, victim blaming, territorial struggles with law enforcement, and a lack of resources as their primary challenges. Campus sexual assault advocates also mentioned barriers like faculty and staff not being aware of the policies that campuses must follow.
- Sexual assault advocates described the biggest challenge of their work as witnessing survivors experiencing secondary victimization behaviors from legal and medical systems. Other barriers included societal attitudes (denial of rape, racism, sexism, classism, etc.), organizational barriers (lack of funding, racism in rape crisis centers, professionalization), and staff burnout. (Ullman & Townsend, 2007). Advocates in another study similar cited victim blaming behavior as a significant challenge they face in their work (Maier, 2008a). Advocates highlighted the importance of their automatic presence at the hospital and their role of supporting survivors, promoting survivor control over the response, and reassuring survivors that the rape was not their fault.
- In an evaluation of STOP funding and domestic and sexual assault programs, Zweig & Burt (2007) found that survivors found services helpful when they felt in control when working with staff, and when agencies interacted with the legal system and other community agencies. Also, when survivors entered the service system network by contacting rape crisis centers first, they rated agency helpfulness higher.
- A study that attempted to follow up with sexual assault survivors after they received health care services found that 3 months after the assault, only 23% of the sample could be contacted by telephone for follow-up and none of the letters mailed to survivors received a response (Boykins & Mynatt, 2007). This suggests the importance of providing comprehensive services at the initial point of contact.

SECONDARY TRAUMATIC STRESS

A few studies that explore the impact of working with survivors of sexual assault are worth noting.

- A study with 154 members of the National Association of Social Work who provide direct services to survivors of sexual and domestic violence found that support from coworkers, supervisors, and work teams was associated with lower levels of secondary traumatic stress, as was having access to strategic plan information for the agency (Choi, 2011).
- A study with 101 sexual assault and domestic violence advocates found that those who were motivated by their own experiences of trauma report more symptoms of secondary/vicarious trauma and burnout, but also report positive changes (like dealing with their own trauma). Those who are motivated by seeking personal meaning report more hypervigilance and self-isolation. Those who say they learn from clients exhibit lower symptoms of secondary/vicarious trauma and burnout, suggesting a potential protective factor (Jenkins, Mitchell, Baird, Whitfield, & Meyer, 2011).

SURVIVOR HELP-SEEKING EXPERIENCES

- Adult survivors of childhood sexual abuse use more hours of services, make more service contacts and are more likely to use telephone and in-person counseling services than survivors of adult sexual assault (S. F. Grossman et al., 2009).
- Kennedy et al (2012) used research to develop a conceptual model of help-seeking. The model suggests that important components in the help-seeking process include the survivor's assessment of their needs, the perceived availability and fit of services, and the impact of past help-seeking experiences and survivors' perceptions of whether those services were actually helpful. Also important are contextual factors, like gender, poverty, race and discrimination, and individual factors like life course transitions, family status, and relationship to the perpetrator.
- The Sexual Assault Among Latinas Study found that one-third of the women who had experienced victimization (physical, sexual, stalking, threats, etc) in their lifetime sought formal services and 70% sought informal support. Help seeking did not differ by immigration status, legal status, or language preference, but formal help-seeking was associated with having a higher level of acculturation (Sabina, Cuevas, & Schally, 2012a). Medical attention was the most common form of formal help-seeking among those who were injured (34.7%). Informal support was most often sought from parents (26.6%) and friends (21.5%). Of those who had experienced sexual victimization only 20.8% sought formal help (only 6.6% from police) and 58.3% sought informal help (about 18% from parents and 18.5% from friends) (Sabina, Cuevas, & Schally, 2012b).

- Another study with adult sexual assault survivors found that 80% told someone about their rape. Those who disclosed to formal services experienced assaults that conformed to stereotypes about rape. They also had higher PTSD symptoms, but engaged in less behavioral self-blame. Those who solely disclosed to informal supports received fewer negative reactions than those who also disclosed to formal supports (Starzynski, Ullman, Filipas, & Townsend, 2005).

MENTAL HEALTH TREATMENT APPROACHES FOR TRAUMA

There are many models of mental health treatment for survivors of sexual violence experiencing PTSD, depression, anxiety or other emotional distress. Due to the large number of studies examining the effectiveness of these treatments, we have selected to share representational findings that point toward some of the methods that are repeatedly shown to be effective, as well as to highlight a few additional promising, but less well researched, treatment approaches.

- Several articles that reviewed research evidence conclude that the following treatments have consistent statistically significant effects of reducing PTSD symptoms, depression, anxiety, guilt, and/or dissociation (Regehr, Alaggia, Dennis, Pitts, & Saini, 2013; Russell & Davis, 2007; J. E. Taylor & Harvey, 2009; Vickerman & Margolin, 2009):
 - Exposure therapy (or prolonged exposure therapy)
 - Cognitive behavioral/restructuring approaches
 - Eye Movement Desensitization and Reprocessing
- At least one study examined the long-term gains of participating in cognitive processing or prolonged exposure therapy and found that 5-10 years after completion of treatment, the effects of treatment (lowered PTSD symptoms, for example) had been maintained, even after controlling for additional medication or therapy. However, around 20% of survivors still met the diagnosis for PTSD (Resick, Williams, Suvak, Monson, & Gradus, 2012).

RELIGIOUS COPING

In one study positive religious coping appeared associated with better psychological well-being and less depression. Negative religious coping (religious struggle and disconnection or using religion to avoid one's problems), however, was associated with higher levels of depression. The sample had high rates of religious coping and African American survivors were more likely to use both positive and negative forms of religious coping (Ahrens, Abeling, Ahmad, & Hinman, 2010).

SYSTEMS RESPONSE TO SEXUAL ASSAULT





HEALTH CARE IN GENERAL

A national sample of US hospitals found that only 17.4% provided comprehensive services for sexual assault survivors. Only 40.2% provided rape crisis counseling, 60.3% provided emergency contraception, 77% provided STI management, and 65.3% provided HIV management (Patel et al., 2013).

BENEFITS OF SEXUAL ASSAULT NURSE EXAMINERS (SANES)

- SANEs utilize an "empowering care" model including providing healthcare, respectful treatment of survivors, believing survivor stories, and respecting survivor control, choice, and decisions. An evaluation of this model found that the vast majority of survivors who received these services found them to be positive and in line with the goals of empowering care (Campbell, Patterson, Adams, Diegel, & Coats, 2008). Survivors found these services "humanizing", though some felt nurses were hurtful when they were not provided with choices and explanation or when nurses acted cold and distant (Fehler-Cabral, Campbell, & Patterson, 2011).
- SANE programs promote psychological well-being among survivors, provide consistent health care, document evidence accurately, improve prosecution, and bring together service providers (Campbell, Patterson, & Lichty, 2005).
- One study found that while most women wanted their physical and emotional health needs met, rather than evidence collected, SANE patients were "overwhelmingly satisfied" with SANEs. However, some women were confused about the purpose of the exam, felt pressured to get the exam, or felt distressed or traumatized during the exam (Du Mont, White, & McGregor, 2009).

EFFECT OF SANES ON PROSECUTION

- In one community, cases after the initiation of a SANE program progressed further in the criminal justice system and more cases reached stages of conviction or plea bargains (Campbell, Patterson, & Bybee, 2012).
- When victim has an exam, police collect more additional types of evidence which increases likelihood of prosecution. When SANEs conduct a suspect exam, police are similarly more likely to collect additional types of evidence, interview the suspect, and refer the case for prosecution (Campbell, Bybee, Kelley, Dworkin, & Patterson, 2012).
- Medical forensic evidence collected by SANEs contributes to case outcomes above and beyond victim (e.g. age, race) and assault related (e.g. relationship to perpetrator, alcohol use) characteristics (Campbell, Patterson, Bybee, & Dworkin, 2009).

CHALLENGES AND CRITIQUES OF SANES

- SANEs report high emotional demand in their jobs, with 51% indicating they have experienced vicarious trauma and 46% indicating some amount of burnout (Maier, 2011a).
- Individual factors (like agreeableness) and workplace characteristics (like perceived empowerment and satisfaction with pay) predict SANEs' intent to leave their position (Strunk & Strunk, 2012).
- 72% of SANE directors cite lack of funding as a barrier to their sustainability (Maier, 2012a). The political nature of state budgets and hospital bureaucracy focus on income generating activities both provide challenges for SANE funding. Lack of funding impacts ability to train nurses, provide professional development, offer adequate compensation, and purchase necessary equipment.
- SANEs are often expected to maintain objectivity and neutrality to enhance their role as expert witnesses (Canaff, 2009). However, SANEs must find ways to balance their role as nurses providing compassionate care with the demands of the criminal justice system (Campbell, Greeson, & Patterson, 2012; Downing & Mackin, 2012). Some strategies used by SANEs include compartmentalizing the various parts of their role, breaking the rules and showing compassion even when it threatens their neutrality, and relying on the rape crisis advocate as a proxy for their own compassionate response.
- In addition, some have suggested that the focus on neutrality actually undermines the potential of SANEs to make more definitive statements about cases or explain the limits of evidence (for example about lack of evidence of injury) that could positively influence prosecution (Rees, 2010). Corrigan (2013) suggests that the emphasis on forensics might also have an unintended consequence of discouraging reporting, investigating and prosecution, reinforcing stereotypes about victims, and undermining fair and thorough investigations.
- McGregor, DuMont, White & Coombes (2009) suggest that research on SANEs needs to also explore issues of consent in terms of exams, social justice, gender sensitive training, and critical analyses of various procedures.

POLICE AND PROSECUTOR DECISION-MAKING

- One study found that only 9.7% of rape cases resulted in charges being filed. Police founded 90% of the reports they received, but made arrests in only 35% of those cases. Most of the factors that predicted prosecutor decision making in this study were "extralegal factors." For example, discrepancies in victim statements reduced the odds of charges being approved by 90% (Alderden & Ullman, 2012a).
- Beichner & Spohn (2012) found that legally relevant factors influenced prosecutor charging decisions in stranger rape cases, while legally irrelevant victim characteristics (victim prior criminal record, victim drinking behavior prior to assault, victim invited suspect to her residence) played a role in influencing charging decisions in nonstranger cases.
- A study found that male police officers were 50% more likely to arrest a suspect than female officers were, even after controlling for a variety of other factors related to arrest in rape cases (Alderden & Ullman, 2012b). Victim resistance to the attack increased the odds of arrest by almost double, while declining a rape kit decreased the odds of arrest by 57%. Other factors like victim's "questionable moral character" and acquaintance or intimate relationship with the perpetrator actually increased odds for arrest. It is important to note that the authors were only looking at whether arrests were made, not whether charges were authorized or cases prosecuted.
- Rapes that co-occur with other crimes (e.g. burglary) are more than twice as likely to be reported and 1.5 times more likely to be referred for prosecution as compared to rapes that did not co-occur with another crime (Addington & Rennison, 2008).
- A study with 891 police officers found that those who endorsed more rape myths were less likely to pursue investigation of rape reports from victims who did not adhere to stereotypes about "genuine victims." A sizable number of officers also overestimated the number of false reports of rape, with 36% of officers saying 11-25% of rape reports involved women lying about being raped, 17% saying 25-50% of cases involve women lying, and about 8% indicating that 50-75% of cases are false (Page, 2008). Furthermore, higher rape myth acceptance among officers was related to lower knowledge and skill about how to interview rape victims (K. Rich & Seffrin, 2012).
- Other studies show factors that may be associated with increased prosecution outcomes include: police conducting a suspect interview (Kelley & Campbell, 2013), police investment of above average investigational effort (Kelley & Campbell, 2013), geographic isolation, eg. rural areas (Wood, Rosay, Postle, & TePas, 2011).



9.7% 

of rape cases resulted in charges being filed

Source: Alderden, M. A., & Ullman, S. E. (2012a). Creating a more complete and current picture: Examining police and prosecutor decision-making when processing sexual assault cases. *Violence Against Women*.

SURVIVOR ENGAGEMENT WITH CRIMINAL JUSTICE

- One study suggested that survivors' decision to participate in prosecution was predicted by support from family/friends, social service providers, and police. That support, however, was predicted by whether the assault and/or victim characteristics fit ideas of a "typical" rape (Anders & Christopher, 2011).
- Assault characteristics (like weapon use, physical injury, public location of rape, and rape occurring as part of a break-in) were associated with a 2-3 times higher likelihood of victim or others reporting the rape (Clay-Warner & McMahon-Howard, 2009).
- A study exploring survivors' decisions to report and participate with prosecution revealed that half of the survivors suggested they reported to prevent the perpetrator from continuing to assault themselves or others. A quarter of the respondents said that support and encouragement from friends or family helped them identify what happened as rape and overcome fears that they would not be believed, which encouraged them to report to police. Survivors also attributed their on-going participation in prosecution to their desire to prevent the perpetrator from assaulting again, as well as to encouragement from responders who offered support or tangible evidence to support their report (Patterson & Campbell, 2010).
- A study by Greeson & Campbell (2011) explored the ways that survivors actively use their agency to achieve specific outcomes in their interactions with medical and legal systems. Some survivors comply with systems in order to achieve the case outcomes they desire, while others do not comply (or defy) in order to protect themselves from harm that may come from further involvement in the criminal justice system. At other times survivors use defiance to challenge the systems in hopes of changing the response to their case.
- Victims with prosecuted cases described detectives as being compassionate, while those with cases that were not prosecuted described troubling, secondary victimization behaviors from their first interactions with the officers (Patterson, 2011a). Victims also report that gentle questioning from officers influences their comfort and ability to disclose information that can strengthen the criminal case (Patterson, 2011b). Building rapport, using a slow and comfortable pace, communicating empathy, and projecting believability were all officer characteristics that survivors found to benefit their comfort and ability to provide important information to the investigation.

BARRIERS TO REPORTING

- Commonly reported barriers for reporting to police in one study included not wanting others to know, not acknowledging what happened as rape (which was most common in alcohol-involved assaults), and concerns about the criminal justice process (Cohn, Zinzow, Resnick, & Kilpatrick, 2013).
- A study with American Indian women found that suspicion of law enforcement, thinking law enforcement would not believe them or would blame them, prejudice, feeling as if they or their family could deal with the perpetrator, conflicts between western and native values, language barriers, and poverty influenced their decisions not to report rape to police (Hamby, 2008).
- Among a sample of those receiving a forensic exam, 75% reported to the police. Of those that did not report, factors such as a history of recent alcohol or drug use, a known assailant, and longer time between assault and forensic exam was associated with their decision not to report. Survivors' reasons for not reporting included concerns about others knowing, feeling partially responsible for the assault, feelings of shame and embarrassment, not wanting the perpetrator to go to jail, and a belief that police would be insensitive or blame them (J. S. Jones, Alexander, Wynn, Rossman, & Dunnuck, 2009).

SECONDARY VICTIMIZATION

- A study by Campbell (2005) interviewed victims and service providers following emergency medical care. She found that victims and providers mostly agreed on the amount of secondary victimization behaviors ("statements/actions that could be distressing to victims") engaged in by providers, but police and doctors rated those behaviors as much less distressing to victims than the victims indicated, suggesting that providers may not realize how these behaviors are experienced by victims.
- Campbell (2006) also found that when a survivor has an advocate present at the hospital, they are more likely to have a police report, less likely to be treated negatively by police and medical providers, report less distress as a result of interactions with legal and medical systems, and receive more medical services. Campbell cautions, however, that it is not clear whether the presence of the advocate itself accounts for the differences or whether communities that invite advocates into the response are also communities that do a better job of treating rape victims.

- In an overview of the research, Campbell (2008) describes some of the difficulties for survivors who engage with the criminal justice system. For example, survivors described how police officers discourage reporting by focusing on the personal/emotional costs of prosecution, warning that they will press charges if it is discovered that she is lying, and repeatedly questioning survivors about what they were wearing, their past sexual history, and other victim-blaming details. Survivors say their interactions with law enforcement leave them feeling bad, depressed, and reluctant to seek further help.
- Advocates described a variety of secondary victimization behaviors they have witnessed police officers engage in, including invasive questioning, victim-blaming, insensitivity, nor proceeding with the investigation, adopting a cold manner and doubting the veracity of survivors who do not conform to stereotypes of how victims should act after being assaulted (Maier, 2008a).
- SANEs also indicated that officer's insensitive manner and victim-blaming attitudes are sources of secondary victimization for victims. The legal system was also seen by some SANEs as a source of secondary victimization, particularly when cases do not progress through to trial or are repeatedly postponed, when a survivor's credibility is questioned, or when the focus seems to be on the rights of the defendant and not on the victim (Maier, 2012c).
- One challenge for SARTs might be combatting "overcoalitioned communities" where providers who are called on to attend multiple community level meetings become fatigued and begin to withdraw from attending coordination meetings (Campbell, Greeson, Bybee, & Fehler-Cabral, 2012).
- Differing orientations to victim confidentiality may pose a challenge to collaboration on SARTs. There is a lack of consensus about how to understand confidentiality and criminal justice and medical professionals may not always understand advocate policies regarding confidentiality (Cole, 2011).
- Certain assaults, such as those that involve alcohol or a known perpetrator, may pose more challenges to the collaboration of SART providers due to differences in reactions toward victims, differing orientations regarding criminal justice goals, and greater uncertainty that leads to more disagreement and frustration (Cole & Logan, 2010).

CRITIQUES OF CRIMINAL JUSTICE GOALS

- Larcombe (2011) argues for a need to move beyond prosecution as a goal and to better articulate feminist, victim-centered outcomes, such as broadening society's understanding of rape, improving the treatment of victims, and increasing respect for victims when they disclose rape.
- Others have explored the concept of restorative justice as an alternative framework for achieving justice for survivors (Bletzer & Koss, 2012; Hopkins & Koss, 2005; McGlynn, Westmarland, & Godden, 2012).

SEXUAL ASSAULT RESPONSE TEAMS (SARTS)

- Greeson & Campbell (2013) reviewed the small body of research on SARTs and found evidence suggesting that SARTs may be successful at improving relationships among responders, improving legal outcomes and improving victims' help-seeking experiences. SARTs, however, still face challenges overcoming organizational barriers, acquiring broad participation, and managing conflicting goals.

COLLABORATION ACROSS SYSTEMS

- SANEs described a variety of challenges to collaboration with rape crisis advocates, including autonomy and turf issues, SANE and advocate roles that are not clearly distinguished from one another, when advocates overstep their role, and differing objectives. Strategies for improving collaboration included open communication, establishing clear roles, and engaging in mutual training to ensure understanding of those roles (Cole & Logan, 2008).
- SANEs described positive relationships with other service system providers as involving open communication, respect toward SANEs, respect toward victims, and appreciation of SANEs. Negative relationships were the result of SANE witnessing mistreatment of victims by police, advocates overstepping boundaries and questioning SANEs, or when prosecutors do not adequately prepare SANEs to testify (Maier, 2012b).
- In one study with rape crisis advocates in Virginia, advocates detailed several barriers to successful collaboration with health care providers including when SANEs overstep their role, do not involve advocates in the medical-forensic process by inviting them to the hospital when an exam is happening, don't make referrals to advocacy services, or when there is poor communication (Payne, 2007).
- Survivor perceptions of whether service agencies are collaborating was significantly and positively related to arrests in sexual assault and domestic violence cases (Zweig & Burt, 2006).





SEXUAL ASSAULT PREVENTION

SEXUAL ASSAULT PREVENTION

As the number of sexual violence prevention programs has increased in the last ten years, research on prevention programs has lagged behind. Most prevention programs that have been evaluated demonstrate at least some changes in knowledge and behavioral intent, however, research on these prevention programs has not been able to detect a reduction of sexual violence perpetration or victimization. Much of the research on sexual assault prevention focuses on programs happening on college campuses. These programs vary in their approach and increasing attention has been paid to understanding how to strengthen prevention programming.

PREVENTION IN MIDDLE & HIGH SCHOOLS

- An evaluation of Shifting Boundaries found promising evidence that the program increases knowledge and behavioral intentions and decreases actual violent behavior among middle school students (B. Taylor, Stein, Woods, & Mumford, 2011). The evaluation of 2700 students in 30 New York City middle schools tested the unique and combined effectiveness of two components- a six session classroom based intervention (including content on consequences for perpetrators, state/federal laws, setting and communicating boundaries, and bystander intervention) and a school-level intervention (including implementation of stay away orders, better staff monitoring of "hot spots" and posters to increase awareness and reporting). Classroom sessions alone were not effective, but both the building intervention and combined approaches increased knowledge about laws and consequences, increased intentions to avoid perpetrating violence and to intervene. These components also reduced sexual harassment by 26-34% and peer sexual violence by 32-47%. The building intervention alone also reduced physical and sexual dating violence by 50%.
- A systematic review of sexual violence prevention programs aimed at reducing rape perpetration, changing attitudes, and increasing bystander intervention among adolescent boys reviewed 65 studies (Ricardo, Eads, & Barker, 2011). Few studies measured actual changes in violence perpetration behavior (only 9), with more studies (47) relying on attitudinal change as a proxy for behavior. Safe Dates, however, showed reductions in sexual violence perpetration among students exposed to the program 4 years earlier, suggesting a long-term effect of the program. 14 studies included in the review measured bystander intervention and suggest that this is a promising new direction in prevention programming. Very few studies looked at prevention at a system-wide level.
- The Men as Allies intervention was evaluated with high school students. Both male and female students showed decreases in rape supportive attitudes and had more accurate ratings of their peers' attitudes (Hillenbrand-Gunn et al., 2010).
- Connection to school, similarity with peer educators, and interest in the presentation predicted the effectiveness of a peer education rape prevention program in a high school setting (Kernsmith & Hernandez-Jozefowicz, 2011). Those students least connected to their school were also less likely to say they felt similar to the peer educators and showed almost no change in attitudes post-intervention.
- A study exploring the potential for male high school coaches to act as educators on sexual aggression found that while coaches do have influence over athletes, they may lack education about sexual aggression, endorse rape myths, minimize the problem, and be resistant to becoming involved in sexual aggression prevention (Lyndon, Duffy, Smith, & White, 2011).
- Weisz & Black (2010) describe the benefits of peer education as a means of reaching teenagers, drawing on interviews with programs using peer education prevention. Peer leadership was seen as empowering, engaging, and as a means of providing role modeling. However, interviewees also recounted challenges with recruiting, training, and supervising peer education programs.
- Black, Weisz & Jayasundara (2012) looked at a prevention program in a middle school and concluded that boys benefit most when prevention programs are presented to same-gender audiences, whereas girls benefit more in mixed-gender audiences.

SOCIAL NORMS APPROACHES

- Peer attitudes were the most significant predictor of willingness to intervene against a peer displaying sexual aggression in one study with 395 male college students, suggesting that personal attitudes are less relevant than perceived peer norms about sexual aggression (Brown & Messman-Moore, 2010).
- An evaluation of the Men as Allies social norms prevention program found that prior to the intervention, males thought their peers had more rape-supportive attitudes than their peers actually reported. Those who received the social norms based intervention had more accurate ratings of their peers' attitudes post-intervention and at follow up than did those in the control group (Hillenbrand-Gunn, Heppner, Mauch, & Hyun-joo Park, 2010).



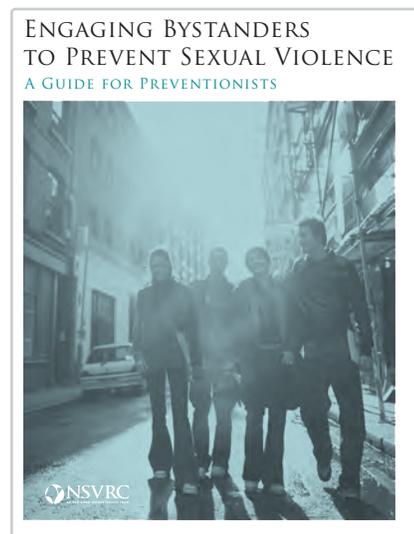
ENGAGING MEN IN PREVENTION

There is a growing body of research on engaging men in sexual assault prevention.

- Piccigallo, Lilley & Miller (2012) examined men's pathways to engagement in antiviolence work and concluded that non-confrontational, alliance-building approaches that address men as potential allies not potential perpetrators are preferred, as are approaches from other men. Also important to men's engagement is receiving a disclosure that makes rape a personal issue and reveals a lack of knowledge and skill, and men's ideas about the effectiveness of a particular opportunity for engagement.
- Focus groups evaluating The Men's Project, an ecological/public health prevention program, found participation in a supportive group helped men challenge sexism in their environment and engage in bystander interventions. Participants also redefined ideas of masculinity and "coolness" in ways that challenged traditional, violent masculinity (Barone, Wolgemuth, & Linder, 2007).
- Almost 80% of male college students who participated in an all-male peer education program (The Men's Program) reported some attitude and/or behavior change in their responses to open-ended questions about what they learned from the program, suggesting that such programs can be an effective way of creating change among men (Foubert, Godin, & Tatum, 2010). Attitude changes reported include increased understanding of the seriousness of rape, the dangers of alcohol, and the need to communicate about consent.
- Presenting scenarios involving men as the victims of rape in prevention programming may increase men's empathy toward female rape victims (Foubert & Newberry, 2006) and their understanding of how rape might feel (Foubert & Perry, 2007).
- One study asked men about their level of interest in a variety of formats of prevention programs and found that many men were resistant to attending prevention programs and felt like programs were not relevant to their lives. Some men felt the programs unfairly target them as potential perpetrators or otherwise felt defensive or angry about prevention programming (M. D. Rich, Utley, Janke, & Moldoveanu, 2010).

BYSTANDER INTERVENTIONS

- Banyard (2011) draws on ecological models to review variables that research has shown is related to bystander intervention, including attitudes, emotional arousal, gender, feeling of responsibility, perceptions of peer support, and situational context. She also makes the case for a need to broaden bystander prevention programs to account for intervention barriers that are rooted in community level variables (campus culture, for example).
- McMahon & Banyard (2012) outline a continuum of opportunities for bystander intervention. They include proactive opportunities that show a commitment to ending sexual assault. Reactive opportunities include situations that indicate a specific risk that could be prevented (primary prevention), responding during an assault (secondary prevention), and reacting after an assault has occurred (tertiary prevention).
- Banyard & Moynihan (2011) look not just at intention to intervene, but self-reported helping behaviors and found that different predictors were significant for behaviors than intentions. Self-reported sense of responsibility for ending sexual and relationship violence, greater confidence as a bystander, and perceptions of greater benefits of intervening relative to costs were all associated with helping behavior.
- Barriers to bystander intervention (such as failure to notice or identify a situation as high-risk, failure to take responsibility, identifying a skills deficit) were negatively correlated with intervention behavior. Men were more likely to report greater barriers to intervening, and intervention likelihood was influenced by perceptions of victim worthiness (Burn, 2009).
- Other factors that research has shown may affect bystander willingness to intervene, bystander efficacy, or actual bystander behaviors: religiosity (Foubert, 2013), pornography usage (Foubert, Brosi, & Bannon, 2011; Foubert, 2013), exposure to primetime crime dramas (Hust et al., 2013), gender (McMahon, 2010), and closeness of team bond for student athletes (McMahon & Farmer, 2009).
- A random sample of 2504 college students found that 46% had heard a Green Dot bystander intervention speech on campus and 14% had received bystander training in the past two years. Students with some exposure to Green Dot reported engaging in and observing more bystander behaviors. Those with more extensive bystander training reported lower rape myth acceptance and more bystander intervention behavior (Coker et al., 2011).
- An evaluation of the interACT Sexual Assault Prevention Program with 509 college students suggests that the program was successful in increasing belief in the efficacy of bystander interventions to prevent rape. The program also increased self-ratings of the likelihood that participants would engage in bystander interventions in the future (Ahrens, Rich, & Ullman, 2011).
- Research evaluating two prevention programs, The Men's Program and the Women's Program, both of which incorporate bystander intervention, found that participation in both programs was associated with increased willingness to intervene and increased bystander efficacy, as well as decreases in rape myth acceptance (Foubert, Langhinrichsen-Rohling, Brasfield, & Hill, 2010; Langhinrichsen-Rohling, Foubert, Brasfield, Hill, & Shelley-Tremblay, 2011).
- "Know Your Power" is a social marketing bystander intervention campaign using posters depicting bystanders intervening and encouraging viewers to "step up" (Potter & Stapleton, 2011). An evaluation of this campaign found that exposure to the posters at least once was associated with increased willingness to help others, an effect that was somewhat heightened if students perceived that the posters depicted familiar people and situations (Katz, Olin, Herman, & DuBois, 2013).
- Bystander intervention programs using social marketing tactics are thought to be more effective (for example, in increasing personal responsibility and confidence in bystander intervention) when the images resonate with the audience and depict familiar contexts (Potter & Stapleton, 2012).



Source: www.nsvrc.org/publications/

RISK REDUCTION APPROACHES

- A study found that rape victims with pre-assault self-defense training were more likely to report that their resistance stopped the offender or reduced his aggression than those without training. Women with pre-assault training reported feeling more anger and less fear during their assault (Brecklin & Ullman, 2005).
- An evaluation of a risk reduction program including self-defense training for college women found that the program did increase protective behaviors in the 6 months follow up period. There was not, however, any difference in rates of sexual victimization, assertive communication, or feelings of self-efficacy (Gidycz, Rich, Orchowski, King, & Miller, 2006). Orchowski, Gidycz & Raffle (2008) evaluated a revised version of the same risk reduction program and found that the revised program did increase self-protective behaviors and resistance self-efficacy, as well as increase use of assertive sexual communication at the 4-month follow up.
- Ball & Martin (2012) found that participants in a martial arts and modern self-defense training were more confident and less fearful than those who participated in a control condition.

need for rigorous outcome evaluations that build in sophistication in order to answer questions about what really works and that move toward measuring actual behavior changes (not just attitude changes). They also suggest that single-session designs are not a sufficient dose to create behavior change.

- Casey & Lindhorst (2009) suggest the need for an ecological approach to prevention that responds to risks at individual, peer, and community levels. They propose an ecological model that is comprehensive in addressing multi-level factors, engages the community, responds to the particular contexts of the community, focuses on structural contributors to the problem, builds on theory, and focuses on promoting strengths.
- Several reviews of the research on the effectiveness of sexual assault prevention programs conclude that most programs improve student knowledge but fail to demonstrate lasting decreases in sexual victimization. Evidence also suggests that longer interventions, single gender audiences, and professional presenters may increase effectiveness of a prevention program (L. A. Anderson & Whiston, 2005; Daigle, Fisher, & Stewart, 2009; Vladutiu, Martin, & Macy, 2011).

THEORETICAL AND CONCEPTUAL ADVANCES THAT CAN INFORM PREVENTION WORK

- The CDC Rape Prevention Education model of community change includes a focus on conducting a community readiness assessment to guide activities, promotes using diffusion of innovations strategies, and advocates for the use of theories of individual behavior (e.g. theory of reasoned action, theory of planned behavior, and health believe model) (Cox, Lang, Townsend, & Campbell, 2010).
- DeGue et al (2013) advocate that the sexual violence prevention field should borrow and apply strategies from youth violence prevention work in order to enhance the effectiveness of prevention programming. The authors suggest a need for more attention to factors like school connectedness, social disorganization, and availability of drugs and alcohol. They also argue for a need to evaluate sexual violence prevention efforts at the community level and suggest several avenues for building on the work of youth violence prevention.
- Tharp et al (2011) outline nine essential elements of prevention programs: 1) comprehensive, 2) use varied teaching methods, 3) driven by theory, 4) promote positive relationships, 5) appropriately timed in development, 6) socioculturally relevant, 7) use outcome evaluation, 8) employ well trained staff to ensure appropriate implementation, and 9) are of sufficient dosage to create behavior change. The authors argue that most sexual violence prevention programs do not adhere to a number of these principles. In particular, they stress the

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**SEXUAL ASSAULT ON
UNIVERSITY + COLLEGE
CAMPUSES**

SEXUAL ASSAULT ON UNIVERSITY AND COLLEGE CAMPUSES

Note: Prevention programming on college campuses is reviewed in the Prevention of Sexual Assault section of this report. Also, a good deal of research has been conducted with college students, sometimes because they are a convenient sample for researchers (e.g. introductory psychology courses often require students participate in research). These samples are generally not representative as there are structural limitations (who goes to college) and self-selection biases (who takes psychology courses and thinks a particular research project sounds interesting). When research with college students was not actually specific to the experience of being a student, we have generally elected not to include it in this section. This allows us to be more targeted with information that relates more directly to campus sexual assault.

PREVALENCE

- A study with 5446 undergraduate women found that nearly 20% of undergraduate women report attempted or completed sexual assault since entering college (C. P. Krebs, Lindquist, Warner, Fisher, & Martin, 2009a). 13.7% experienced a completed sexual assault. 15.9% experienced an attempted or completed sexual assault prior to entering college. 9% of sophomores, 7% of juniors, and 6% of seniors experienced a completed sexual assault in the previous 12 months.
- 9.7% of undergraduate women reported experiencing a completed sexual assault since entering college at historically Black colleges and universities (HBCU) in one survey completed by 3,951 students. This rate was significantly lower than the comparable rate at non-HBCUs (13.7%, see above). The lower rate for HBCUs seems related to lower alcohol use frequency among HBCU women (C. P. Krebs et al., 2011).
- Banyard et al (2005) compared two samples of college women 12 years apart (1988 and 2000) and found a decrease in unwanted sexual contact experiences in the previous 6 months (from 34-20%), but stable numbers of students experiencing unwanted sexual intercourse (9-6%) in the past 6 months.
- 20.4% of female college students and 6.6% of males (mostly freshmen) reported alcohol-related sexual assaults in the previous 2 months (Howard, Griffin, & Boekeloo, 2008).
- In one academic year, 9.5% of women in one survey reported rape and 11.7% reported verbal coercion (Messman-Moore, Coates, Gaffey, & Johnson, 2008).
- Another study found that during the freshman year, 19.3% of women reported at least one sexual victimization experience (Mouilso et al., 2012).



of college rape survivors told someone

CHARACTERISTICS AND RISKS OF SEXUAL ASSAULT ON CAMPUS

- Burgess (2007) found that rape myths held by male college students fell into five factors: justifications for sexual aggression based on women's behavior, belief that women should hold more responsibility for sexual assault and that men are unfairly accused, peer pressure and misreading of women's sexual intent, acceptance of alcohol and coercive tactics, and acceptance of traditional gender norms and dislike of the feminine. Endorsement of each of these factors was linked to self-reported sexual aggression, with the justification factor most highly correlated with aggression.
- Flack et al (2008) tested the notion of the "red zone" or the particularly high risk of sexual assault during the first few weeks of the first semester in college. Using survey data from 207 first and second year students at a small, liberal arts university, the researchers found only one increase in rates of sexual assaults- between the end of the first month and mid-October during the second year in school. The authors point out that this time period coincides with the fraternity and sorority rush period which features frequent parties, drinking, and other hazing events, although they do not have the data to test if there is a causal relationship. The sample is small and limited to one university, so additional research is needed to determine if this temporal pattern is generalizable and, if so, to better understand why.
- College men who perpetrated sexual aggression over a 3 month period indicated that they were at risk at the start of the study (based on ratings of their self-perceived likelihood of using coercion and other tactics, including using arguments or pressure and using drugs or alcohol to obtain intercourse) (Gidycz et al., 2011). 17.6% of men surveyed reported perpetrating some form of sexual aggression since age 14, including 5.8% who reported perpetrating rape. Three months later, 10% of the men reported engaging in sexually aggressive behavior during the time lapse, with 2.4% having perpetrated rape.
- A study with 652 male college students found that those with rape supportive attitudes and those who perceived norms that support rape were more likely to report having engaged in sexual aggression perpetration on a follow up survey one year later (Thompson, Koss, Kingree, Goree, & Rice, 2011). During their first year and during their second year in college, 11-14% of the men reported perpetrating unwanted sexual acts and about 4% reported perpetrating rape.
- Risk factors for sexual assault victimization during college in one large study included having experienced a forced sexual assault prior to college, having experienced an incapacitated sexual assault before college, experiencing dating violence, and drinking and marijuana use (C. P. Krebs, Lindquist, Warner, Fisher, & Martin, 2009b).

CAMPUS SUBCULTURES: GREEK LIFE AND ATHLETICS

- Focus groups with 35 women from 17 sororities found that violence was largely absent from the formal agendas of sororities and that members have a strong interest in helping one another but lack knowledge and skills, suggesting a potential avenue for engaging sororities in anti-violence work (K. M. Anderson & Danis, 2007).
- Fraternity membership was associated with perpetrating sexual assault, an effect partially explained by increased peer pressure to have sex and increased alcohol consumption among fraternity members (Franklin, Bouffard, & Pratt, 2012).
- A study by Minow & Einolf (2009) found that sorority members had a rate of sexual assault that was 4 times the rate among non-sorority members. This increased risk remained even after the authors controlled for alcohol consumption and attendance at Greek parties which are both correlated with experiencing sexual assault. They did find that participating in Greek events that did not involve alcohol was associated with a lesser risk of sexual assault, indicating a possible protective factor.
- McMahon (2007) explored rape myth attitudes in the student athlete subculture. While survey measures showed low rape myth acceptance, focus groups and open ended interviews revealed more subtle forms of rape myths and victim-blaming attitudes, as well as athlete specific myths (e.g. that female athletes are not likely to be victims due to their strength and confidence).

20%



of undergraduate women reported attempted or completed sexual assault since entering college

Source: C. P. Krebs, Lindquist, Warner, Fisher, & Martin, 2009a.

THEORETICAL AND CONTEXTUAL UNDERSTANDINGS OF CAMPUS SEXUAL ASSAULT

- Armstrong, Hamilton & Sweeney (2006) present a framework for understanding high rates of sexual assault on college campuses, centering on party cultures that feature high rates of drinking, gendered differences in sexual agendas, expectations that women be "nice", and other contextual factors. Students resist criticism of party culture, despite the presence of sexual assault, because it is also a source of fun.
- Bay-Cheng & Eliseo-Arras (2008) use interviews with undergraduate women to explore the role of gendered norms in sexual assault, including norms around women's sexual passivity and subordination of women's interests to those of men. They also explore the intersection of these gendered norms with neoliberal norms, such as those that focus on personal responsibility, arguing that neoliberal and gendered norms together reinforce women's "consent to unwanted sex."
- Jozkowski & Peterson (2013) explored college students' understanding of consent and found that participants largely thought of men as sexual initiators and women as sexual gatekeepers, with women's pleasure seen as secondary to men's.
- Smith & Freyd (2013) expand research on the role of betrayal in trauma by exploring institutional betrayal, or the belief that an institution failed to prevent sexual assault or respond in a supportive manner. Survivors who reported feeling institutional betrayal (mostly from their university/college) had higher anxiety and trauma-specific symptoms than those who did not feel betrayed by the institution.

HELP-SEEKING AND CAMPUS RESPONSES

- In a national sample of female college students, only 11.5% had reported their most recent rape to law enforcement and only 2.7% of rapes involving drugs or alcohol were reported. 18.7% of rape victims received medical care and 17.8% received assistance from a rape crisis center or other victim service program (Wolitzky-Taylor et al., 2011).
- Branch & Richards (2013) explored how receiving a rape disclosure affects friends of a survivor. Friends described feeling angry (e.g. at the perpetrator), shocked about what happened, and concerned for the survivor. Some described experiencing a change in their worldview (e.g. increased fear of danger in the world).

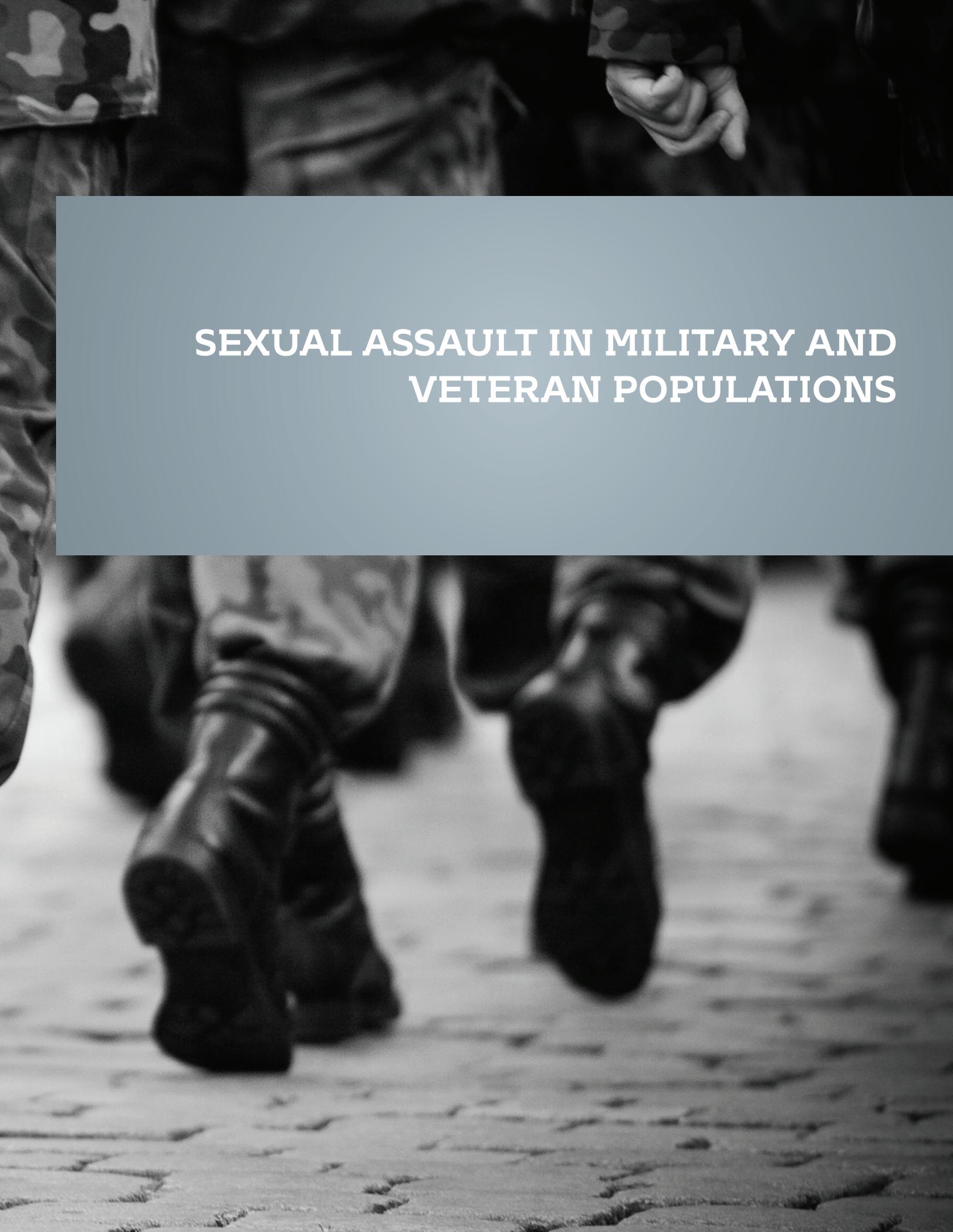
- Orchowski & Gidycz (2012) explored survivors' disclosure of rape and found that 55% told someone. Of those who told someone, 13.5% told their mother, 10.8% told another family member, 45.9% told a male peer, and 94.5% told a female peer. Only two people disclosed to formal authorities. 19% disclosed immediately, 51.4% disclosed the next day, 21.6% within a week, and 8.1% waited more than 2 weeks to disclose.
- A national sample of female college students found that 41.5% had a friend disclose rape to them, and 72% of those who received a disclosure encouraged their friend to report to police or other authorities (Paul et al., 2013).
- A large study with students at HBCU found that while 69.3% of those who experienced a forced sexual assault and 55.7% of those who experienced an incapacitated assault told someone, very few disclosed their sexual assault experience to formal supports. In 13.9% of forced assaults and 7.6% of incapacitated assaults, the survivor sought help from victim services or healthcare, and only 9.9% of forced assaults and 3.4% of incapacitated assaults were reported to the police (Lindquist et al., 2013).
- The most prevalent perceived barriers to reporting rape in one study with college students were: shame, guilt, embarrassment and not wanting friends/family to know; confidentiality concerns; and fear of not being believed (Sable, Danis, Mauzy, & Gallagher, 2006). Zinzow & Thompson (2011) asked survivors about their reasons for not reporting and found the following barriers: 70% said they handled it on their own, 68% said they did not think it was serious enough, 45% said they didn't want anyone to know, 43% didn't want to involve the police or courts, and 42% said they did not report because they felt shame or embarrassment.
- Campus sexual assault advocates reported needs for increased funding for prevention and response services, better strategies for assisting international students, and better coordination of campus programs at the state level. Some advocates also described resistance from administrators who wanted to "keep the lid on" sexual assault statistics on campus (Carmody, Ekhomu, & Payne, 2009).
- A study exploring student perceptions of campus sexual assault resources found that students are concerned about sexual assault on campus, appreciate security measures on campus, and want more education on sexual assault but preferred posters and online resources rather than pamphlets (Garcia, Lechner, Frerich, Lust, & Eisenberg, 2012).
- Hayes-Smith & Levett (2010) found that a majority of students were not aware of many of the sexual assault related resources available on campus.
- Campus sexual assault advocates in one study described both positive collaborations with law enforcement (e.g. advocates regularly invited to train officers) and strained relationships stemming from their different obligations. Campus advocates also described some of the challenges of getting faculty and staff to understand what the policies require (Payne, 2008).
- An National Institute of Justice (NIJ) report in 2005 found that colleges and universities inconsistently implement federal policies around sexual assault on campus. Most were reporting data, but only 1/3 were doing so in full compliance with the law. Only half of the campuses allowed for anonymous reporting. Resources provided to students (e.g. information about filing criminal charges) were also inconsistent at campuses (Karjane, Fisher, & Cullen, 2005).

ALCOHOL AND OTHER DRUGS AS A RISK FACTOR FOR CAMPUS SEXUAL ASSAULT

Some of the research on the connections between alcohol and sexual assault focuses on women's drinking behavior. While this could be used to direct blame to survivors for their participation in "risky" behaviors, this research can inform the development of prevention programs. For example, it is helpful to understand the circumstances surrounding many campus sexual assaults. The connections between drinking and sexual assault provide information about perpetrators' behavior (e.g. targeting intoxicated individuals).

- A large study of sexual assault on campus found that most sexual assaults occurred after the victim voluntarily consumed alcohol (C. P. Krebs et al., 2009a).
- One study found that 29.6% of respondents had experienced a drug-related sexual assault, the vast majority of which involved alcohol (96.1%) and voluntary consumption (84.6%) (Lawyer, Resnick, Bakanic, Burkett, & Kilpatrick, 2010).
- A survey with college students found that those who engage in sexually coercive behaviors while drinking had higher sex-related expectations of alcohol. Those who experienced unwanted sexual contact reported higher alcohol consumption, fewer protective strategies, and greater negative consequences from drinking (Palmer et al., 2010).





**SEXUAL ASSAULT IN MILITARY AND
VETERAN POPULATIONS**

PREVALENCE OF SEXUAL ASSAULT IN MILITARY AND VETERAN POPULATIONS

Prevalence estimates of sexual assault among active duty and veteran military populations vary for several reasons. 1) Samples are drawn from different pools and may not be equivalent nor representative of the larger population, 2) definition of sexual victimization varies with some using a completed rape standard and others including a broader range of experiences like sexual harassment and sexual identity challenges, 3) method of assessing for sexual victimization (Suris & Lind, 2008). The National Intimate Partner and Sexual Violence Survey (NISVS) provides methodologically rigorous estimates that are directly comparable to non-military prevalence estimates. However, NISVS did not systematically sample male military personnel or spouses, or veterans of any gender.

- The National Intimate Partner and Sexual Violence Survey, a large, nationally representative study, included two sub-samples drawn from military populations totaling 2836 women (the Department of Defense commissioned sub-samples only for females). These sub-samples included 1408 active duty women and 1428 spouses of active duty men. 36.3% of active duty women and 32.8% of wives of active duty men had experienced sexual violence involving some sort of physical contact. These rates are comparable to the non-military population rate of 40%. Active duty women who were deployed in the previous three years were significantly more likely to experience contact sexual violence than active duty women who had not been deployed in the prior 3 years (M. C. Black & Merrick, 2013).
- A report of research conducted by the Department of Defense (2013) found:
 - 30% of women and 6% of men reported unwanted sexual contact prior to joining the military. 23% of women and 4% of men reported unwanted sexual contact since joining the military.
 - There were an estimated 26,000 active duty service members who experienced unwanted sexual contact in 2012.
 - In fiscal year 2012 there were 3374 reports of sexual assault involving service members, a 6% increase from the prior year, most likely due to increased reporting as a result of increased attention to the issue and changes in policy.
 - The Department of Defense estimates that only 11% of sexual assaults in the military are reported. The top reasons for not reporting included not wanting others to know (70%), felt uncomfortable making the report (66%), did not think the report would remain confidential (51%), believed nothing would be done with the report (50%), and had heard about negative experiences from other victims (43%).
 - Those who did report their sexual assault did so because they thought it was the right thing to do (72%), wanted closure (67%), and wanted to stop the perpetrator from doing it to someone else (67%).
- A study with female veterans found half had experienced rape at some point in their life, with about a quarter experiencing rape while in the military (Booth, Mengeling, Torner, & Sadler, 2011).
- Lifetime prevalence of rape in one study with active duty Air Force women was 28% (Bostock & Daley, 2007). 31.8% of the sample were sexually harassed by a military supervisor or boss and 26.7% were sexually harassed by a military coworker.
- Of men diagnosed with combat-related PTSD, 41% had experienced child sexual abuse and 20% had experienced an adult sexual assault victimization (Lapp et al., 2005).
- Participants in a VA Women's Health Survey found that 24% reported a history of sexual assault while in the military (McCall-Hosenfeld, Liebschutz, Spiro III, & Seaver, 2009).
- A sample drawn from VA primary care patients found a sexual assault lifetime prevalence rate of 38% in women and 6% in men (H. M. Zinzow, Grubaugh, Frueh, & Magruder, 2008).
- 13% of male naval recruits in one study reported pre-military perpetration of sexual assault (Stander, Merrill, Thomsen, Crouch, & Milner, 2008). Among those men, 71% reported more than one incident of attempted or completed rape (McWhorter, Stander, Merrill, Thomsen, & Milner, 2009). They also reported using substances to incapacitate victims more often than force and targeting victims they knew rather than strangers. Those with a history of attempted or completed rape were more likely to perpetrate similar acts during military service.
- Within California, a study with female veterans found that 61.3% experienced sexual harassment during their service and 37% experienced military sexual trauma. Those who had experienced sexual harassment or trauma had higher rates of PTSD, anxiety, and other mental health concerns. Two-thirds of those who had experienced military sexual trauma said they did not receive the services they needed post-assault (Blanton & Foster, 2012).



**UNWANTED
SEXUAL CONTACT**

26,000

**ESTIMATED ACTIVE DUTY
SERVICE MEMBER VICTIMS**



14,000



12,000

CONSEQUENCES OF SEXUAL ASSAULT IN MILITARY AND VETERAN POPULATIONS

- Lifetime substance abuse disorders were more common among female veterans with a sexual assault history (64% female veterans with a sexual assault history vs. 44% female veterans without a sexual assault history) (Booth et al., 2011).
- A study of female veterans receiving VA primary care found associations between sexual trauma, PTSD, and lifetime eating disorders. Sexual trauma that occurred during military service was more strongly associated with eating disorders than childhood sexual abuse (Forman-Hoffman et al., 2012).
- A study found that the strongest correlates with military sexual stress were working in an environment that seemed to tolerate sexual harassment, a history of severe childhood maltreatment, and more high-magnitude stressors like combat experience (Murdoch et al., 2010).
- A large study of homeless veterans receiving mental health care from the VHA found that those with a history of military sexual trauma had a higher likelihood than those without sexual trauma of having mental health conditions like depression, PTSD, anxiety, substance use disorders, bipolar, and suicide. Veterans with military sexual trauma used more mental health services than those without (Pavao et al., 2013).
- Women veterans with lifetime sexual assault experiences (31% childhood sexual abuse, and 25% military sexual trauma) had more problems with sexual functioning, experienced more pain during intercourse, and were less likely to report being in an emotionally satisfying relationship (Sadler, Mengeling, Fraley, Torner, & Booth, 2012).
- A study with Marines found that military sexual trauma was associated with increased risk of post-traumatic stress symptoms, especially for men. Military sexual trauma was also associated with worse perceived physical health among men (Shipherd, Pineles, Gradus, & Resick, 2009).
- Female veterans receiving care at outpatient VA clinics who had civilian histories of sexual assault had significantly poorer physical health, psychiatric functioning and quality of life. Those with military sexual assault had even lower scores on these indicators (Suris, Lind, Kashner, & Borman, 2007).

REPORTING STATISTICS



67%



81%

ACTIVE DUTY SERVICE MEMBERS DID NOT REPORT

Source: Defense Manpower Data Center. (2013). 2012 Workplace and Gender Relations Survey of Active Duty Members (Survey Note No. 2013-007).

SERVICES AND INTERVENTIONS IN MILITARY CONTEXTS

- Despite having more extensive traumatic histories and greater psychological needs, only 38% of female veterans with sexual assault and 25% of male veteran survivors utilized mental health services through the VA in the past year (Zinzow et al., 2008).
- Of veterans who reported military sexual trauma to the VA, 75.9% received care (mental health care, non-mental health, or both) related to sexual trauma, with males using less care than females (J. Turchik, Pavao, Hyun, Mark, & Kimerling, 2012).
- Among military academy cadets, those who experienced sexual victimization were significantly more likely to view their superiors as less moral and more tolerant of sexual victimization (Snyder, Fisher, Scherer, & Daigle, 2012).
- An evaluation of the Navy's Sexual Assault Intervention Training (SAIT) found that women who completed the SAIT program had higher factual knowledge about rape and increased empathy for rape victims. However, SAIT did not seem to decrease rape myth acceptance among women (Rau et al., 2011). Among men, SAIT increased rape knowledge, reduced rape myth acceptance, and increased empathy for victims (Rau et al., 2010). Men reporting a history of sexual coercion behavior had less rape knowledge, greater rape myth acceptance, and lower empathy for rape victims.
- Female veterans with a history of military sexual assault reported more use of VHA services, less satisfaction, poorer perceptions of VHA facilities and staff, and more problems with VHA services (Kelly et al., 2008).
- Among veterans who were victims of sexual assault, those who sought help from legal or medical providers (either military or civilian) reported that the response left them feeling anxious, guilty, depressed, distrustful, and reluctant to seek further help. Victim blaming behaviors of legal and medical personnel were correlated with increased post-traumatic stress symptoms (Campbell & Raja, 2005). 70% of those who disclosed to military legal officials were discouraged from filing a report, 65% said the officials refused to take a report, and 70% said they were told that the assault was not serious enough to pursue.

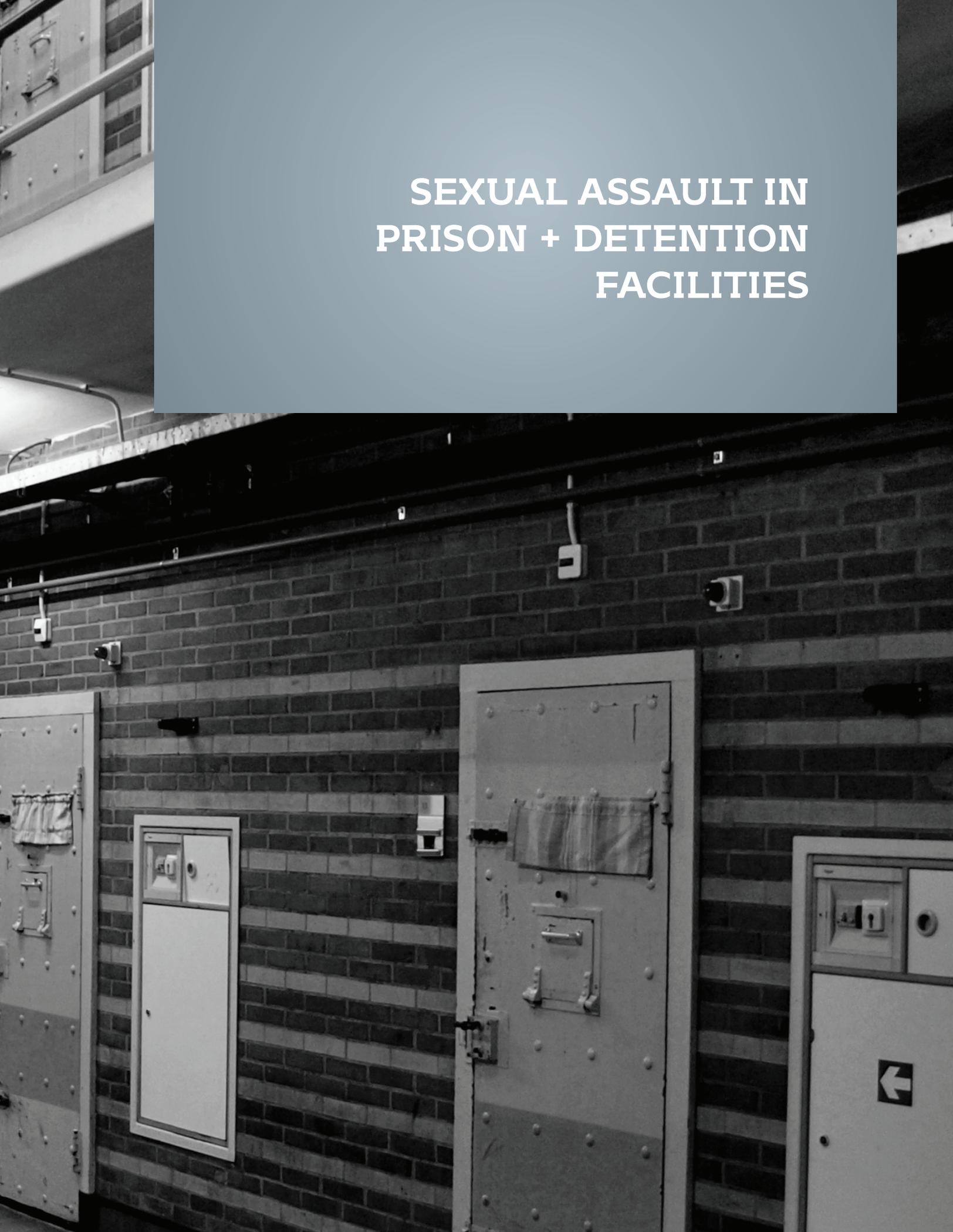
THEORIES ABOUT SEXUAL ASSAULT IN MILITARY CONTEXTS

Some literature explores the context and potential reasons why sexual assault occurs in military populations. Many of these pieces are theoretical and conceptual and therefore should not be considered conclusive. Even when the authors collect data to support their theory, it's generally not strong enough to make clear generalizations. Additional research is needed to further explore the factors that contribute to sexual violence in the military.

- Smith & Freyd (2013) extend theory on the role of betrayal in exacerbating responses to trauma to include institutional betrayal, meaning a feeling that an institution created an environment that allowed violence to happen, made it difficult to report, or otherwise did not act to protect victims. The authors collected data from survivors of sexual violence, primarily within university settings but also including some in a military setting, and concluded that those who reported institutional betrayal had higher levels of anxiety and trauma symptoms.
- Jeffreys (2007) highlights the foundational role of aggressive masculinity in the military and in warfare, and connects this masculinity to sexual violence.
- Hillman (2009) discusses the role of US military law in propagating a connection between "authentic soldiering" and sexual violence. For example, military legal precedent has created an impression of male dominance and female vulnerability, lessened the extent of accountability for service members, and reinforced racist assumptions regarding predators of sexual assault.
- Haaken & Palmer (2012) explore the military's use of incest as a metaphor for sexual violence among military personnel and question whether this framing is actually useful.
- Callahan (2009) suggests that sexual violence is in part rooted in the organizational culture in the military, particularly focusing on the training of new recruits which involves the deprivation of personal control. Sexual violence is, in this view, a consequence and response to experiencing that "control deprivation."



SEXUAL ASSAULT IN PRISON + DETENTION FACILITIES





In federal and state prisons, inmates with serious psychological distress are

9X MORE LIKELY

to be sexually abused by another inmate than those with no indication of mental illness

Source: Bureau of Justice Statistics, "Sexual Victimization in Prisons and Jails Reported by Inmates, 2011-12", May 16, 2013.

PREVALENCE

- According to a Department of Justice report, 4% of prison inmates and 3.2% of jail inmates reported experiencing sexual assault in a 12 month period. 2% of prison inmates (or an estimated 29,300) reported a sexual assault by another inmate, 2.4% (or 34,100) reported an assault by prison staff, and 0.4% (5500) reported assaults by both inmates and staff. Prisoners with serious psychological distress had higher rates of sexual assault. Gay, lesbian and bisexual (GLB) inmates had the highest rate of sexual victimization with 12.2% of GLB prisoners and 8.5% of GLB jail inmates reporting sexual victimization by another inmate, and 5.4% of prisoners and 4.3% of jail inmates reporting sexual victimization by staff (Beck, Berzofsky, Caspar, & Krebs, 2013).
- A study in one maximum security prison found that 18% of male inmates reported sexual threats from other inmates and 8.5% reported experiencing a sexual assault by another inmate during their incarceration (Hensley, Koscheski, & Tewksbury, 2005). Respondents who identified as gay or bisexual were over-represented among those experiencing victimization. The sample, however, was small with a low response rate, so there may be a bias in who responded to the survey.
- A study with 168 incarcerated women found that about 9.5% of inmates reported being coerced to engage in sexual activity by another inmate and 22% reported a forced sexual experience (inclusive of groping, forced oral sex, and forced vaginal or anal sex) while in prison (Walsh, Gonsalves, Scalora, King, & Hardyman, 2012).
- A study with female inmates found 17.2% had sexual victimization experiences while in prison, 3% were victims of completed prison rapes. 68.4% experienced lifetime sexual victimization, with 43% reporting a lifetime completed sexual assault experience (Blackburn, Mullings, & Marquart, 2008).
- Jones & Pratt (T. R. Jones & Pratt, 2008) suggest that we still do not have a clear sense of the prevalence of sexual assault in prisons due to methodological limitations (such as small samples) and inconsistencies in the research (for example in how sexual assault is measured and what experiences are included).
- Wolff & Shi (2009) surveyed over 6000 male inmates and found that 3% experienced a sexual assault over a 6 month period.

PRE-DETENTION SEXUAL ASSAULT PREVALENCE

- A study with female inmates found that 70% had at least one experience of rape in their lifetime and about half had experienced child sexual abuse victimization (McDaniels-Wilson & Belknap, 2008).
- Another study with female inmates found that 50% of the sample had experienced child sexual abuse, 54% had adult sexual assault victimization, and 38% reported both kinds of experiences (Walsh, DiLillo, & Scalora, 2011).

BARRIERS TO REPORTING

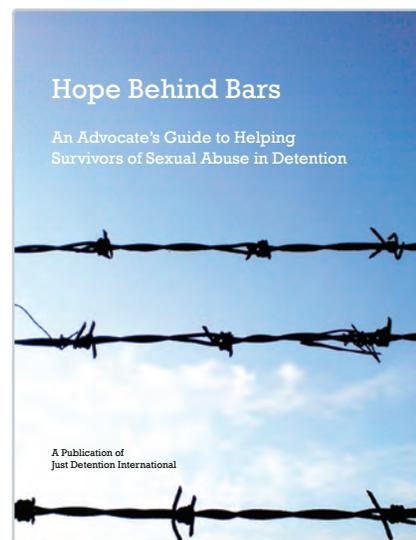
- Previous victims of prison sexual assault and gay or bisexual inmates (who are at increased risk of being sexually assaulted) had decreased intentions of reporting rape if it were to occur. Women inmates were more likely to recommend that others report rape. Inmates who knew someone who had recently been sexually assaulted were also more likely to recommend that others report rape (Fowler, Blackburn, Marquart, & Mullings, 2010).
- Barriers for male inmates reporting rape include the stigma against snitching. Inmates who were earlier in their sentence were less likely to see reporting rape as snitching. White inmates were more likely to see reporting rape as snitching (Garland & Wilson, 2013).
- Male inmates in one study suggested that the most salient barriers to reporting rape were embarrassment, fear of harassment, and a fear of retaliation from the perpetrator (Levan Miller, 2010).

PERPETRATORS

- Morash, Jeong & Zang (2010) compared characteristics of a sample of male inmates who perpetrated sexual violence with those who had not perpetrated such incidents. They found that child sexual abuse victimization, a life sentence, and adult sexual assault convictions predicted inmate's unwanted sexual touching of other men. Threatened, attempted and completed sexual assault penetration of another inmate was predicted by a history of juvenile robbery, adult sexual assault convictions, more time in prison, and youth.
- Victims of prison rape in a sample of inmates in 10 prisons were asked questions about their worst experience of sexual coercion while incarcerated. Men reported that the perpetrators of their worst-case experiences were 72% inmates, 8% staff, and 12% staff and inmates collaborating. Women, however, reported that their worst-case experiences were perpetrated 47% of the time by inmates and 41% by staff (Struckman-Johnson & Struckman-Johnson, 2006).

SURVIVORS

- A study of substantiated prison rape cases found that male victims tended to be more recently incarcerated, younger, smaller and less aggressive, although this was not always the case. The strongest factor associated with prison rape victimization was having experienced childhood sexual abuse (Morash, Jeong, Bohmert, & Bush, 2012).
- Almost all of the male survivors of prison sexual assault in one study reported some emotional consequence of the assault, with about half reporting depression, nightmares, difficulty sleeping, anger and/or fear (Wolff & Shi, 2009). 66.7% reported experiencing an injury as a result of the assault.
- More than half of both male and female inmates who had experienced sexual coercion (includes rape) while incarcerated reported depression, while male victims were more likely to report suicidal thoughts (37% males, 11% females) and attempts (19% males, 4% females) (Struckman-Johnson & Struckman-Johnson, 2006).



Source: www.justdetention.org





**SEXUAL ASSAULT IN
THE CONTEXT OF
DOMESTIC VIOLENCE**



CALCASA's Unifying Fields Project

Building Linkages Between Domestic Violence and Sexual Violence (UFP), a Blue Shield of California Foundation funded project, is an effort to foster a more cohesive unified presence of sexual and domestic violence services and advocacy among dual-service organizations.

PREVALENCE

- The National Intimate Partner and Sexual Violence Survey found that 1 out of 10 women in the US (or about 11.1 million women) has been raped by an intimate partner in her lifetime. 1 in 6 women (or 19 million) have experienced sexual violence other than rape by an intimate partner. In the 12 months prior to the survey, an estimated 686,000 women were raped by an intimate partner and 2.7 million experienced sexual violence other than rape. 1 in 12 men (or about 9 million) have experienced sexual violence other than rape by an intimate partner in his lifetime (M. C. Black et al., 2011). 1 in 5 women and 1 in 7 men who experience rape, stalking or physical violence by an intimate partner are first victimized between the ages of 11 and 17, suggesting a need for prevention to start early (Breiding, Chen & Black, 2014).
- Martin, Taft & Resick (2007) suggest that research indicates that marital rape is experienced by 10-14% of married women and 40-50% of battered women, and that marital rape often occurs in the context of higher rates of violence and relationship dissatisfaction.
- One study found that 17.9% of the sample of women age 18-30 had reported sexual victimization in the past 2 years, the majority committed by intimate partners (M. Testa et al., 2007).

CHARACTERISTICS AND RISKS

- One study that interviewed 53 women at domestic violence shelters found that participants described a variety of abusive behaviors related to sexual relationships, including refusal to use condoms, preventing them from accessing health care, birth control sabotage, infidelity, and forced sex (de Bocanegra, Rostovtseva, Khera, & Godhwani, 2010). 66% of the women interviewed reported forced sex. Some described threats of having the children taken away or being denied food if they refused to comply with their partner's demands for sex. Some of the women also described being afraid to go to bed at night due to the frequency of forced sex.
- Two additional studies similarly reflect that sexual assault in intimate relationships is often accompanied by a range of coercive, degrading and abusive tactics and that women felt coerced into sex because of a fear of what would happen if they said no. Stalking behavior also seems to be associated with intimate partner sexual assault (Logan, Cole, & Shannon, 2007; Logan & Cole, 2011).

CONSEQUENCES

- A review of research suggests that victims of marital rape have high levels of PTSD, depression, gynecological problems, and negative physical health (Martin et al., 2007).
- Intimate partner rape may result in pregnancy. Compared to women who have experienced physical violence only, those who report also experiencing sexual violence report fewer live births and more elective abortions (McFarlane, 2007).
- Women who experienced more than one sexual assault, in addition to physical violence in their relationship, were 3.5 times more likely to report an increase in substance use and those reporting any sexual assault were 5.3 times more likely to report suicide attempts (McFarlane et al., 2005).
- Children of mothers experiencing both physical and sexual violence from an intimate partner had higher levels of externalizing (e.g. acting out) and internalizing (e.g. depression) behavior problems. Older children were at increased risk, especially for depression and anxiety (McFarlane et al., 2007).
- A study with low-income, ethnically diverse women found that sexual assault by a current partner (compared to assault by a former partner or a non-partner) was the strongest predictor of PTSD, stress, and dissociation (Temple, Weston, Rodriguez, & Marshall, 2007). This is probably a result of the continuous threat of repeated sexual assault and the resulting stress.

HELP-SEEKING

- A study with 1072 victims of intimate partner violence found that 44% experienced sexual violence in addition to physical violence. Those who experienced sexual violence used more services, but were also more likely to say they did not seek help when they needed it. Fear was the greatest obstacle for seeking services (Cattaneo, DeLoveh, & Zweig, 2008).
- Another study found that seeking help from social service and criminal justice agencies appears to be the most effective way to end sexual assault in the context of a violent relationship (Martin et al., 2007).



NO MORE

**TOGETHER WE CAN END
DOMESTIC VIOLENCE & SEXUAL ASSAULT**



**POPULATION-SPECIFIC
SEXUAL ASSAULT
INFORMATION**





OLDER ADULT SURVIVORS

- A study comparing elder sexual abuse cases reported to Adult Protective Services (APS) with those reported to criminal justice systems (CJS) found that APS reported cases were more likely to involve victims who lived at home, did not receive rape exams, that have cognitive disabilities, and offenders were mostly spouses/partners or family members. CJS reports more often involved victims abused in institutions, rape exams, and offenders under age 40 who also committed other non-sexual crimes. Offenders in CJS cases were less likely to be identified, but more likely (once identified) to be prosecuted, convicted or plea bargained (A. W. Burgess, Ramsey-Klawnsnik, & Gregorian, 2008).
- Older victims of sexual assault are more likely to be living alone at the time of the assault, be assaulted in their home, have higher levels of psychiatric and cognitive disabilities, and require ambulance involvement compared to younger victims. Use of physical violence during the assault, vaginal penetration, and physical trauma was equally likely across age groups (Del Bove, Stermac, & Bainbridge, 2005).
- In one national study, 7.8% of women over the age of 55 reported having experienced a sexual assault (on average 50 years prior to the study). Survivors were more likely to have arousal and avoidance symptoms of PTSD than those who were not sexually assaulted. The authors caution that the sample size was small for the analysis conducted, however the results are suggestive of the fact that some older adults may be currently experiencing PTSD symptoms linked to traumas that occurred many years previously (Acierno et al., 2007).
- Similarly, a study by Cook, Dinnen & O'Donnell (2011) found that while older women report lower lifetime and past year physical and sexual assaults than younger women, those who have experienced sexual or physical violence report greater psychiatric distress (like PTSD or depression), suggesting that some women who were assaulted many years ago continue to report PTSD symptoms.

MALE SURVIVORS OF SEXUAL ASSAULT

Consequences

- A study with male college students found that survivors of child sexual abuse were more likely to also experience adult sexual assault (defined broadly), and that both victimization and revictimization are associated with posttraumatic stress, hostility, depression, and general distress (Aosved, Long, & Voller, 2011).
- A study using a large dataset, the Behavioral Risk Factor Surveillance System (sample included 59,511 men), found that men who reported attempted or completed unwanted intercourse had lower ratings of mental health, lower life satisfaction, more activity limitations, and lower emotional and social support (Choudhary, Coben, & Bossarte, 2010).
- In a study of male college students, 51.2% reported at least one sexual victimization experience since age 16, with 17% of those victimized reporting a completed rape. Sexual assault victimization was related to increased drinking behaviors, increased drinking consumption, increased tobacco use, increased sexual risk-taking behaviors, and increased sexual functioning difficulties (J. A. Turchik, 2012).
- In a review of the literature, Tewksbury (2007) found that among male survivors of sexual assault, feelings of shame, stigma, fear that one's sexuality will be questioned are common, and anger or hostility are common. For male victims, sexual assault may be related to poorer physical health, somatic complaints, sleep difficulties, depression, anxiety disorder, and substance abuse.

Help-seeking

- One small study looking at male adolescent and adult survivors of sexual assault who received services from sexual assault treatment centers in Ontario, Canada found that almost one third of the male survivors had a disability, and many of the survivors reported other factors that may have increased their vulnerability (transgendered, homeless, in prison, etc.). All survivors accepted at least one service and 86% accepted five or more services from the treatment center, with crisis counseling, injury treatment and referrals being the most common services (Du Mont, Macdonald, White, & Turner, 2013).
- A qualitative study with 16 resilient male survivors of childhood sexual abuse explored how the men made meaning from their abuse. Three meaning making styles were identified: making meaning through action (helping others, using creative expression to process), using cognitive strategies to understand why the abuse happened (including understanding perpetrator and sociocultural explanations for abuse), and using spirituality as a resource for making meaning (F. K. Grossman, Sorsoli, & Kia-Keating, 2006).

- Only 29% of male survivors in the National Violence Against Women Survey sought medical or psychological help after the assault. Most of those that sought help had been injured in some way (Light & Monk-Turner, 2009).
- Though male sexual assault survivors in one study were 3.4 times more likely to be depressed and 2.4 times more likely to have suicidal ideation, only 15.4% sought counseling (Masho & Anderson, 2009).

gay men

78.6% 

bisexual men

65.8% 

heterosexual men

28.6% 

reported having only male perpetrators of sexual violence other than rape

Source: Walters, M. L., Chen, J., & Breiding, M. J. (2013). The national intimate partner and sexual violence survey (NISVS): 2010 findings on victimization by sexual orientation. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

LESBIAN, GAY, BISEXUAL, TRANSGENDER SURVIVORS

- The National Intimate Partner and Sexual Violence Survey, a large nationally representative survey (Walters, Chen, & Breiding, 2013), found that:
 - Bisexual women had significantly higher lifetime prevalence of rape and sexual violence (46.1%) compared to lesbians (13.1%) and heterosexual women (17.4%). This was true when looking at rape by any perpetrator as well as when examining rape by intimate partners
 - Lifetime prevalence of sexual violence other than rape (being made to penetrate, sexual coercion, unwanted sexual contact, non-contact unwanted sexual experiences) was 46.4% for lesbians, 74.9% for bisexual women, 43.3% for heterosexual women, 40.2% for gay men, 47.4% for bisexual men, and 20.8% for heterosexual men
 - The majority of lesbian, bisexual and heterosexual women reported having only male perpetrators. 78.6% of gay men, 65.8% of bisexual men, and 28.6% of heterosexual men reported having only male perpetrators of sexual violence other than rape.
- In a study comparing sexual assault revictimization and mental health outcomes among heterosexual women, lesbians, and gay men, child sexual abuse was associated with increased rates of adult rape for all three groups. Those who experienced both child and adult assault (were "revictimized"), regardless of sexual orientation, had more negative mental health outcomes like psychological distress, suicidality, alcohol use, and self-harm (Balsam et al., 2011).
- Among lesbian and gay sexual assault survivors, internalized homophobia is associated with PTSD symptom severity and among gay men internalized homophobia was a bigger predictor of PTSD and depression severity than the severity of the assault (Gold, Marx, & Lexington, 2007; Gold, Dickstein, Marx, & Lexington, 2009).
- Findings of a study suggest that risk factors for adult sexual assault may vary across sexual orientations, with alcohol being the strongest predictor for lesbians and childhood sexual abuse being the best predictor of adult sexual assault in gay men (Han et al., 2013).
- A study with 342 GLB individuals found that 63% reported some form of sexual assault, and 40% reported revictimization (assault in childhood and adulthood). Gay men and bisexual men and women were more likely to report revictimization than lesbians. Sexual victimization was associated with psychological distress, with those who were revictimized showing higher levels of distress (Heidt, Marx, & Gold, 2005).
- A study with lesbian and bisexual women found that 51.2% reported childhood sexual abuse, 71.2% reported adult sexual victimization. 56.4% of women's most recent incident of sexual assault occurred after coming out. Bisexual women reported more severe adult sexual assault experiences and greater levels of revictimization. The majority of participants were victimized by a male perpetrator (Hequembourg, Livingston, & Parks, 2013).
- Hughes et al (2010) found that sexual minority women had higher levels of childhood sexual assault and sexual revictimization than heterosexual women, which appeared to place sexual minority women at heightened risk for hazardous drinking.
- While heterosexual women in a large convenience sample were more likely to experience rape than lesbian or bisexual women, lesbians were more likely to be assaulted by relatives. Bisexual women were more likely to disclose assault to formal supports and romantic partners, but received the fewest positive social reactions and had higher PTSD symptoms (Long, Ullman, Long, Mason, & Starzynski, 2007).
- In one of the few identified studies exploring sexual violence in transgender populations, 573 transgender male to female women with a history of sex work in San Francisco or Oakland, CA were surveyed. 38% were raped or sexually assaulted prior to age 18. The sample also had high rates of depression, suicidal ideation, suicide attempts, physical assault experiences, and experiences of transphobia (Nemoto, Bödeker, & Iwamoto, 2011).
- Trans women and men with histories of physical or sexual violence were more likely to have a history of suicide attempts and alcohol or illicit substance abuse than those without violent experiences (R. J. Testa et al., 2012).
- A systematic review of literature on sexual assault against lesbians, gay men, and bisexual men and women found prevalence estimates of lifetime sexual assault ranging from 15.6-85% of lesbian and bisexual women and 11.8-54% of gay and bisexual men. Lesbian and bisexual women were more likely to report childhood sexual abuse, adult sexual assault, lifetime sexual assault, and intimate partner sexual assault than gay and bisexual men, while hate crime related sexual assault was more often experienced by gay and bisexual men (Rothman, Exner, & Baughman, 2011). The authors note that non-probability based samples tended to produce higher estimates than probability based samples.

SURVIVORS WITH DISABILITIES

- A study using data from the National Youth Risk Behavior Survey found that female adolescents with physical disabilities were more likely to report having been physically forced to have sexual intercourse than those without disabilities (19.6% vs 9.4%) (Alriksson-Schmidt, Armour, & Thibadeau, 2010).
- National Violence Against Women Survey data, a large representative study, found that women with severe disability impairments were four times more likely to be sexually assaulted than those without disabilities, while those with moderate disabilities were not at much different risk than those with no disabilities, (Casteel, Martin, Smith, K, & Kupper, 2008).
- A representative sample from Massachusetts found that lifetime sexual violence among men with disabilities was 13.9%, men without disabilities was 3.7%, women with disabilities was 26.6%, and women without disabilities was 12.4%. Men with disabilities were more than 4 times more likely than those without to report lifetime and past year sexual violence (Mitra, Mouradian, & Diamond, 2011).
- A study with 135 survivors of rape who had intellectual disabilities found that 82.2% perceived the perpetrator's reactions as wrong with 52.6% citing non-consent as the reason it was wrong, 11.1% citing pain or injury, and 8.9% saying it was a broader moral wrong. 76.3% of these survivors wanted the perpetrator to be imprisoned while the rest were unable to articulate an opinion on consequences (Pillay, 2010).

SURVIVORS IN RURAL AREAS

- A study using National Crime Victimization Survey data found that a higher percentage of rural divorced/separated women (3.1 per 1000) were victims of rape than urban divorced/separated women (1.4 per 1000) (Rennison, DeKeseredy, & Dragiewicz, 2012).
- Annan (2006) suggest that familiarity in rural contexts makes it hard for survivors to report sexual assault. Isolation (e.g. lack of phone or car) in rural areas may be a barrier for help-seeking. Given the degree of poverty in rural areas, concerns about paying the hospital bill may decrease reporting. There may also be a high incidence of victim blaming in rural settings.
- A small pilot study explored the feasibility and effectiveness of rape crisis centers providing trauma-focused treatment via video-conferencing to sexual assault survivors who live in rural areas where services would be otherwise inaccessible. Findings suggested treatment of this sort could reduce PTSD and depression symptoms. Participants also reported satisfaction with the services (Hassija & Gray, 2011).
- DeKeseredy et al (2007) provide a theory for understanding sexual assault in rural areas, focusing on how social and economic change influence rural patriarchy and male peer support.
- DeKeseredy, Schwartz, Fagen & Hall (2006) explore the role of male peer support and patriarchal control in the lives of 43 rural women who have experienced sexual assault by former husbands or partners. 74% were sexually assaulted when they expressed a desire to leave the relationship, 49% were assaulted while they were making attempts to leave, and 33% were assaulted after leaving. 67% of women reported that their partner's male peers contributed to the assault, including frequent drinking with friends, advice from friends that encouraged abuse, and associated with friends who were also abusive.





AMERICAN INDIAN AND ALASKA NATIVE SURVIVORS

- NISVS found that 26.9% of American Indian (AI) and Alaska Native (AN) women reported rape in their lifetime and 49% reported sexual violence other than rape. 20.1% of American Indian or Alaska Native men reported sexual violence other than rape in their lifetime (M. C. Black et al., 2011).
- A study of 152 sexual minority American Indian and Alaska Native women (lesbian, bisexual or two-spirit) found that 85% had experienced sexual assault, and 78% had experienced physical assault, which was associated with worse mental and physical health (Lehavot, Walters, & Simoni, 2010).
- In another study, 17% of urban AI/ANs between 18-44 years old reported experiencing non-voluntary first sex (Rutman, Taualii, Ned, & Tetrick, 2012).
- A sample of 1368 members of six Native American tribes found that 14% of women reported rape since age 18 (Yuan, Koss, Polacca, & Goldman, 2006).
- Using National Crime Victimization Survey data, one study found that American Indian and Alaska Native (AIAN) victims of sexual assault are more likely to have assaults that involved weapons and that required medical care for injuries. Perpetrators of rapes against AIAN women were more often interracial and under the influence of alcohol or drugs, compared to those who assaulted White and African American women. And while sexual assaults against AIAN women are more likely to come to the attention of police, they are less likely to result in an arrest (Bachman, Zaykowski, Lanier, Poteyeva, & Kallmyer, 2010).
- Using National Violence Against Women Survey data, Hamby (2008) found that American Indian survivors' reasons for not reporting to police include suspicion of law enforcement, prejudice, conflict in values between Western and native worldviews, language barriers, and poverty.

- Bryant-Davis, Chung & Tillman (2009) suggest that for those who experience sexual assault within a larger context of interlocking systems of oppression (like racism, sexism, and poverty), the trauma of sexual assault is heightened. Intergenerational and historical trauma is also part of the contemporary context in which native survivors experience sexual assault.
- Lehavot, Walters & Simoni (2010) frame violence against American Indian and Alaska Native women as a current manifestation of colonization that negatively impacts agency, health and mental health.
- Smith (2010) describes a current manifestation of colonialism in which tribal communities are unable to prosecute non-Native offenders who commit sexual assault on tribal lands.

SURVIVORS OF HUMAN TRAFFICKING

Human trafficking is a complex issue that cannot be fully explored within the scope of this document. However, a few key points are worth noting.

- A review of research on human trafficking (Logan, Walker, & Hunt, 2009) suggests that around 12.3 million people are in forced/bonded labor or sexual servitude and 800,000 people are trafficked across national boundaries annually. Due to the illicit nature of trafficking, it is extremely difficult to get accurate prevalence estimates. Somewhere between 23-66% of trafficking is for sex work purposes. Trafficked sex workers and those trafficked for other reasons (labor, for example) are vulnerable to sexual exploitation. Sexual assault and the fear of sexual assault may serve to keep trafficked persons entrapped. Service sector responses to trafficking are hindered by the difficulty of identifying trafficking victims, the complex social and legal needs of victims, societal discrimination and anti-immigrant sentiment, few resources and services, increases in fear and safety concerns, and the complex nature of criminal cases.

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Everyone has a role and a responsibility in ending sexual violence, and the healing of survivors cannot be separated from the healing of society.



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