

part 1

1.1. introduction to part 1

Part 1 of Medical Responses to Adults who have Experienced Sexual Assault addresses the context of sexual assault in present time.

This part is designed to:

- give doctors access to empirical research material on the nature and incidence of sexual assault in our community,
- help doctors challenge common unfounded assertions and stereotypes about the nature of sexual assault and sexual assault victims,
- provide tools for appropriate understanding and care of women and men who experience sexual assault,
- provide an understanding of legislation and legal processes,
- provide access to a range of support mechanisms and specialist services, *and*
- provide self-care resources and support for doctors working with sexual assault victims.

Two broad categories of sexual assault presentations are likely in a medical setting:

Historical

Many victims of sexual assault will only disclose after extended periods of time. Common reasons for delayed disclosure are explored in Part One. The longer the time between a sexual assault and presentation for medical care, the broader the spectrum of skills and understanding required to identify and respond to the needs of a patient. Identification of historical sexual assault is explored in Part One and in Case Study Two.

Acute

A crisis presentation, that is where sexual assault occurred in the recent past (usually understood as from immediately prior to 72 hours and up to seven days prior to presentation for medical care) is more easily identifiable in that the impact of recent traumatic events is more likely to be evident, especially if your patient is presenting for a medical examination to specifically address issues arising from the sexual assault.

Again, broadly speaking, skills and responses in a crisis care setting require a more concentrated application at least initially, than in a historical presentation. Differences apply in each of these two settings, such as the requirement for forensic examination in a recent sexual assault, or the need to carefully build trust with a patient who was sexually assaulted many years prior and has disclosed to others previously with outcomes that can range from silencing or minimising her experience, to disbelief or judgements about her behaviour and responses.

The use of appropriate language, the principles of providing effective support and continuing care, dealing with personal attitudes and beliefs that may compromise your capacity to provide care, and referral agencies for providing services beyond the scope of your practice are all covered in Part One and in the case studies. Forensic examination and medico-legal report writing are comprehensively covered in Part Two.

The activities and readings in Part One will give you the opportunity to establish a solid foundation for providing appropriate medical care with a view to ensuring long term improved health outcomes for adults who have experienced sexual assault.

1.3. psychosocial context of sexual assault

This chapter looks at the psychosocial context of sexual assault. It examines social and community myths, issues of power, gender, culture and ethnicity, and issues for newly arrived Australians and New Zealanders. The psychosocial context also frames the beliefs and actions of victim/survivors of sexual assault; thus this chapter explores factors affecting decisions to seek medical or legal help subsequent to sexual assault.

What deters individuals who have experienced sexual assault from reporting to police and seeking support?

'I was so scared of disbelief. Scared of opening up to a complete stranger. I don't think I could trust a policeman. I'm not sure where the information would go'.¹

¹ D'Arcy M. *Speaking the Unspeakable: Nature, Incidence and Prevalence of Sexual Assault in Victoria*. Melbourne: CASA House; 1999:

There are many factors which may deter victims from reporting sexual assault. They include:

- some people feel more comfortable dealing with it themselves,
- not identifying what has happened to them as sexual assault,
- fear of the perpetrator,
- fear of not being believed,
- fear that reporting will involve them in a lengthy and unsupportive legal process and recognition that a very low percentage of prosecutions for sexual assault result in convictions and sentence,
- fear of repercussions/ostracism from their family and friends, *and*
- many victims have internalised societal myths about sexual assault and blame themselves, feel guilty, responsible and ashamed.

An awareness of the commonly held unstable assumptions about sexual assault is important because these assumptions – often referred to as ‘myths’ - work to keep people who have been sexually assaulted silent about their experience and make them feel guilty and ashamed about the crime that has been committed against them. Such feelings impede the recovery process and medical professionals should take every opportunity to challenge these misconceptions.

'I wanted to tell psychologists (about the sexual assault) but they always dismissed it. I got the message that it didn't matter'.²

² *Ibid*: 46.



Reading 2:

Scott D, Walker L, Gilmore K. Section 2: Common myths surrounding sexual assault. In: *Breaking the Silence* 2nd edn Melbourne, CASA House, 1995: 13-24.



Activity 5:

Answer true or false to the questions below, and record the reason for your answer.

Are the following statements true or false? Why?

- Sexual assault, especially rape is a rare occurrence – it couldn't happen to me (or my sibling or child).
- Men only rape young, sexually 'attractive' women.
- Sexual assault is primarily a sexual crime.
- Women secretly want to be raped.
- Women 'cry' rape.
- Incest/child sexual assault is not really harmful.