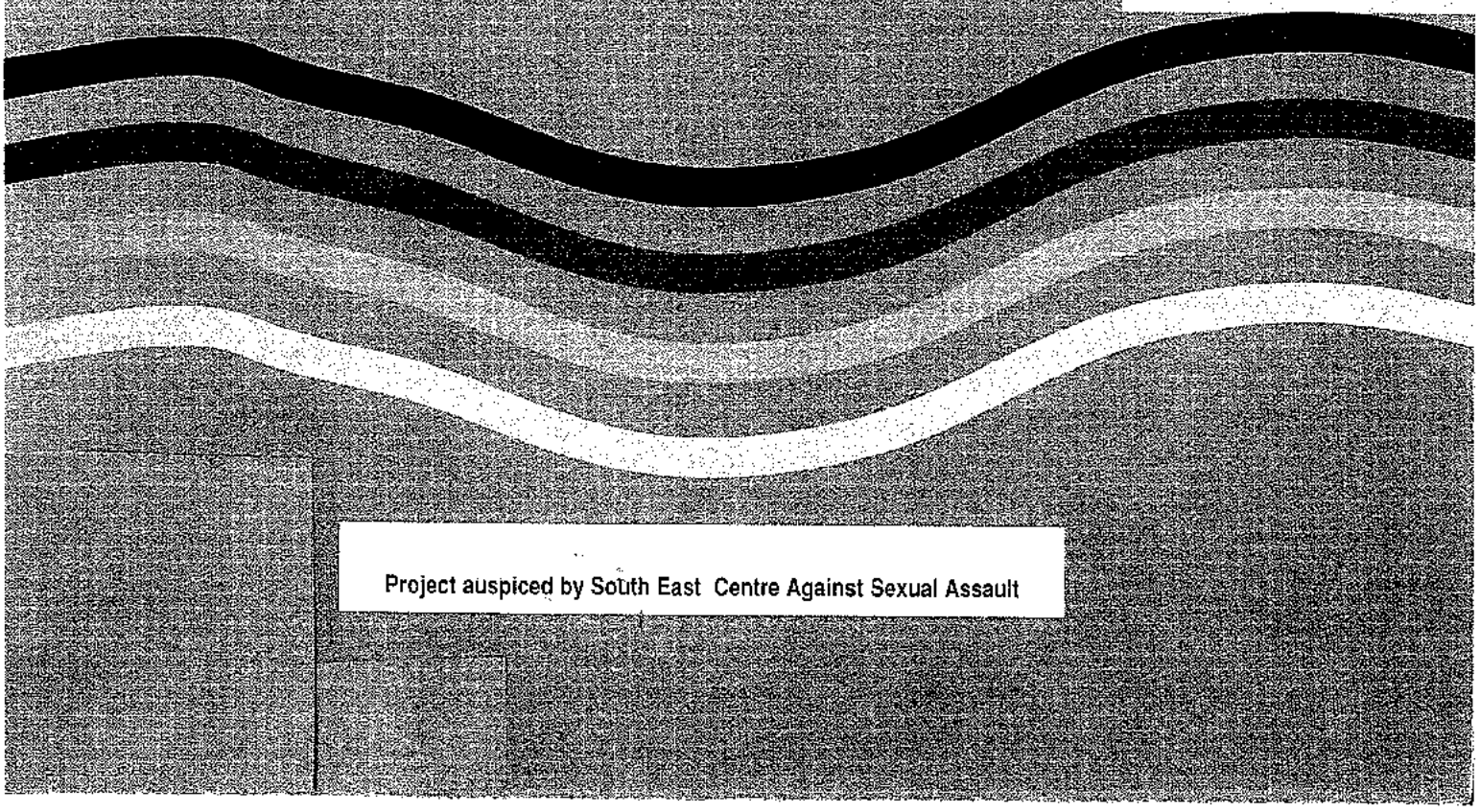
Certified Truths

Women who have been sexually assaulted — their experience of psychiatric services



Project auspiced by South East Centre Against Sexual Assault

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Project auspice: South East Centre Against Sexual Assault, Monash Medical Centre

Researched and written by Carolyn Graham

Editor	Sophie Arnold
Design /Layout/Cover	Letizia Mondello
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This has been a participatory project that has involved many women through all stages of the development of the study, the gathering of women's stories and the content of this report. The contribution of each person is appreciated and the diversity of experience, insight, ideas and sensitivity that the women generously provided is acknowledged.

In particular, I would like to thank all the women who shared their experiences, on which this report is based. While this process involved the sharing of great sadness and anger, I was struck by the generosity of spirit of each woman and their desire to participate in bringing about changes that could benefit other women in the future. Thank you for sharing with me your warmth, humour, courage and sincerity.

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Carolyn Graham

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contents

preface

This report has been written with a broad audience in mind. While it is anticipated that the entire report will be of interest to many people, other readers will be most interested in particular sections.

To assist readers, the following overview of each chapter is provided.

Chapter 1 provides background on the development and theoretical underpinning of the project and the methodology used.

Chapter 2 documents the stories the women told of being sexually assaulted, the impact of such assault and their experiences of psychiatric services. The text is almost exclusively the stories of the women interviewed. This provides readers with sufficient primary material to understand the experiences of these women and make their own interpretations.

Chapter 3 summarises the themes generated from the issues, concerns and experiences expressed by the women interviewed.

Chapter 4 provides conclusions and recommendations arising from this report. These include the urgent need to acknowledge the special requirements of women in mental health services and the development of women sensitive policies and practices.

Chapter 5 provides an overview of relevant literature, originating from a variety of disciplines, as a guide for those who wish to further explore the issues raised.

chapter one

introduction

When you speak and when you are heard you are committing a political act. Those who are silent, who are silenced, have no access to change, to choice or to control of their lives (Sara Paretsky, 1994).

PROJECT BACKGROUND

This research project, 'Women who have been sexually assaulted — their experience of psychiatric services' was initiated by the Centres Against Sexual Assault (CASA) forum in 1992.

The first centre against sexual assault was established in Bendigo in 1979. It was not until the mid-1980's, however, that CASA's were set up in regions across Victoria. These centres provide crisis care and short-term counselling support for victims of sexual assault.

In recent years, counsellors/advocates at centres against sexual assault have become concerned by a recurrent theme emerging from discussions with women clients who were current or past consumers of psychiatric services. These women related that their experience/s of sexual assault and its impact had not been explored or dealt with adequately by mental health services.

At the same time, counsellors were concerned about the anecdotal evidence of sexual assault occurring within psychiatric hospitals.

These concerns then led to the seeking of funding to explore the experience of psychiatric services by women who have been sexually assaulted. Funding for a twelve month research project was obtained from the National Women's Health Program, to be auspiced by the South East Centre Against Sexual Assault Centre, Monash Medical Centre. A project steering committee was then formed to guide the project (Appendix 1) and a researcher appointed to develop and conduct the research.

PROJECT RATIONALE

In spite of the greater use by women of mental health services (Chesler, 1972), there is a 'dearth of formal research on women's experience of being diagnosed and treated for mental health problems' (Gerrand, 1993, p21). The experience of men is most often universalised and applied to women (Broom, 1991). Traditionally the bio-medical model, with its focus on an 'individual, pathologising approach to women's mental health,' (Dennerstein, 1991, p9) has dominated mental health research. As a result, the questions asked and research methods used have commonly not reflected the central concerns of women.

The challenge to understand more clearly how and why issues faced by women with mental health problems have been marginalised or ignored in the past has been assisted by feminist critiques of social science. These critiques have highlighted the gender base of knowledge and demonstrated how previous theories have never been constructed or based on the experiences or ideas of women (Harding, 1987). Building on these critiques, feminist approaches within the field of mental health have not only highlighted 'issues faced by women with mental health problems, but in turn acknowledge that these issues often reflect women's general status and position in society' (Gerrand, 1993, p6).

Translating some of these quite recent explanations and understandings into the local context, Gerrand has exposed how mental health services in Victoria have been 'largely gender-blind. By "gender-blind" I mean that women and men were not differentiated in terms of policy or service development...The problem with gender-blind policy is that it ignores differences in the service needs of women and men. The use of gender-blind language is equally problematic as it can disguise known gender differences' (Gerrand, 1993, p2).

Furthermore, Dennerstein demonstrates how the dominance of the bio-medical model and the disregard of women's particular mental health needs has contributed to a scant recognition of the influence of socio-cultural factors to a woman's mental health. 'Women's social and sex role obligations and position in society and their experiences of physical and sexual violence could all be expected, from a social health perspective, to have a bearing on a woman's mental well being' (Dennerstein et al, 1991, p11).

Despite the obstacles, in recent years there has been an increase in the number of studies that acknowledge gender difference and seek to explore the impact of women's experience on mental health. This is particularly true with respect to the effect of childhood sexual abuse (Kendall-Tackett, 1993), with epidemiological investigations providing insight into issues of prevalence, incidence, impact and causality as it relates to sexual assault and mental health. However, frequently these studies still rely on research methods that involve 'the translation of individuals' experience into categories predefined by researchers - [that] distort women's experience and result in a silencing of women's own voices' (Jayaratne & Stewart, in Fonow & Cook, 1991, p85). What is missing is an understanding of 'her story — the diagnosis and treatment of mental illness in women' (Ashurst, 1993, p1) from the perspective of women.

Based on the issues discussed above, and a recognition that 'the experience of consumers is a rich, informed and generally untapped source of information for the development and planning of mental health services' (Cox, 1994, p1) this research project was conceived. The main aims of the study were to document women's individual and shared experiences of issues concerning mental health and sexual assault and to enable women's experiences that have previously been privatised or fragmented to be made visible and 'to become an acceptable part of public discourse' (Gerrand, 1993, p6).

THE DEVELOPMENT OF THE PROJECT

Using the above rationale as the starting point, the project steering committee decided on four guiding principles:

- to allow women's experience to be heard and documented;
- to ground analysis in women's experience;
- to raise awareness of issues related to psychiatric services;
- to incorporate feminist research principles into the project.

With these principles in mind, a broad consultation with users and providers of mental health and sexual assault services was conducted. A discussion paper was written that outlined the different priorities, needs and approaches favoured by those consulted. Following deliberation by the steering committee, a research protocol was developed that was based on qualitative methods.

It was agreed that the focus of the study would be the exploration of women's reality, not the prediction of outcomes or the verification of hypotheses. Women's reality was to be explored in terms of:

- individual women's experience of mental health problems and psychiatric services;
- how women interpret these experiences, particularly as they relate to sexual assault.

A basic assumption of the research, therefore, was that women's subjective experience in these areas has an important contribution to make to our understanding and theorising of sexual assault and mental illness and appropriate treatment approaches. The expectation is that actions and changes resulting from the findings of this study will have a positive effect for both women consumers and service providers.

LANGUAGE AND TERMINOLOGY

In recent times, social and literary theory and feminist critique has placed language on the political agenda (Foucault, 1971; Spender, 1980; Moi, 1985; Weedon, 1987; Cameron, 1990). The essence of this view is captured by Weedon who states 'language is the place where actual and possible forms of social organisation and their likely social and political consequences are defined and contested' (Weedon, 1987, p21). This statement would

appear to strongly apply to the mental health and sexual assault treatment fields where terminology, and the meanings attached to words, forms the crux of many debates (see for example CASA House, 1990; Gerrand, 1993; Victorian Department of Health and Community Services, Psychiatric Services Division, 1994).

This variable use of language posed a difficulty in the preparation of this report. During the study, it was found that the language used and the understanding of the meaning of certain symptoms can, depending on who is the speaker, be quite different. For example, some women interviewed do not self describe as having a mental illness. However they have been given a psychiatric diagnosis from service providers. Also the words women use and the meanings they ascribe to their experience can be quite different to the way in which similar information is articulated in the literature.

A further issue in this regard relates to the diagnostic and legislative framework that exists in Victoria. This framework defines who is eligible to access psychiatric services. So while some women may not believe that they have a mental illness, they may accept a psychiatric label. This acceptance is based on a recognition that the 'psychiatric system' requires that they are diagnosed with a 'mental disorder' in order to gain care from a psychiatric service.

In trying to solve this dilemma of language and terminology the original assumptions and aim of the research were recalled. These included that the purpose of the research is not to decide whether the women interviewed are mentally ill or not, rather it is their experience of the psychiatric system (particularly as it relates to sexual assault) that we are interested in. For the purposes of this report, it was decided, therefore, to follow two general rules.

Firstly, that the words of the speaker be used whenever that person is being quoted either from the text of the particular interview or the relevant literature. Secondly, in the use of general terms to establish the framework of this study, the following definitions and terminology would be used.

Sexual assault and psychiatric services are the general terms used to describe this study. Within this report the following definitions are used:

Psychiatric services / mental health services: includes public and private hospital based services, public community-based mental health clinics, private psychiatrists and non government community-managed mental health services.

When referring to in-patient psychiatric services, this report recognises that the medical model of illness and disease underpin these services. Mental health services refers to a broad range of services that support people with a mental health problem. This incorporates those mental health services that are based on a psycho-social rehabilitation model, as well as those operating within a medical framework.

Sexual assault: includes penetration and attempted penetration and/or sexual contact (genital and non genital) of a woman without consent or of a child.

Sexual assault is the preferred term as it is argued that 'not only does this cover a wide range of unwanted sexual acts towards adults and children, but also to stress the fact that sexual assault is [a crime and] primarily an act of aggression , not the result of uncontrollable sex drives' (CASA House, 1990, p4).

A 'woman with a mental health problem' is the description used when referring to the women interviewed as this is seen as a more neutral description than, for example, psychiatric illness as it does not necessarily imply disease.

Mental illness, mental disorder and mental health to be used when this is the language used by the 'speaker' in written materials or the interview text.

Client: used when referring to use of any service other than a hospital. Patient will be used when referring to hospital experience. It is acknowledged that 'patient' has an implicit paternal assumption. However it is used in this report as it conveys a consistent meaning to the user and provider of in-patient hospital based services.

METHODOLOGY

> *We have to hold facts lightly, continually testing them against experience and logic, recognising their connection to the rules and context within which they appear, and most importantly, never ceasing to scrutinise the values that necessarily permeate them (Tesh, 1988, p177).*

There is a paucity of research that documents women's 'everyday lived experience' (Stanley and Wise, 1983) of the impact of sexual assault and the way in which psychiatric services respond. This research, therefore, is exploratory and aims to identify issues, concerns and themes from women's experience which can inform current policy and practice and provide the basis of further research. By implication, a naturalistic interpretive research methodology was adopted using qualitative methods. These methods are 'particularly suited to investigating problems and issue that are poorly defined or for exploring issues that are not well understood' (Australian Health Ethics Committee, 1993, p1). The methodology chosen was also feminist. This means that as far as possible:

- Women were to be consulted and involved at all stages of the research;
- Research methods were to be non-exploitive of women;
- Research methods were to provide participating women with maximum choices and support;
- Data collection was to focus on enabling women to tell their stories about their reality as it has been experienced and lived by them;
- Women's experiences were to be the primary 'voice' of the findings;
- This research aims to bring about change in the provision of services as identified by the women interviewed.

This study was conducted by a researcher employed full-time for twelve months, with a steering committee to provide advice and direction.

The researcher undertook all stages of the research which included the initiation and facilitation of broader consultations at the planning, implementation and reporting stages of the project, involving clients and service providers from a broad background. Other tasks included: the development of the research protocol, ethics committee applications and funding submissions for a second stage of the project; liaison with services, support people and women in the recruitment and interview of women; the conduct of a literature review, the conducting of interviews and their transcription; analysis of the data and the writing of the report.

Literature review

A literature search and review of relevant Australian and international literature was conducted. This informed both the development of the research protocol and an understanding of women's experience.

The aim of the research

The aim of the research was to explore practices within psychiatric services which relate to sexual assault and the impact of these services on women who have experienced sexual assault.

The questions asked

The research questions that derived from the research aim and which informed research methods were:

1) What are current practices within public and private psychiatric services in relation to sexual assault?
2) How do psychiatric services respond to women who disclose sexual assault?
3) How could psychiatric services be more effective in supporting women who have been sexually assaulted?

The women interviewed

The emphasis in qualitative methods is on depth and detail. Given the exploratory nature of this research, there was a need to gain a range of experiences while also gathering enough information of individual women's experiences to provide a contextual understanding. Funding limited the research to a period of twelve months and the employment of one full-time researcher, with advisory and administrative support.

The project steering committee agreed that the study population was to consist of women who:

- were over 18 years of age;
- were currently not psychotic nor had been in the previous six (6) weeks (as agreed on by the individual women and their support people);
- were currently using a psychiatric service, or had at some time since 1986 (the passing of the Victorian Mental Health Act);
- identified that they had been sexually assaulted (as defined on page 4).

A non-representative purposive sample was used in this study which was considered the most appropriate given the exploratory nature of the research and the need to 'select information rich cases for study in depth' (Patton, 1987, p53). This study does not attempt to be representative, therefore, it is recognised that limited generalisations can be made. What the findings do provide is a rich insight into the issues that are seen as centrally important to the women interviewed.

Thirty-one (31) women were interviewed. There are no set rules for determining the size of a purposive sample. For this study, the decision to increase the sample size from sixteen was made after fifteen interviews had been conducted. It was decided that the variety of experiences had not reached 'saturation' point and that there was still inadequate depth and detail to meet the research aim. Of the thirty-one (31) interviews, thirty (30) were analysed, One woman requested to withdraw from the research project, after the interview had been conducted.

It needs to be reiterated that general characteristics of women to be interviewed were not pre-determined and the sample was not representative. However, a breadth of experience has naturally occurred among the women interviewed. Some of the characteristics of the sample outlined later in the report were not gathered by structured questioning. Instead, all women at some time during the interview chose to provide this information.

The age spread of the women interviewed (refer to table 1) ranged from ages 18 to 49, with an average age of 34. The number of women in the three age groupings of 20-29, 30-39 and 40-49 was reasonably similar, with only one woman under 20 years old. Five (5) women live in country Victoria, with the other women living within metropolitan Melbourne. Parental background was not specifically asked. However four (4) women volunteered that their parents were from a non-English speaking background (all European) and two (2) women are Koori.

Table 1: Age of women interviewed

Age group	18 -19	20 - 29	30 - 39	40 - 49	Total
No. of women	1	12	9	8	30
% of women	3.33	40.0	30.0	26.66	100

The recruitment of the women

Women were contacted through psychiatric and sexual assault services and invited to participate in an interview. A range of services, nominated by the Steering Committee, were contacted and asked to participate in the project.

Principles that the steering committee adopted for determining which services were to be approached, the responsibilities of services if they chose to participate, and the options available to women who agreed to be interviewed were as follows:

- Services were to be representative of the diversity of mental health and sexual assault services;
- Services were to include those located in metropolitan Melbourne and country Victoria;
- Services would be asked to approach a maximum of two female clients that they knew met the research criteria;
- Services would not only agree to approach two women about possible interviews, but also agree to provide support to the woman, as outlined later in this text.

With these principles in mind, the three recruitment methods devised were :

- Workers within nominated services were to approach female clients about participation in the project;
- Information about the project was to be sent to nominated consumer based organisations and self help groups with an invitation to members to participate in the project;
- The researcher was to speak to clients at services and invite women to self select for interview.

While each of the three methods were offered, only the first two methods were chosen by services. These two methods worked in practice as:

- Forty-seven (47) services or organisations were sent letters that explained the aims of the research, the recruitment options and the responsibilities of services if they chose to participate. An information sheet was included for potential women interviewees (See Appendix 2).

Of the forty-seven (47) services and organisations approached, eleven (11) were located in country Victoria and thirty-six (36) within metropolitan Melbourne.

- Workers within each of the services were asked to approach two clients who they were aware met the research criteria. If a woman was interested in knowing more about the project, the worker discussed the information sheet with her.
- If the woman was interested in talking further to the researcher and/or wished to participate, the worker gave the woman a 'Permission to contact form' (Appendix 3) to fill out and return to the researcher.
- When a woman agreed to be interviewed, the worker within a service who had been nominated as the woman's support person was contacted by the researcher. This was to arrange an interview time of two hours and to arrange an interview room, if required.

Of the forty-seven services and organisations, seventeen services and two organisations agreed to participate in the project.

A similar process was followed with women who made contact through an organisation, rather than a service.

Of the forty-seven (47) services and organisations, seventeen (17) services and two (2) organisations agreed to participate in the project. (refer to table 2)

Table 2: Organisations/ services from where women were recruited

Organisation / service provider	No.	%
Community mental health clinic	3	10.0
Private psychiatrist / psychotherapist	2	6.6
Non-government community managed mental health clinic	12	40.0
Generalist community health service	1	3.3
Centre Against Sexual\ Assault	9	30.0
Mental health consumer organisation	1	3.3
Sexual assault survivors group	2	6.6
Total	30	99.8

Of fundamental importance in the recruitment of women to be interviewed was that they be fully informed. Before agreeing to be interviewed women were informed of the following:

- the aim of the interview;
- the interview process;
- the support process running parallel with the interview process;
- the choices available;
- the confidentiality procedures;
- the need to feel safe;
- the right to withdraw from the process anytime up to six weeks after interview;
- the recording of interviews;
- the format and circulation of the research draft and report.

The process of recruitment therefore took place as follows:

- The women were first told about the project by a worker in the services or organisations;
- If interested in either finding out more information or participating in the project, the women filled in and returned to the researcher a 'Permission to Contact' form.
- The researcher then rang the women and gave them the choice of talking further either on the phone or meeting at a place suitable for them. At this point the researcher informed the women that she did not have a clinical background and that a support process was built into the interview process;

- On agreeing to be interviewed the women were asked to nominate a professional, with whom they had on-going contact, as their support person;
- The women were asked to indicate days and times that they could be interviewed and the venue for the interview.

ETHICS APPROVAL

To conduct research with current or past patients of public hospital or community-based mental health clinics, ethics approval has to be gained from relevant institutional ethics committees. In the first instance, approval to proceed with the project had to be gained from the Monash Medical Centre Human Research and Ethics Committees. Following this applications to the research and ethics committees of the following institutions were submitted:

- Royal Park Hospital services the inner north and south and northwest metropolitan regions;
- Austin/NEMPS (services in the north and eastern metropolitan regions and some country regions; and
- Warrnambool and District Base Hospital.

The process of submitting an application and having it assessed and approved is extremely time consuming because:

- committees meet on average once a month;
- there is no consistency in the documentation required from committees at different hospitals and each require extensive information and copies;
- the guidelines of each hospital committee is different;
- information on the ethics application process, the parameters of each committee's responsibility and the basis for decision-making by the committees is extremely hard to access, or impossible, as this project found with one hospital;
- if any changes are required by a committee, the application cannot be re-submitted until the next meeting which is up to a further month later.

The outcome of submissions (which all contained the same information) to committees are as follow:

Approval gained from both the research and ethics committees of the Monash Medical Centre and Royal Park Hospital. Neither required any changes to the protocol as originally submitted.

The Warrnambool and District Base Hospital ethics committee felt unable twice to grant ethics approval. The concerns which the committee cited were as follows:

- 'The Hospital does not believe that self selection is appropriate and may lead to the results being biased;

- There is a risk that individuals may be affected by recalling their experience and return to a psychotic state. Nor is there any mechanism stipulated in the research project to cope with this eventuality;
- The individual researcher does not have sufficient experience and qualifications to interview selected women' (Letter, CEO, 1993).

The process with the Austin/NEMPS research committee was as follows:

- After the research committee had met with the researcher, a letter from the committee was received by the project. This requested some changes and additions to the research protocol;
- As the Steering Committee of this project were unclear about what was actually required by the research committee, it wrote a letter to the Chair of the research committee asking for further information;
- A response to this letter was not received. The Chair was then rung on three occasions requesting a response to the letter and the project was assured that a response from the committee was in the mail;
- A further letter was then written to the Chair of the committee requesting that the information asked for be supplied as a matter of urgency;
- Six months later, there still has not been any further correspondence received from the research committee.

The Austin/NEMPS is the largest provider of psychiatric services in Victoria. Access to a large range of services and patients/clients within metropolitan Melbourne and country areas was therefore not possible. A number of services and women who were keen to participate in the project could, therefore, not be involved as there was no ethics committee approval.

The interview guide

'The fundamental principle of qualitative interviewing is to provide a framework within which respondents can express their own understandings in their own terms' (Patton, 1987, p157). To achieve this, in-depth, open-ended interviews were planned using an interview guide. The interview guide (Appendix 5) was developed by the researcher in consultation with clients and service providers of psychiatric and sexual assault services and steering committee members.

The purpose of the interview guide was to delineate areas to be covered during the interview and to suggest sensitive open-ended wording of questions. The guide was used in a flexible manner in that questions were not asked in any particular order. Questions were instead asked as they were relevant to issues the women chose to talk about. The interviewer asked questions as required to provide a clearer or deeper understanding of the particular experiences of the women.

Conduct of interviews

The features of the interview process were:

- women's choice of the venue for interview;

- women's choices in terms of the support process;
- reiteration of the purpose of the interview and research process as an introduction to the interview (Appendix 4);
- explanation of confidentiality measures;
- request to audio tape interviews;
- explanation of the consent form (appendix 6) and the signing of it by the woman prior to commencement of the interview;
- women were encouraged to ask questions throughout.

These features are elaborated further:

Twenty four (24) women chose to be interviewed at the service where their support person was employed, while six (6) women chose to be interviewed at home;

As indicated previously, a support process was built into the interview process. The choices women were provided with were:

- choice of a support person that they trusted;
- choice of having the support person sit in on the interview;
- choice of debriefing with her support person after the interview and;
- option of at least three counselling sessions with her support person, after the interview.

All but two (2) women chose as their support person professionals with whom they had on-going contact. One (1) woman chose to use the self help group that she belongs to as her support. Another woman who has very strong family support and regularly uses a community mental health service also chose not to nominate a support person. Her comment at the end of the interview about the 'built in' support process was 'having the choice and respecting that choice is the most important thing'.

Twelve (12) women chose to have their support person sit in on the interview, as observers, with all but two (2) women choosing to debrief with their support person immediately after the interview. A number of women commented that they appreciated the recognition that talking about sexual assault and psychiatric experiences was a sensitive and painful process. They particularly appreciated the provision of a support process, and the choices provided within this process.

... women commented that they appreciated the recognition that talking about sexual assault and psychiatric experiences was a sensitive and painful process.

In discussing the consent form with women, a comprehensive overview of the purposes, methods and sensitivities of the interview and study was provided. It was also emphasised that the woman could stop the interview at any time, and that if she chose to do this, her support person would still be available to her.

The woman's support person was present when the researcher went through all aspects of the research process as detailed above. At the completion of this explanation, woman were given the opportunity to ask questions. Following this, all women signed a 'Subject Consent' form.

The measures to protect confidentiality were:

- All tapes of interviews were given a number, rather than a name;
- All tapes, transcripts, consent forms and any other identifying material is stored in a locked cabinet.
- No specific names of either individuals or organisations referred to in interview, to be used in the report.
- Any identifying information would not be included in the research report.
- Interviews were taped so that women's actual words could be the basis of the findings and minimise interpretation by the researcher.

The length of interviews varied between forty five minutes and two hours, with the average length about one and a half hours.

Data analysis

Content analysis of interviews was conducted in order to identify themes and patterns that emerged from the women's stories rather than being predetermined prior to data collection and analysis.

All interview tapes were transcribed to enable detailed and rigorous analysis. Transcription incorporated the first level of analysis with the noting of themes and patterns as they emerged. Following the transcription of each set of five interviews, draft categories of analysis were developed and refined.

Content analysis of the data was conducted by the inductive analysis of transcripts analysis with the aim to:

- identify recurring similarities and differences within the data to enable the development of patterns, categories and basic descriptive units;
- enable interpretation of the data so that the meaning and significance of descriptive patterns, relationships and linkages could be made.

Apart from organising the data and making sense of it, it was important that the data was 'looked at' in a variety of ways to verify the findings. This included looking for rival themes and explanations and ensuring 'the best fit between data and analysis' (Patton, 1987, p159). Analysis and interpretation of the data thus included the following steps:

- The recording of themes, issues and concerns as they emerged during the process of transcription;
- The merging of themes, issues and concerns into tentative coding categories through the grouping of the same underlying experience, idea or concept;
- The further development and refining of categories as analysis became deeper and rival themes were explored. After the development of six tentative coding categories a seventh was developed and these became the final categories to be used for interpretation;
- The re-reading and coding of transcripts to highlight quotes that relate to categories;

- The re-looking at all the data and the development of descriptive categories. Some of these were the same as the coding categories;
- The summarising of descriptive data under sixteen headings;
- The aggregation of summarised descriptive data to identify patterns and themes that may not have been identified at the time of category formation, or which challenged earlier interpretations.

Report writing and establishment of validity

> *I believe that the printed word can convey much of the speaker's original intent if the writer places it carefully and sensitively in its new context and seeks approval for that placement with the person who spoke (Haig-Brown, 1991, p65).*

It was important that the process of writing this report be consistent with principles adopted throughout the research. The Steering Committee made a decision that the report should be written with a broad audience in mind. Therefore it was decided that women 'telling their stories and perspective in their own words' would form the bulk of the report.

The draft report was circulated to all women interviewed with the request that they check the report to ensure that it fairly related their experiences and to enable them to make any comments. At this stage, the women were also invited to talk about the impact of their involvement in the project. Ten (10) women took the opportunity to provide feedback.

In the majority of cases, quotes by the women are indented in the text. Information that the women gave in another part of the interview, but which provides a context for a quote, is indicated by a square box around the information. Words that the women emphasised during the interviews are highlighted in bold.

chapter two

the women's stories

...experience means taking real life as the starting point, its subjective concreteness as well as its social entanglements (Fonow & Cook; 1991, p66).

Why should one of the thousands and hundreds of thousands who have known the pit of betrayal - the fear of madness or madness itself - not tell of it? Break the taboo of respectability which has been broken so seldom. Challenge the system that keeps millions in line. Try to explore the region from whose bounds only silent and censured travellers return (Millett, 1991, p313).

The overwhelming message in the stories of women interviewed was the great pain that each of these women have suffered in their lives. Emotional and mental pain arising from the experience/s of sexual assault.

Ongoing pain from the burden of carrying the 'secret' and from the feelings of re-abuse when disclosure of sexual assault was responded to with silence, with disbelief and/or with anger.

Frightening pain from the flashbacks and/or memories suppressed for anything up to forty years.

The pain of isolation and not 'belonging' anywhere.

The pain of confusion when she 'lost the plot'. The pain of powerlessness when her reality was not listened to by psychiatric professionals.

The pain of devastation and grief following sexual assault by a psychiatrist who then abruptly ended the professional relationship.

The pain of stigma and of 'becoming' her psychiatric label.

The pain of having to repeatedly ask: 'will somebody please listen and believe me?'

Resonating through these women's stories also is the courage of these women. For some, the courage to continue trying to maintain their mental health despite the recurring pain, the disappointments and the despair that they had experienced. For others, the courage to overcome years of abuse and institutionalisation and to re-establish a sense of self and 'stability' within the community.

Common to all the women interviewed was also their great humility. A humility (which some would call 'submission to the system') towards institutions within society and their custodians, despite feeling 'let down' by them on numerous occasions.

Moreover, the generosity and trust of these women meant that they were prepared to relive some of their past pain and to trust a stranger, despite previously having had their trust broken by people close to them.

Individually and collectively they said that they participated in the research because they wanted to help other women. This help was described in terms of prevention and service responsiveness. In respect of prevention, it is the hope of the women interviewed that, through the reading of their experiences, other women may avoid the trauma of sexual assault.

The women were also united in hoping that psychiatric service providers on 'hearing' women's stories, might improve their understanding of the connection between unresolved issues concerning sexual assault and the women's mental health problems.

It is hoped that through such improved understanding, services would become more responsive to the needs of women as identified by the women interviewed.

The challenge in writing this report was to do justice to the women's stories while making the report accessible to its audience. In keeping with the exploratory nature of this study, the following synthesis of women's stories is presented thematically. Potentially this 'breaking up' of stories could desensitise the reader to the fact that they are about a woman's lived experience. Furthermore, unlike case studies, it is acknowledged that a thematic approach can make it difficult for the reader to place comments within context.

It is hoped that despite the fragmentation that inevitably occurs with such a thematic approach that the 'woman' is never lost in the text. Every endeavour was made to provide context to the women's stories through adding to quotes, as appropriate.

The findings are presented in two broad groupings, the first focussing on sexual assault while the second looks closely at mental health and psychiatric services. This structure derives from the way that women told their stories. They chose to talk about how the sexual assault affected them, the health and social problems that they associated with these experiences and the exacerbation of these problems by the denial of their reality by others. There is very little 'commentary' by the author in this part of the report. The reality of women's experiences is in how each woman speaks for herself.

THE CIRCUMSTANCES OF SEXUAL ASSAULT

Table 3 shows the varying circumstances in which the women interviewed for this study had been sexually assaulted.

Table 3: When women experienced sexual assault

	No. of women	% of women
Child sexual assault	14	46.66
Adult sexual assault	6	20.00
Both child and adult sexual assault	10	33.33
Total	30	100

The greatest significance of these particular findings are that almost all the perpetrators of child sexual assault were male family members or trusted family friends. Consistent with previous findings (Finkelhor et al, 1990) the majority of the perpetrators of child sexual assault (Table 3) were family members (27 of a total of 34, including de facto).

Table 4: Perpetrators of child sexual assault

Perpetrators relationship to child	Number
Father/Stepfather	12
Mother	2
Brother/stepbrother	6
Mother's boyfriend	3
Grandfather	1
Cousin/uncle	3
Family friend	4
Teacher	1
Stranger/unknown	2
Total	34

Note: 24 women were sexually assaulted as children.
Seven were assaulted by more than one perpetrator.

This picture is different when one looks at the perpetrators of adult sexual assault (refer to table 5). Here, while the majority were still known to the woman (15 out of a total of 23), this was most often at the acquaintance level only. Of note to this study, is that four adult sexual assaults were committed by a male psychiatric in-patient, one by a nurse, one by an ex- psychiatric in-patient and one by a psychiatrist.

In terms of gender, thirty-two (32) perpetrators of child sexual assault were male and two (2) female with twenty-three (23) male perpetrators of adult sexual assault and one (1) female.

Table 5: Perpetrators of adult sexual assault

Relationship to victim	Number
Brother	1
Estranged husband	1
Male psychiatric in-patient	4
Psychiatrist	1
Psychiatric nurse	1
Cult members	1
Aquaintance	5
Strangers	9
Total	23

Note: Ther were sixteen (16) victims of sexual assault. Seven (7) women reported more than one assault.

THE EFFECT OF SEXUAL ASSAULT

Each woman chose to talk about how sexual assault had impacted on her life. Despite the different contexts in which the sexual assaults occurred, there was a consistency in the words that the women used and a commonality in the way the women described how the experience had affected them.

The consistent words that women used about the general impact of sexual assault related to loss. A loss 'of trust', 'of self esteem', 'of body - my body is a separate entity' combined with feelings of 'pain', 'anger', 'fear', 'depression' and 'difficulty in maintaining relationships, particularly sexual relationships'. The pervasiveness of how women feel sexual assault has impacted on their lives is captured in the following three quotes:

'Sexual assault immobilised me as a person. It has impacted on my mental health, I have

been emotionally stuck for thirty years. I was stunted and didn't develop from that time. It has a catastrophic effect on self...you haven't got a sense of self.'

'Sexual assault has affected everything I have done or thought or been. Until three years ago I had no conversation of more than one sentence because anything was too scary to talk about'.

'Women who slash themselves often feel that it is the only way that they can get the badness out of themselves. This badness emanates from sexual assault'.

The impact of child sexual assault

In respect to the impact of child sexual assault, women talked about the loss of childhood and all that that entails.

> 'I think that the sexual assault has had an incredible effect on me actually, really quite an enormous one...being sexually assaulted changes the person in some ways that can never be changed back again. It changes your understanding of the world and how things work in a way that is permanent. I also think there is a sense of loss of childhood innocence and sense of safety and trust and a myriad of other things that children expect during childhood that you never regain. Because you obviously never have the chance again to go back and have all those things that you feel a child should have'.

> 'I changed from a sweet kid to an obnoxious brat from the time of the sexual assaults...When I have flashbacks I slash up or strangle myself'.

> 'It may have happened back there but I think your early childhood experiences or any sort of violation like that impacts as you are developing as a child...it happened to me in my teens, but it has affected me in the same way that it has affected people who have been sexually assaulted at a younger age...you need to be re-nurtured and to learn skills how to nurture yourself'.

> 'When my father grabbed me at seven I knew it wasn't fatherly. Even though I didn't know anything about sex I knew that it wasn't fatherly love, I knew it was nasty. Sexual assault has made me depressed, low self esteem and there is also the sense of loss. I used to see girls my age with their fathers and I used to think, what is it like to have a father. Is it nice, it looks nice'.

The impact of adult sexual assault

Comments specific to adult sexual assault demonstrated the significant effect on women's lives that sexual assault caused.

> 'After the sexual assault, you don't sleep, you don't eat properly...How I deal with my feelings is that I see the community mental health outreach worker every now and again and I cut myself up after the assaults, it relieves anger, pain. The pain is still there but it relieves some of it at the time'.

> 'I won't have a bar of relationships'. 'I didn't work again' [since a violent rape by a stranger 14 years ago]

'You lose a lot emotionally when you get raped, I hate saying that word, I don't know why, because it's just such a label and also on a personal level it is so hard to say. [When I was raped] I lost my whole flat, I lost everything that I had built up. That was my monument of success [after many years in institutions and homeless] and it was just taken away and it lost all its specialness and the whole place felt so unsafe. Something that I had built up to be so safe, could be destroyed with me having no control.'

'The rape affected me in that I am more wary than ever of a lot of peoples' potential for danger, whether male, female...life does go on but to know that there are people like that that just don't care about other people's self esteem or intentionally want to hurt them or know that potentially they are able to kill you is another thing.' The rape 'has delayed me in pursuing any goals, a secure job, fitness etc'.

'After I was raped I cut my wrists...the doctor stitched me up and asked "why did I do it"? I said because I was depressed...slashing up made me feel better because it was letting the bad out of me, the dirt, the filth. I just didn't know how else to get it out of my system'.

The impact of sexual assault within a psychiatric hospital

Women raped by another patient while an in-patient in a psychiatric hospital also similarly described the impact of the assaults. However they also talked about their disbelief that this could occur within a psychiatric hospital and be seemingly condoned by workers through a lack of response to their experiences. Comments reflective of the women's reaction to this experience were:

'It is when you are most vulnerable you are in one of the least safe places'. 'I don't think the world is a rosy place but I just didn't realise that it is that bad in our mental institutions'.

'When I told the staff they moved the guy to the end of the corridor, but he was still in the same area....I slit my wrists after the assault'.

The impact of sexual assault by a psychiatrist

One woman described how she had been devastated by her psychiatrist initiating and controlling a sexual relationship with her at a time that she was extremely vulnerable. He rang her one day and told her that he would not see her any more as a patient or as a lover. She described the effects as:

'Devastating. I lost everything, trust, religion, ability to have relationships. I am incredibly apprehensive, nothing is safe anymore...I attempted suicide'. 'I cannot lie down and forget it...The impact on my life has been firstly, when you seek help it is almost like laying yourself bare, especially if you have got something like agoraphobia because you hide it, you hide it for years, and you want to be seen as normal. What made this psychiatrist so significant was that on the day my mother died, she said to me 'you've got to go and seek help because I won't be here for ever'. That was almost like my promise to her...He knew this story and my commitment to my mother and this was my last chance, I am going to get better, I want to lead a whole life,...I have

probably never been so vulnerable as at that time and here was a man saying I will look after you... He took everything that he knew about me and used it'.

The impact of sexual assault on the lives of women interviewed is clearly significant and destructive. It is also clear that this impact was exacerbated by the responses they encountered to their disclosure of sexual assault.

The response to disclosure and its impact

'I think that if you are walking around with a great big gashing wound you would be believed that you are carrying pain' (woman interviewed).

While all women interviewed had seen a psychiatrist (public and/or private) at some time in their life, twenty-six (26) had disclosed sexual assault to a psychiatrist. A further two (2) women had disclosed to a psychiatric nurse, but not to a psychiatrist, and two (2) women had disclosed to a social worker and a counsellor.

Of the women interviewed, twenty-two (22) had used a Centre Against Sexual Assault. Nine (9) different services had been used - four (4) metropolitan, four (4) rural, Telsasa (after-hours telephone counselling, information and referral) and one (1) service in New Zealand.

Of the women interviewed, sixteen (16) first told someone about their sexual assault experience/s when they were children and fourteen (14) when they were adults. There were broadly four (4) different contexts in which the women disclosed: as a child; an adult to family, friends or a lecturer; an adult to a psychiatric service provider; and as an adult to a worker at a Centre Against Sexual Assault.

Within the literature there has been a developing recognition of the trauma most people experience when they disclose experience/s of sexual assault (Herman, 1981; Martyres, 1994). General themes that emerge from the women speaking about disclosure of sexual assault are:

- that many women did not disclose child sexual assault for a long time after the experiences due to fear of the perpetrator or people's reaction etc;
- that in most situations woman have perceived a negative response to disclosure of sexual assault in terms of silence or disbelief. This has added to their despair;
- that as adults, women make a considered decision to disclose sexual assault. Furthermore, that women have an expectation that the person disclosed to will respond in an active way.

Why the women did not disclose at the time of sexual assault/s

The consistent reasons that women gave for remaining silent about sexual assault were fear, confusion and community attitudes that they felt dictated that sexual assault was a taboo subject. The following comments capture the shared understanding of the women interviewed about this 'need' to keep silent:

'When I disclosed at twenty two years old I didn't know what to think but I just had to tell someone. Why should we have to keep it a secret? I was the one that was

harmed. I didn't ask for it...yet within families these things are kept so quiet, the victim is suppressed and frightened to talk, even by the mother.'

'I kept it a secret because I remember that he threatened me that if I ever said anything that he would just deny it and that he would get back at me one way or another. So I just didn't say anything'. Another reason why I didn't want to say anything earlier on was that I wasn't sure that I would get the support I needed from my family'

'I never told anybody...I know that there were threats. He used to say if you tell my mum and dad [the girl was staying with family friends while her parents were away], your mum and dad won't come and get you...I remember when Mum and Dad did come home, him holding my hands back and saying "if you **ever, ever** tell anybody I will be after you and you will never be able to escape." And I think, I don't know what happened but I think that I just did. I was scared'.

A woman interviewed had been critically physically ill as a child. How she made sense of her experiences at the time, the 'collusion of silence' around her illness and sexual assault and why she kept silent about the assaults for forty years are shared below:

'Sickness was in my mind, as a child, connected with the sexual abuse. That I had to keep silent about it...The sexual assault started when I was eight and I knew by the time I was about twelve that I actually had a stone in the bladder. But I still had the sense that whatever my brother did to me put it there or caused it...I certainly did my best to keep it secret, but I couldn't keep the illness secret from my mother, she was my mother and she did nothing either. For the first couple of years I thought I was having a baby because I knew that what he did caused you to have a baby and I knew from hearing aunties talk about it that it hurt. So I assumed that was what was happening...I just got sicker and sicker'.

'There was never any question of why I had become sick, why I had become that sick, how it happened...No one in the medical profession questioned that either...the school never did anything about it. There was a collusion of silence in all aspects of my life'.

'I couldn't say anything for a long time because of my fear about how the person was going to see me. Would the person see me much more differently, would I be treated any differently?...'

Children's perception of community attitudes about sexual assault was also talked about by some women as a reason for their fear to tell anyone about their experiences.

'I couldn't say anything for a long time because of my fear about how the person was going to see me. Would the person see me much more differently, would I be treated any differently?...I was scared that I would be questioned on things like, why I didn't do this and why I didn't do that. There was guilt I guess about the questions that could be asked and why I didn't do certain things and fearing a lack of understanding of why I didn't do it'.

Disclosure as a child

Women who disclosed sexual assault as a child reported negative responses to their

disclosure. The impact of these responses was significant, resulting in the women keeping their 'secret' to themselves until some time in adulthood when it could no longer be kept silent. Six (6) women first disclosed sexual assault as a child to a family member. The responses and the impact of these are captured by the following:

> 'I tried to talk about the sexual assault between four and 17 years old but nobody [family] wanted to know about it. I thought they thought that I was making it up. I was angry that people wouldn't believe me and then I thought I was to blame for the whole thing anyway. After a while I just couldn't talk to anyone about it'.

> 'I first told my family members and I was not believed. I was very savagely attacked by my brother. It made me feel devastated because I didn't understand why he didn't believe me because my dad had done it over a number of years...I first disclosed to my family to see if I could get support from them...because they didn't believe me I didn't disclose again for a fairly long time and because I was emotionally drained from that'.

> 'I remember I did tell my mother when I was about three...I didn't get a very good response. I got screamed at and told that it was my fault...I had everyone being angry with me, maybe that is why I never really talked about it anymore. Because the result that followed was much worse than if I hadn't spoken'.

> 'I tried to tell my mother when I was about 10. She told me not to be so stupid and laughed at me'.

> 'My mother never admitted that it happened, she knew alright because he told her. She just wiped it, she won't recognise it in any way whatsoever. So I kept it quiet until I was 22".

Disclosure of sexual assault to friends while a child met with the following responses:

> 'I told a friend, somewhere about the sexual assault [when I was a child] but I don't know who to. Most people have had the same reaction towards me, they tend to say "'I see" and then leave it at that which makes me feel pretty rotten because they don't want to talk about it'.

> 'I have disclosed sexual assault to very few people. I told a girlfriend when I was a teenager,...but when I said something, there was like a shield went up. I could basically understand, but I guess because we were close friends I found it difficult because there was no-one in my life for a long time and there was a lot of pain of suppressed stuff'.

> 'My friend who I went to school with knew...she asked questions but it was very secretive, I didn't really go into it. Secretive because I was ashamed of it, I didn't really want anyone to know because I was very ashamed so I blocked a lot of it out'.

Three women interviewed had first disclosed sexual assault to either a doctor (GP) or a nurse or a social worker as a child. Tragically, protection of the girls from further sexual

assault did not occur, nor were feelings about these experiences followed up.

> 'The Doctor (GP) found out [about the rapes] when I had just turned twelve. I went there because I caught an infection [STD]...No-one talked to me about my feelings, about what happened'. "They had a children's court hearing...I said 'I don't want to go home because my father raped me." My father denied it and they let me go home...I had a nervous breakdown at the age of fifteen'.

> 'I went into hospital [general] for medical reasons at twelve years old...I disclosed to a nurse and I was really upset and I remember I was crying, I spent the whole night crying. I'm not too sure if she believed me...I think that she would have referred me to the psychiatrist...I didn't find the psychiatrist any good at all...he was mainly talking to mum,...I had little input...I wasn't asked what really happened, what sexual encounters did you really have with this person? There was no opportunity to talk about it'. 'I was still allowed to go home even though he was still on the scene'.

> 'When I was a kid and I was taken to doctors and hospitals, they were very naive of assault. Going back 14 years ago to the first sexual assault. I had my femur broken, and the kinder teacher was the one that was concerned and then as soon as the social worker was brought into see me, she ticked it off her box, no more issue'.

Disclosure as an adult

Of the sixteen women who first disclosed sexual assault as adults, eight of these disclosures were of child sexual assault. Some of the responses from family, lecturers, friends, members of sexual assault survivor's groups and a GP are outlined below. As will be evident, most of the reactions were not considered by the women to be supportive, instead adding to their distress. The exception, not surprisingly, was when women disclosed within a survivor's group.

Three (3) women within this study had experienced sexual assault by a woman and found that their disclosure was responded to with complete disbelief. The impact of this double denial made further disclosure and resolution of issues associated with it extremely difficult for these women.

A woman raped at 30 years old by a member of a bible study group found the response of her friend and later her family added to her distress and confusion.

> 'I rang up a very trusted male friend and told him what happened and he said...you really should get the police involved. I said yeh, because I even want this lady [friend she first turned to for help] to be dealt with as well because she has done the wrong thing by me as well as this man who assaulted me. Her response was as bad, equally as bad...I realised that she was trying to tell me that I was to blame.' 'My whole family knew that something was wrong. But I was told by that first lady that 'I wouldn't want anyone to look at me and know that I had been raped. So family...they are not going to know that your faith is real if you tell them what happened. They are not going to want to go to church'.

The woman 'speaking' above did tell her family several weeks after the sexual assault when

she developed what was labelled as 'reactive psychosis'. Her feelings about the family's response follow:

> 'I think what was a big damage to me was my family not understanding. I appeared all right but inside I was hurting a lot and I was just putting on a brave face and letting my own faith build me up. But I needed the strength of other people around me, people who were really strong and who could cope with that kind of trauma. Who could understand me'.

Similarly, a woman raped while a psychiatric in-patient, told her family a year later. Her family's response was:

> 'Mum didn't want to know about it or talk about it. She was very embarrassed. Same thing happened with my brothers'.

'I was offered no support around the sexual assault except sedative injections...I wasn't given any opportunity to talk to the social worker about what was happening at home. So I was treated for the anxiety but to my knowledge nobody asked me at all about the reasons for the anxiety.'

Two (2) women who first disclosed child sexual assault as adults to lecturer did not receive supportive responses:

> 'I have only disclosed in the last three years. The first person was very negative, she was a lecturer at uni. She didn't want to know about it and shut me off every time I tried to talk about it'.

> 'They sent me back to the school that I had been to as a student. This triggered all the memories...I sat in the staff room and cried for two days...The first lecturer came out and sat with me while I was crying and all she could talk about was 'everybody has problems in front of the class'. It was my third teaching round and I hadn't had problems like that before. So she kept wanting to put it down to the fact that I was nervous in front of a class. It was real denial of what I was saying'.

After another woman disclosed sexual assault:

> 'completely collapsed from saying what I said. She [the nursing lecturer] did the right thing and admitted me to the nurses ward.' 'I was offered no support around the sexual assault except sedative injections...I wasn't given any opportunity to talk to the social worker about what was happening at home. So I was treated for the anxiety but to my knowledge nobody asked me at all about the reasons for the anxiety.'

Two women interviewed told their GP about their experience/s of sexual assault. One woman first disclosed incest to her GP at the age of 19. His response was to diagnose:

> 'me with schizophrenia because I was going on and on about all these domestic violence and sexual assault flashbacks and was therefore very upset and distressed'.

The second woman, after a violent rape by a stranger went to her GP. She said:

> 'I was quite sick, I was frightened, I was so upset, so I went to a doctor and asked him

if I was still a virgin or not? I told him that I was getting a few things thrown at me at work [verbal] and he put me down as schizophrenic. The Doctor didn't believe that I had been raped. I felt as though my dignity was gone'.

Disclosure within a sexual assault survivors group

Eight women interviewed had participated in a sexual assault survivor's group. All had found this very helpful in terms of realising that they 'are not alone' and that there are 'other women who have had similar experiences.' The key impact of survivor groups for the women interviewed is that 'they believe me and support me.' It was commented by several women that it was important to have a structure, for example a self help book to work through and 'someone with the skills to put the lid back on at the end of the meeting'. Comments made included:

> 'It was an enormous comfort just to have the friendship and the understanding of the other women there'. 'My real sense of it is that the only people who really understand how you feel and what the whole thing is, are other survivors'.

> 'Spinsters [survivors group that uses art to express their experiences and feelings] are my family, they get angry when I tell them things...they get angry when I wasn't able to. To have someone do that is amazing'.

Disclosure to a private psychiatrist

The response of service providers within psychiatric services (as broadly defined on page 6) to women's disclosure of sexual assault and the impact of this on the woman is reported below. The discussion relates specifically to issues around the disclosure of sexual assault. The emphasis of the later section is on the way in which the women interviewed understand their experiences in a hospital setting and their mental health problems.

Twenty-six (26) of the women disclosed sexual assault to a psychiatrist. These women spoke passionately about the despair, anger and/or problems that resulted from the responses of the psychiatrists in public and private practice to their disclosure of sexual assault. The responses of psychiatrists were most commonly described by women with words such as 'disbelief', 'silence', 'trivialisation' or 'denial'. The words that women used to describe the impact of these responses on them included 'devastating', 'reinforcing of feelings of guilt and shame', 'angry', 're-abuse', 'invalidating' and/or 'mutilated myself'. Conversely, while nearly all women had repeated negative experiences of psychiatrists response to sexual assault, some had recently had positive experiences. The women's experiences as shared below relate to responses from psychiatrists, psychologists and psychiatric nurses working in a variety of settings.

All women who had been a client of a private psychiatrist/s had been provided with counselling or therapy, with the psychiatrist also prescribing and monitoring medication as applicable. The following quotes provide an insight into how the responses of some private psychiatrists to disclosure of sexual assault have been seen as unhelpful, at the very least, by women. This will be followed by women talking about the provision of helpful support.

A woman at nineteen years old started having vivid flashbacks of incest experiences as a

child. She showed her writings on this to the private psychiatrist she was seeing and talked about some of these experiences:

> 'he just stared into my eyes and did nothing. Thought, what the fuck is going on and you know the process of being hospitalised and not having that issues responded to just quashed it and made me feel like it is not real ... but then the last time I saw my psychiatrist I said "why didn't you do anything when I told you about what happened in my family" and he said "I thought that it might make your symptoms worse", but in a way it made me worse anyway just having that silence happening'.

The response from a private psychiatrist to another woman's disclosure that she had been sexually assaulted and that she could no longer deal with the depression caused by the memories of this was:

> 'She didn't believe me that my mother sexually abused me and then she started thinking that my father's abuse was Freudian. So I stopped talking about sexual assault all together'.

Another woman spoke about seeing a private psychiatrist for five years and that she 'just got worse and worse'. She has since had sexual assault counselling and feels that she no longer has mental health problems. In respect to the psychiatrist she said:

> When I did disclose it [sexual assault] to the psychiatrist not much was done about it. Her reaction was sort of 'don't worry about it there is no need to feel guilty, its not your fault. Get on with your life and don't worry about it'. But you can't just get on with your life'.

' ...he just stared into my eyes and did nothing. Thought, what the fuck is going on and you know the process of being hospitalised and not having that issues responded to just quashed it and made me feel like it is not real...'

Another woman saw a private psychiatrist for ten years. Subsequent to this she had sexual assault counselling from a CASA and said that for the first time in her life she has 'control over her anxiety'. She explained how the psychiatrist

> 'didn't really follow up any of the issues around the sexual assault. In fact each time I said anything about it, particularly towards any anger I felt about it, I would get a very bad reaction. So I tended to try not to say anything to her'. 'It is what makes me angry that all those ten years were wasted when I was ready to go and I wanted to talk about it and I was stopped. Even when I mentioned the body memories of what happened I got a very angry reaction'.

She also talked about why she finally left the psychiatrist and sought assistance from another area.

> 'I have a lot of body memories...that really made my doctor angry. I didn't know how to handle it, I felt really uncomfortable and scared. That is one of the reasons that I stopped therapy. I needed to find someone who works in this area and is not going to feel threatened by what I have to say'.

Another woman started having flashbacks, memories and feelings after a miscarriage in her mid twenties. She found these memories were becoming increasingly stressful, so sought help from a private psychiatrist. Over the following few years she saw three psychiatrists, none of whom she believed helped her with the fundamental problem. Responses to her disclosure of ' flashbacks' and 'body memories' included: 'don't be silly', 'I'm not sure whether you have been abused or imagined it' and 'I'm honoured that you have come to see me'. However no suggestions were made on how she might deal with the memories. After the third psychiatrist she said:

> 'walked out of the office thinking no-one is going to listen...I felt really devastated I didn't know what to do because it was still happening. It was like being on a roller coaster, always new things coming up...So I decided that I wasn't going to see anybody after that. I just buried myself in my work...and I got home from work one night and I took an overdose of sleeping pills. I ended up in hospital'.

In contrast to these women's experiences, when other women had been able to talk about their experiences of sexual assault it had an extremely positive effect on them.

> 'I disclosed the sexual assault to the psychiatrist. The first session with her was just amazing. She didn't allow any silence at all which was what I was scared of. She asked questions non stop, it was just incredible. It was incredibly upsetting but I think it helped me understand what was happening. The questions she asked started to make sense of forty years of confusion. Until she started asking questions I had no idea of some of the stuff that actually happened...She helped me to understand the dynamics of the silence around my sickness. She said 'wasn't there someone you could go to and tell'? I realised then that I had done everything in my power to keep it [sexual assault] secret. When I finished with the psychiatrist I had this feeling of power, this sense that for the first time in my life I had some power over my life'.

Another woman interviewed grew up in a satanic cult and is a client of both a psychotherapist and a private psychiatrist — the latter primarily for hospitalisation on dates that traumatic memories are triggered. Her first contact with a psychiatrist was during the two years that she was confined to a wheelchair with what was thought to be multiple sclerosis [since labelled as conversion disorder]. The traumas of her childhood were not explored and she found 'the psychiatrist no help at all'. Over the past four years she has seen the psychotherapist three or more times a week, with therapy focussed on working through the multitude of abuses and integrating her multiple personalities. The woman summarised the effect of this support as:

> 'I think that she has done a lot more to keep me out of hospital, to improve my health, to keep me working and to keep me paying taxes than any psychiatric hospital has ever done'. In reference to the cost of different services she commented 'I think that one of the biggest problems in the psychiatric system is that psychologists fees [as distinct from psychiatrists] are non rebateable'.

A poignant comment from one woman about the private psychiatrist that she had seen was:

> 'She was really good. She was really aware of the power imbalance and tried to

encourage me to ask questions. She just treated me like a human being, she was good'.

A woman who was sexually assaulted by her psychiatrist commented that 'I have had the worst psychiatrist and the best'.

> 'The hurt was so deep that it took me months to realise that what had happened to me was appalling. His [the second psychiatrist] therapy was so damn good, I really believe that he saved my life. Of course we had to go right back to the beginning to the reasons I saw a psychiatrist in the first place...the first psychiatrist had taken everything about me and used it to his advantage. I was absolutely crushed...I felt that my new psychiatrist immediately believed me...over the next few months he gave me a lot of literature on people who had been abused by their doctors...that always validated me that he must believe me...That validation of feelings was very important'. 'He was reiterating that 'it wasn't my fault'. You go to psychiatrists for help not to be abused'.

Disclosure to a hospital based psychiatrist or nurse

The reaction of professionals within psychiatric hospitals to a woman's disclosure of sexual assault mirrors the negative experiences described previously.

One of the women interviewed had been an in-patient at psychiatric hospitals for fifteen years. Two years ago she had sexual assault counselling at a Centre Against Sexual Assault and since that time has had stable mental health. She talked extensively and clearly about 'all those years in hospital', but not with any anger, but rather regret. Regret that whenever she raised the pain of sexual assault with different psychiatrists that,

> 'they didn't ask me much about it...I wanted them to talk to me more. Nothing came out again for years, they just gave me medication...and left me in limbo, by myself. What would have been useful was talking again, getting it out of my system and asking me questions to get it out of me. I didn't know what to say...I knew then that talking would have helped me but I didn't know where to begin or how to start'.

However towards the end of her hospitalisation she developed a friendship and trust with a number of female psychiatric nurses. This proved valuable for the woman as she:

> 'used to talk to the nurses about issues that were upsetting me...I did tell them about sexual assault in the end. All that used to come up in the end was the incest. 'My father this, my father that, I did this and I did that, it wasn't my fault. Did I seduce him in any way? I blamed myself for it. The nurses kept saying that it wasn't my fault. That he was my father, he was supposed to have looked after me, I should have been able to trust him. That was helpful for me'.

The following experiences of a woman who had her first psychiatric admission at 35 years old are indicative of the sentiments of virtually all women interviewed.

> 'The psychiatrist at the hospital was the first professional that I ever disclosed sexual assault to. ...you always get the feeling that they don't really want to know that part of it...I said 'hey this is what it is, its the incest side of it that is worrying me and you are not believing me'. And then right through , [crying] every time I mentioned it

they didn't want to know about it and they gave me the impression that, oh well she is in here, she is depressed and we will deal with that. Whereas the incest was pushed aside and not looked at...I would have found it useful for them to talk about it and say, 'hey we know this has happened to you, we will get you some help to deal with it, so that you are able to live with it. Because since 1988 to now I still haven't had help for my incest. Help would be just counselling. Someone to talk to about it and someone who understands what you are going through and someone who believes you and listens to what you are saying'.

The distress of 'not being listened to or heard' and the impact of this, is a common theme in all the women's stories:

'A couple of times I've been an in-patient and I have had a male contact nurse and I needed to talk about it (because I was having flashbacks). He just refused to talk about it...yet I raised it so I wanted to talk about it...There have been times when immediately after that I have gone and tried to strangle myself. I reckon it sucks'.

'All I really wanted was the psychiatrist to sit there, to listen, to have some sort of input because he is a professional person...I wanted to talk about sexual assault and for him to help me to find a way to deal with those issues that were coming up for me at the time'. 'From when I was in hospital as a child and all the way through my life I have talked about it, I have disclosed many many times...but within the psychiatric system everyone seems to get the same thing. They put you on medication and it is a vicious circle. They talk about what has happened in the last week but they never talk about the underlying problem that makes you feel unhappy and distressed. I felt I was in a rut, I was in this great big dark hole and I just couldn't climb out, I couldn't see any light. I had really had it right up to here with the psychiatric services...and I thought I am never going to get counselling again, I've had it, that's it...I got to the stage of wiring myself up and putting it into the power point and I tried to electrocute myself. Because nobody was talking about anything except what was happening during the week and medication. No-one was talking to me in a meaningful way'.

'They put you on medication and it is a vicious circle. They talk about what has happened in the last week but they never talk about the underlying problem that makes you feel unhappy and distressed...'

It is relevant to note that a psychiatric report on the woman 'speaking' above states that 'in 1991 a diagnosis of major depressive episode complicating personality disorder [was made]...[which is] consistent with the difficulties that victims of sexual abuse face'.

Similarly, another woman said:

'I was a voluntary patient. After a month they told me my behaviour was the result of being sexually abused ...But they never suggested any counselling for the sexual abuse...I did request counselling later on but they never organised it. I was angry, I felt frustrated and I was very lonely'.

A number of women talked about the ways in which they had made sense of the disinterest of the psychiatric workers in the memories of sexual assault which they saw as central to their mental health problems. Their interpretations revolve around three explanations: symptoms are only interpreted within a medical model of disease that is treatable with drugs; workers own inhibitions about sexual assault; and the power dynamic that results in patient's explanation of their reality not being heard or dismissed as 'delusional'. This is captured in the following quote:

> 'I felt the sexual assault was believed but that the psychiatrist didn't think it was important. It was like she wondered why I was talking about this when I had a chemical imbalance. It was like 'we believe you but so what'?...it depended on the person but I found that a lot of the male staff in particular, either they were embarrassed or they don't feel that they are entitled to discuss it with you.'

Women's experience of psychiatrist's response to sexual assault can be summarised as 'I have got the general impression from psychiatrists that they are not at all concerned about sexual assault issues'.

Disclosure within a community-based mental health clinic

The women's experience of the way in which psychiatrists within community-based mental health clinics respond to disclosure of sexual assault was varied. Certainly some women reported devastating responses of 'silence' or denial. However, some women reported more positive experiences. One woman was able to clearly differentiate between supportive and disempowering experiences within a community-based mental health clinic.

> 'One doctor had to do research on me, I stress on me, sort of like 'you are an interesting specimen'. But this doctor that I have now I hope to stay with because he is really good. He said to me 'no amount of psycho-therapy will cure your chemical imbalance but no amount of lithium will cure the fact that you have been sexually assaulted'. So I thought that was really good, it was a way of merging the psychiatrists model of genetic disease and the fact that I was sexually assaulted... Makes me feel that he sees me as a whole person, not as something that needs lithium or something that needs psychotherapy but rather as a human being with a right to be depressed for a start'.

Another theme that was generally consistent was the women's positive feelings about the range of services that community-based mental health clinics provide. It is not so much the clinics' services but the way that the services are provided that was seen as more positive than hospital-based services. In the main, community based services were seen to be more responsive to the needs that women defined for themselves. As one woman put it:

> 'I have used the local mental health service. I see a psychiatrist there and a case manager plus I use their services, for example I go to the women's group. I find it great, really good. They are very supportive...I think it is a great system. My case worker is a social worker...the psychiatrist is in charge of your medication and you can talk to him one on one if you want to...I find the psychiatric counselling good but he has never asked whether I have resolved the issues around sexual assault. So if they weren't resolved he would not be picking them up'.

This last point is added to by another woman who said:

'Even at the mental health clinics they just don't want to know about sexual assault'.

One woman spoke of the importance of knowing that support within the community was available once she was released from hospital. She said:

> 'A lady from a community mental health service talked to me about what would happen, the support I would get after being released. That was very helpful, made me feel very secure, it was a gentle approach...important to know that there was support in psychiatric care and CASA together...The psychiatrist [at the service] gave me the option of whether to talk anything over with him or with a CASA. I thought that the male and female combined was a good way of gaining trust back from a male and gaining female support through her listening'.

One woman talked about her perception of the lack of power of workers at the community-based mental health clinic that she attends and the collusion of silence that this creates. She said:

> 'At the community mental health clinic I see a psychiatrist, social worker and a psychologist. Each offers something different. None of them have been interested in looking into it [her rape while an in-patient]. They shy away from it, it is too hard, I'm sure of that. Two have shown sympathy but are not interested in taking it any further...they are fairly disempowered because if they said some of those things, were outspoken, then they are seen as bucking the system and they are not in a position to do that. **It is bucking the system to talk about the truth'.**

Disclosure within a non-government community-managed mental health service

The women's comments generally about the services and support provided by non-government community-managed mental health services was positive. General themes were 'feeling safe', 'provided with choices', 'workers listen and give you time to discuss issues', and 'they understand you'. Women described the services they attended in similar positive ways:

> 'If I have problems with guys here and I tell someone it is taken very seriously [as distinct from hospital where her complaints were ignored resulting in a rape]...I'm just listened to a lot more and given a lot more time, time that I need to discuss issues. If I am upset I can ring also. I feel that I am listened to a lot more.'

> 'Here at this place I have been able to talk about the sexual assault. I have found real relief here'.

> 'It is strange that a place like this club can give so much support to people like me when big organisations like psych hospitals and clinics can't give it, I can't understand it...I feel safe with the workers here talking about my incest...they sit down and take the time to listen and that's all we want...It is an issue that is very sensitive to a lot of people, and a lot of us later in life have a lot of problems dealing with things that come up from sexual assault. I want to be able to talk about it and have someone

'...they sit down and take the time to listen and that's all we want.. I want to be able to talk about it and have someone listen to me.'

listen to me'.

'It is a good support place and I feel safe here'. 'The co-ordinator has talked to me a fair bit about sexual assault, that has been useful. Having people understand me is good too'.

Two women who participate in a young women's program conducted by a non-government community-managed mental health service talked about how 'it provides a supportive environment' and the value of 'hearing other women's stories'. Their feelings are captured by the following quote:

'This project makes a difference to me because I know that there is someone who gives a fuck. There is not a doctor standing there making labels on you...the worker is just there to be part of my world and she understands that you have a world. A lot of people that hit that hospital, the hospital think "the hospital is their world." Its not'.

Disclosure within a Centre Against Sexual Assault

Twenty-two (22) of the women interviewed had used a service of a Centre Against Sexual Assault (CASA). Six (6) of these women had used crisis care services after a sexual assault. The remaining sixteen women had used counselling, advocacy and information services for past sexual assault. Unlike other services referred to earlier in the report, Centres Against Sexual Assault have been specifically established, with government funding, to provide support to victims/survivors of sexual assault. Included in the brief of CASA's is firstly, the provision of crisis care support for victims of recent sexual assault. Secondly, the provision of counselling and individual advocacy support for survivors of both recent and past sexual assault survivors.

Therefore, when a woman uses a sexual assault service, she will already have identified sexual assault as an issue for her, and will understand that the CASA is there to allow her to talk about this issue. This difference in focus between Centres Against Sexual Assault and psychiatric services is important to consider when comparing the women's comments on CASA's with those made about psychiatric services.

Six (6) women had used the crisis care services of a CASA after a recent sexual assault. Four (4) considered the support offered beneficial. Comments included:

'I still felt very insecure about the rape but the CASA gave me that gradual affirming that things will be okay and that one day this guy will be brought to justice. And that hey, we are behind you, so if you ever need us just ring. So it was good just to know that'. 'Counselling has definitely been the most useful in dealing with these issues...there was no counselling when I was in hospital [despite her problem being defined as a reactive psychosis to rape]'.

After a woman was raped it was suggested by her therapist that she contact a CASA. Her comments were:

'The phone contact with the CASA was again excellent, I don't remember what they

said but I just felt like someone understands... (they arranged for me to see a counsellor that knew me) that just made a huge difference because I have such a complicated history and because of the multiple personality disorder it just made everything easier'.

She went on to talk about how much she appreciated the CASA counsellor's sensitive handling of the police and equally the response of the police to this information.

'The CASA counsellor understood completely how difficult it would be for me to involve the police but she thought that it was important to do . But she didn't in any way coerce me to involve them if I didn't want to. I was given plenty of support, plenty of privacy and plenty of time....The two policewomen were very good'.

A woman who was sexually assaulted by strangers in 1991 and 1993 talked about the difference in experience with police and CASA.

'When I got attacked again last year, the child protection squad helped me. They took me to hospital, had a talk with me....and someone from a CASA came in. They were helpful. The police didn't come down on me like a ton of bricks like happened in 1991 with other police. In 1991 when they interviewed me I just got too upset. There were no women in the room at the time and they didn't call a CASA. In 1993 I had mainly females and that was good because it is easier to talk to females than males'. 'The CASA was helpful. They just talk about what is going to happen if the person is found guilty...they help with the court case. They also help with my feelings by talking with me a lot. At the sexual assault centre I know that they are really listening to me. Psychiatrists don't really listen, my psychiatrist didn't want me to charge the bloke'.

Two (2) women did not feel supported by a sexual assault centre following rape. For one (1) woman her negative experience was compounded by her treatment by the police and hospital. She said:

'When they took me to hospital all these police people started checking me out and I found out that they don't always have a woman doctor. I'm not sure what was worse, sexual assault or how I was treated after it. You have to tell your story to ten different police officers. I wasn't told I had a choice about whether they did an examination...[we stopped at a CASA on the way to hospital but] no CASA person came to the hospital'.

Later the same woman went to a CASA for counselling but found it unsatisfactory as she felt that she was being told what she should feel rather than listening to what it meant to her. This was similar for another woman who talked of her experience in terms of:

'I was referred to a CASA when raped, went to the police and then to a CASA...after the police surgeon had finished examining me this woman from a sexual assault centre came in and said 'hi, I'm from CASA, you look terrible, it must be awful to be raped' and I saw her for a few weeks. I don't know what I was supposed to get out of it. They have got this idea that you feel dirty and all this stuff and guilty...I was more angry than anything.' The sexual assault centre wasn't very helpful and I had a psychosis six weeks later'.

Of the five (5) women who were sexually assaulted while an in-patient of a psychiatric hospital and reported it to staff, only one (1) was offered the support of a CASA. Her comments on the value of this were:

> 'I told a male nurse what had happened and he got a female nurse to talk to me. She asked me what did I want to do about it and I said 'I want to report it, I want to make a complaint.' The police and a CASA were called in....the sexual assault woman was really good but I couldn't speak to them privately, my psychiatrist was always there. It was only the CASA that I could really turn to about it'.

Common themes emerged when the women talked about counselling provided by sexual assault centres for past sexual assault experiences. These included words such as: 'had sexual assault validated'; 'was listened to'; 'warm and friendly'; 'helpful talking about it and being believed and not blamed for it'; 'written materials were great'; and 'helped with a referral'. The only common regret expressed was that CASAs only offer short term counselling. For many women interviewed, they perceive that the sexual assault counselling provided by sexual assault centre has been the catalyst for the resolution of their distress and for some, their mental health problems. Some quotes that demonstrate these perceptions follow.

> 'What was helpful at the CASA was that they didn't push me to talk about it, they just let the conversation flow how ever it came out, they let me talk about it in my time. When I talked about it they asked questions, that helped me. They were always warm and friendly to me...when I was talking to the counsellor I felt as though I could talk about anything, I just wanted to get all this off my mind. All the things that sounded bad to me and were affecting me because I had memories all the time. So I brought them up and now I don't think about them anymore.'

'Counselling has definitely been the most useful in dealing with these issues...there was no counselling when I was in hospital.'

> 'I think that all my physical and mental health problems had to do with sexual assault. The sexual assault centre is the first place that has ever helped me to work through sexual assault [despite being in psychiatric hospitals for nearly 15 years] and now I'm real well. I can't believe it. I have a voluntary job, I don't wear dark sunglasses any more, I don't think that what I wear that I am going to be raped, that I'm asking for trouble like I used to. She has opened up a whole new world for me, I've got more confidence'.

> 'My sister convinced me to get help...I knew that all these ailments, mental ones all stemmed from sexual assault...It was a good step, a big step but its a good step. Finally having my sexual abuse validated was meaningful. Importantly I stopped blaming my self and realised that I wasn't the perpetrator, that I had felt responsible and that I had taken the blame for it. I stopped being a victim...It gave me a greater knowledge of why I was feeling detached and had all of these emotional and psychological problems and symptoms...I realised that the detachment that I had was when I was escaping out of my body in order to cope with the sexual abuse.' What I found most useful at the CASA was...they understand it is a delicate issue...delicate in the sense that you are really

dealing with this broken child which is not an adult, that is how it feels for me. It is hard for me to feel like an adult at 44.'

'The crucial reason why the sexual assault centre was useful was that she believed me and didn't make me feel guilty about the whole thing. I had always thought that it must have been something that I had done wrong'.

'The services that I have found useful have been CASA and my psychologist because they have always been willing to talk about it, to listen. There is just this understanding when you walk through the door of both CASAs I have been to that 'we are trying to understand; it might not have happened to us but you are welcome here; we are not labelling you'. That is very important to me personally, it is also a sense of nurturing too that I never had as a child'. I have always said that I got much more help and support from the rape crisis centre than from the private psychiatrists'.

'The sexual assault counselling was helpful because of their attitude to it. It was an issue that was treated as important and how I felt about it was seen as important and relevant to who I am'.

'The six sessions helped me to say it shouldn't have happened, it did happen, life goes on, it helped me deal with it there and then...it just helped me realise that I had to deal with it there and then so that I could move on. I felt very stuck until then, I needed to talk about it'.

'The reason I am coming to a CASA is because I want to get it out [memories of sexual assault]. It has obviously been there boiling up for too long and it needs to come out now. I think that maybe going into hospital was my way, my sub-conscious way of saying 'I think that I am ready to deal with it now' [not addressed in hospital despite her pleas to talk to somebody about it]'. 'CASA has made me feel a lot more secure, where as before I came here I didn't think that there was light at the end of the tunnel'.

An important and extremely valuable resource for women making their own sense of their experience of sexual assault has been the provision of relevant reading materials:

'She also gives me reading materials. I have been able to read it and look at it and think oh I can relate to that. A lot of it just threw back into my face what I have been saying and this is how I have been acting and made me realise that I am not the only one that has been affected in this way'.

Despite the quite profound changes that many women believed had resulted from their interactions with a CASA, this was not the case for all women. A common characteristic of women who felt that a sexual assault centre had not helped them was that all except one (1) woman, had been an in-patient in a psychiatric hospital. These women found that either a CASA, as a matter of policy, would not see them or it was suggested at the first session that 'she was not ready'. This reaction was devastating for the women concerned and reinforced the feeling that had been developed within the psychiatric system that 'we are our label'. As some women explained:

'I haven't found the sexual assault centre particularly useful because first they were

'My sister convinced me to get help..Finally having my sexual abuse validated was meaningful. Importantly I stopped blaming my self... I had felt responsible and that I had taken the blame for it ...I realised that the detachment that I had was when I was escaping out of my body in order to cope with the sexual abuse...'

reluctant to see me because I had a psych history'. I rang them the first time because I was having the incest flashbacks, they didn't know that I had been in hospital...the first time it was good to talk about my experiences with an authority figure, about my father and have it believed...But then they said I had to see my psychiatrist [who was not willing to discuss it]'.

'I reckon that sexual assault should not be pushed under the carpet but the psychiatrists say 'yeh, yeh that happened to you but we don't want to know about it'...So I went to see a counsellor at a CASA and I was talking about my incest and they said that I wasn't ready. When they said that I didn't know how to feel. I had gone there for some help and they said I wasn't ready to deal with it because I was crying. I get very upset when I talk about my illness and they said that I wasn't ready to cope with that. I felt so unsupported. I went outside to my boyfriend, because he had taken me there and I said 'oh no not again' and they were my exact words. Not again'.

'I have been to a CASA, they weren't very helpful at all. Each week I went from one worker to another, different workers. I went once a week for three weeks but I became fed up going from one worker to the next, asking the same questions. I hoped that they would be able to help me so that I stopped hurting myself all the time because every time I think of what happened to me I cut myself up or hang myself, or overdose...They didn't explain why I got different counsellors. They just told me"if you think of the assaults smash plates". I didn't like that because that just gave me a good idea for slashing myself up, because you still can slash yourself with a plate'.

Choosing as an adult to disclose sexual assault

'The claim is often made that women and children lie about sexual assault....However the incidence of false accusation for rape, as for other serious crimes, is very low, at approximately 2% (Williams and Gardener, 1989, p125)...Rather than false accusations [sic] about rape and child sexual assault, these are the most under-reported of crimes (Telephone Service Against Sexual Assault, 1993, p6).' Similarly there are claims that women have false memories of sexual assault, yet as Brewin reports 'scepticism about the value of patients' accounts is widespread, but the grounds for this scepticism can largely be refuted by examining the empirical evidence' (Brewin, 1992, p84).

Certainly all women interviewed made it very clear that when they chose to disclose sexual assault, this was a considered decision. Furthermore, they expected an active response to their disclosure. As a child, disclosure usually represented to them a call for help to stop the abuse. As an adult disclosure was commonly motivated by a 'need to get it out of my system' and/or 'as a means of talking about it because the memories were so distressing'. Comments illustrative of the above were:

'If you talk about something, [such as sexual assault] then you are ready to talk about it. If they don't respond then it can make it worse... in terms of your state of being'.

'When people don't believe me about the rape [because they label me as an act out person] it makes me more angry because people in this situation don't lie. Believe someone if they say this'.

'The abuse really has to be looked at when you are ready to, when you are experiencing memories about it, when it is bothering you, when it is very painful...I was ready when I was seeing the psychiatrist, I felt that I was ready to talk about it because I mentioned it. It was hurting me, it was there and something had to be done about it and yet not much was done about it at the time'.

'None of us have the time in this life to lie about these things, what we say happened or is happening and you just need to be listened to'.

'Going to survivor groups I became aware of Freud's theories of survivors making it up...this guy I went to see I knew that he had actually survived a concentration camp when he was a child and so he probably realised that generally people don't lie about traumas they have been through. Or if they do have some sort of fantasy it relates to something really traumatic anyway'.

Commonly women talked about the memories becoming so distressing that they knew they had to talk about it.

'I didn't tell anyone about my anger and the sexual assault [as an in-patient] for about three years. When I had another breakdown I just knew that I needed to do some talking and that was one of the first things that I talked about'.

'I just guarded that part of my life [child sexual abuse] and tried to forget it for so long but I couldn't...it all started coming to the surface and it just boiled over so I had to start dealing with it'.

'I was really depressed and I wasn't seeing my friends, I was really scared so [I decided to see a psychiatrist and talk about the abuse]'.

A number of women also spoke of the fear of causing pain to someone else if they disclosed sexual assault as seen by the following quotes:

'I'm always terrified of other people's reactions, that my story will scare them'.

'I started to feel that if I talked to anyone [about sexual assault] I would contaminate them and all this poison in me would get on them'.

Implicit in the women's stories has been a point when they have felt a 'state of readiness' to talk about and work through issues around sexual assault. While the catalyst for this 'readiness' was personal to

'The abuse really has to be looked at when you are ready to, when you are experiencing memories about it, when it is bothering you, when it is very painful...'

each woman, as a group they were consistent in their need for their experience and feelings to be validated and the disclosure actively responded to.

Many women commented that the idea that it is inappropriate for a professional to raise or follow through issues of sexual assault with a woman at an acute stage of her mental health/ psychiatric problem, 'was absurd'.

> 'That is just ludicrous because why are they [client] upset in the first place? They are probably upset about sexual assault anyway so why not ask them if they are at least. I know that during two of my admissions the main thing on my mind was sexual assault and if someone had said 'oh we can't talk about that it might upset you', I would have just looked at them and thought, but I'm upset you know'.

WOMEN AND MENTAL HEALTH: THE LINKS

> *The past is the present, when there are wounds to heal..(a line from a film on the Holocaust entitled The Rose Garden).*

In this section, the women's understanding of their mental health problems will be shared. In addition, the women's experience of in-patient psychiatric hospitals will be discussed based on the themes that emerged from their stories. As in the previous section, the women's voices speaking about mental health, hospital care and sexual assault are compelling.

Precipitating factor to mental health problem

While twelve (12) of the women had had their first contact with a mental health service when they were under 20 years old, the average age of first psychiatric contact was 24 years of age (refer to table 6). Of these first contacts, fourteen (14) were as psychiatric in-patients.

During the interviews, the women talked about what was happening in their lives when they first sought help from a psychiatric service.

More than half of the women interviewed believed that recent sexual assault or memories of past sexual assault were significant catalysts for the development of their mental health crises (refer toTable 6) as indicated by the following:

> 'I blocked out the memories of childhood sexual assault until after I was raped, that was when the memories came back...Hospital admissions were triggered by distress in the first instance...they didn't make any direct links between the brutal rape and my breakdown and depression'.

Table 6: Age of first contact with psychiatric services

Age group	11 -19	20 - 29	30 - 39	40 - 49	Total
No. of women	12	9	7	2	30
% of women	40.0	30.0	23.3	6.6	99.9

'I had forgotten the incest experiences and then I started having flashbacks. It was the second time that I gave that information to the psychiatrist that I was hospitalised'. I remember the first time I was hospitalised [20 years old], my father had given me a Matiste poster of two people fucking. It is very explicit...The first time I was hospitalised I was saying that he gave me this poster and it was of two people just fucking and no one wanted to deal with it. He gave it to me when I was nineteen which is perhaps not too young to give something like that. But every time I have a nervous breakdown I think about it a lot and think was it appropriate?...I remember that I was having a particular issue with the poster when I was first hospitalised'.

Several women talked about the 'pain' of remembering sexual assault being too great with a need to escape from reality:

"When I was in hospital...what was wrong was my memory of my past...These memories I feel actually put me into a psychosis because I was trying to be in non-reality. I didn't want to have any memory of my past and I didn't want to be in the here and now because I couldn't cope with the here and now. The medication didn't block any memories, it just made me more confused'.

"[After the rape] I was totally off my tree and had lost the plot completely because reality was just too hard to deal with. Reality was too painful'.

The birth of a child or a miscarriage was a trigger for memories and subsequent mental health problems for three women interviewed. One woman talked about experiencing sexual assault from her step-brother from the ages of eight to sixteen years old At sixteen she became pregnant and

"had the child and had it adopted. I didn't see it. I just went through denial, like it didn't happen to me... But when I had my daughter it all came back...I disowned her, I didn't want anything to do with her, because of what had happened to me as a child. I love my daughter with all my heart but I just couldn't handle her then. I realise now that the post natal depression was to do with the first one...The first professional that I told was the psychiatrist in hospital. She just wrote down notes, she didn't offer me any counselling, nothing'.

'...Hospital admissions were triggered by distress in the first instance...they didn't make any direct links between the brutal rape and my break-down and depression.'

'...The first professional that I told was the psychiatrist in hospital. She just wrote down notes, she didn't offer me any counselling, nothing.'

"At the time that I decided to see a psychiatrist I was incredibly depressed, I could hardly function at all. The year before I had had a miscarriage and the issues to do with child sexual assault had come up...by the time I got to see this psychiatrist I was a real wreck'.

"I had a big shock, I had a miscarriage and after that I stared having these sexual assault flashbacks, something I had always known but didn't know...so I went to see a psychiatrist'.

The connection between mental health problems and sexual assault: the women's perspective

Of the thirty (30) women interviewed, twenty-nine (29) believed that there was a link between their mental health problems and the impact of sexual assault experiences. For some women this link was clear to them from the first time that they developed a mental health problem (refer to table 7). For other women this insight has developed over a period of time as they have reflected on experiences in their lives and mental health problems. The following quotes make this more explicit.

'I definitely see a connection between my mental health and memories of sexual assault. Basically it has had a large effect on the foundations of my life'.

'I can remember that when I was a child I used to get so scared about dad coming in. When he did come in I used to feel like I dissociated, I split into bits and I went across the room and watched what was happening. Eventually I don't think I came together again. So for years I lived in that depression of just feeling that I had to die'.

Table 7: Reason for first contact with a mental health service

Reason stated for first contact	No. of women	% of women
Un-precipitated memories/flashbacks/ of sexual assault	6	20.00
Recent sexual assault	6	20.00
Miscarriage or birth of child as catalyst for memories of sexual assault	3	10.00
Death of mother	2	6.66
Problems at home / school	7	23.33
Serious physical illness	3	10.00
Acute mental illness episode	3	10.00
Total	30	100

'It is always the past, memories of sexual assault coming back to me that sees me ending up in hospital'.

'When I was slashing up they [doctors and nurses] said "you are attention seeking"...They should have said what's going on in your mind, why do you want to slash up?...It was because I felt dirty, it was to get the shit out of me, the dirt, my father out of my system'.

'Certainly the depression is related to the sexual assaults, although I don't know about the psychosis. But when I get depressed I can get psychotic'.

'I am getting control of my life back. It is linked to having sorted out some of the abuse stuff. This has been by a combination of CASA counselling, counselling from a psych nurse in hospital and the community psych nurse. I don't think that there is any medication that could wipe out what I wanted to wipe out'.

The women's experiences of in-patient psychiatric services

Of the thirty women (30) interviewed, twenty-four (24) had had experience of being a psychiatric in-patient at some time since 1986, with twenty-one (21) having had multiple in-patient admissions.

Twenty seven of the women interviewed had been given a 'psychiatric diagnosis/label' at some time. Of these twenty-seven (27) women, sixteen (16) had been given a number of diagnoses. In respect to treatment and/or support provided by psychiatric services, pharmacological (medication) intervention was the dominant treatment that the women experienced.

It was important to all women interviewed that psychiatric in-patient services are available to them when they become mentally unstable. As indicated so far, women interviewed have a range of issues and concerns about the responsiveness of hospital staff to their needs. While women talked extensively and at times passionately about the inadequacies of current service provision, they also recognise that the only option for care and treatment of mental health problems is psychiatric services. Therefore each time they had required hospitalisation, they had hoped that this time their needs were going to be met. When this had not occurred, the women felt that it had contributed to their escalating despair.

The women talked about two (2) specific concerns they have in relation to access to public psychiatric services. The first concern was that deinstitutionalisation might result in access to a hospital bed only occurring if they 'do something drastic'.

> 'I've used the CATT teams many times...I was psychotic and they wouldn't put me in hospital... deinstitutionalisation is taking away a safe place for me'.

The second concern was their fear of being denied access to psychiatric services, particularly hospitals, if they have been given a 'personality disorder label'. (This is discussed further in the section which examines diagnostic issues).

The women who had in-patient experiences talked about how the structure of hospital-based psychiatric services, which are based on a hierarchy of professional groupings, creates a barrier to women's needs being identified and responded to in a manner that is meaningful to the women.

The women generally found it difficult to establish trust or a relationship with psychiatrists or the medical officers. The factors that the women identified as contributing to this were:

- the infrequency of contact with their psychiatrist;
- psychiatrists rarely being available for women when they needed;
- the rotation of medical officers.

> 'The other thing that has really frustrated me is that I have seen about twenty doctors [within mental health services] over the past seven years and I haven't had one doctor consistently treating me. So whenever you see a new doctor/psychiatrist they ask you a series of questions about yourself. You have to go through it all again and then your file goes missing. It makes you feel really frustrated and quite unimportant, you just feel like one of the millions'.

> 'You see the psych nurses most, you mightn't see your doctor for three or four days'.

> 'The turnover of doctors in hospital is unsettling, particularly if they change while you are in there...It is really the pits'.

While among the women interviewed there was a general disenchantment with the way that psychiatrist within psychiatric hospitals operate, there were exceptions:

> 'It depends on the psychiatrist, with some of them there is this really big barrier between you and them, but some of them are really warm and humane, so I think that it depends on the person you get'.

Another fundamental problem for the women was their need to be able to talk and be listened to. However, they felt that this was not a priority for psychiatrists and medical officers. Instead, the women felt they saw their main task as being to assess, diagnose and determine treatment. (These issues are discussed further in the diagnostic and treatment issues sections).

Generally women referred to psychiatric nurses as the group with whom they had the most contact, and who they were therefore most likely to develop a trusting relationship. However, nearly all the women specified that this applied to female nurses. A number of women talked about psychiatric nurses in terms of 'friends' or 'the most help to me'. Negative comments about psychiatric nurses were rarely personal, but rather in terms of them 'sitting in the office all day' and thus not being accessible to patients/clients. Some pertinent comments were:

> 'I prefer female psych nurses because you can talk to them. Male nurses you can't talk to them because I feel fearful to talk to them'.

> 'I made friends with a lot of nurses...very easy for me to develop trust with nurses,

not males. I used to talk to the nurses about issues that were upsetting me'.

'One nurse who didn't see my file was the only person who treated me as a person at all...I actually felt like a valid person and that was the biggest kick to my self esteem...she wasn't scared and wary of me'.

'...She has made me see so much that I had locked away...There is always an improvement in my attitude after I have spoken to her...'

One woman described her experience of hospital care as 'most unsatisfactory'. She believes that because she doesn't 'fit the box so that they can treat you' her specific care needs are not taken into account or fulfilled. When she asked a psychiatric nurse why she had been ignored when a horrific memory had significantly upset her she was told:

'"you have your own private therapist and we don't know where you are up to in therapy and if we talk to you we could do a lot of damage." I said to her "I don't want therapy." When I am getting these really terrible flashbacks of the babies that I have lost and the murders that I have witnessed and the horrific things that had happened to me when I was a small child, I simply wanted somebody to sit on the end of the bed and be there'.

Several woman had mixed feelings:

'Staff try to make patients feel safe and cared for in a little way, but not as much as they could...I think that staff just don't care enough about the patients as they should, its just a job to them...but I must admit I do have a relationship with some nurses, because I have been in there for so long'.

'The relationship with patients depends on the nurse. There have been times when I have had contact nurses that have been cold and hard and it is like they are just there for the money, not for the job that they should be doing. Yet there are some nurses that go out of their way to make sure that you don't drop down any lower than you already are'.

All the women talked about the need for sensitivity by staff to their reality. When this occurred, the women appreciated it:

'I punched a male nurse in the gob because he looked like my stepfather [who sexually assaulted her]...He goes 'what part reminds you of your father?' I go 'your haircut' and the next day he immediately changed it. That made me feel as though he was kind'.

While women found psychiatric nurses generally the most supportive when they were in hospital, this did not carry over into dealing with issues of sexual assault. It was consistently said that 'they also don't want to know about sexual assault.' Where the response of the psychiatric nurse was perceived as supportive, this was seen as a significant factor in the woman overcoming her mental health problems.

'a particular nurse at the hospital that I can talk to...She has been a pillar of strength.

She has made me see so much that I had locked away...There is always an improvement in my attitude after I have spoken to her. I do trust her and she listens'.

Professional responses to sexual assault

Women reported that they were rarely listened to by professionals or their words were discounted. Issues around sexual assault which they believed were significant to their mental health problems were not dealt with by professionals within the hospitals. How some women described this process of invalidation was:

'when I was admitted to the psychiatric hospital I was thinking about sexual assault a lot and I was in a depressed stage at that time. They wrote a report on me and it had as part of my symptoms 'ruminating about sexual assault'. It was like it was not only disregarded as something I had to deal with, but also it was actively written off as a symptom of illness or depression' .

'It makes you feel worse if they don't understand. I think that even with my last admission I was experiencing a lot of the sexual assault flash backs and I don't think they knew how to deal with them. The whole rape incest thing, I think they could learn a bit more about how to deal with it especially towards the patients'.

'When I mentioned it and said I was sexually assaulted and that is part of my illness, they said you are depressed, you need some tablets and time in hospital. Whereas to me it was my incest that was my illness, I can't get over that...[What I needed them to say was] we know that this has happened to you, we will get you some help to deal with it, so that you are able to live with it. Because since 1988 to now I still haven't had help for my incest. Help would be just counselling, someone to talk to about it, and someone who understands what you are going through and someone who believes you and listens to what you are saying'.

'When I mentioned it and said I was sexually assaulted and that is part of my illness, they said you are depressed, you need some tablets and time in hospital. Whereas to me it was my incest that was my illness, I can't get over that...'

'I was psychotic but I still needed somebody to talk to...I knew that the medication was important, but just as important was the need to talk about the sexual assault'.

In terms of whether psychiatric services have a responsibility to assist women to deal with issues to do with sexual assault, the following quote captures the women's responses:

'If you are admitted into hospital and thus admitted into their care, then I think that they do have a responsibility to help you deal with sexual assault issues, especially if that is the reason why you needed to be admitted'.

Advice to psychiatrists and medical officers on how they could become more perceptive to the cause of women's destructive behaviour was offered by one woman as:

'They just need to be more observant of the behaviour of patients. Because like in my case, everytime that I have been hurting, or I have had a flashback, or I have been in hospital and I have tried

to mutilate myself or strangle myself, it would usually happen after a flashback that I couldn't control or get in touch with a nurse and talk through it. So if the doctors took more notice of the behaviour of patients maybe they might find out more about what is troubling the patients. I think that everyone generally in the psych field, just need to know more about how to deal with sexual assault'.

'...was psychotic but I still needed somebody to talk to...I knew that the medication was important, but just as important was the need to talk about the sexual assault.

The potential benefit of admission protocols including questions about a history of sexual assault was talked about by many of the women interviewed. They made it clear, however, that adding these questions to admission protocols would not alleviate current problems within psychiatric services in relation to 'silence' around sexual assault. The key factor is that service providers respond to any disclosure in a supportive and appropriate way. Women emphasised the need for training to be provided in this area. Training needs are further explicated in Chapter 3.

Lack of safety within in-patient psychiatric services

Many women reported not having felt safe while a patient in a psychiatric hospital, due to an absence of policies and procedures that protected them, their experiences of being sexually assaulted or of witnessing sexual assault of other female patients. Their concerns stemmed from:

- that sexual assault of female patients is not uncommon;
- that there are few institutional policies or practices to prevent the sexual assault of female patients;
- that women's complaints of either sexual harassment or sexual assault are rarely responded to adequately from the perspective of the woman clients;
- that mixed wards and lack of choice of the gender of service providers often exacerbate a woman's unsafe feelings.

Of the women interviewed, seven (7) had been sexually assaulted or sexually harassed while in hospital. Four (4) women were sexually assaulted by another patient and one (1) sexually harassed by another patient. One (1) woman was sexually assaulted and one (1) woman sexually harassed by a staff member (nurse). Another six (6) women talked about witnessing other female patients being sexually assaulted. These facts are disturbing, but the lack of policies and practices that could have prevented these assaults occurring is equally disturbing and illustrated by the following:

'I was concerned about the man involved because he was harassing me in the locked ward. I did tell the staff about it but they didn't really take any action. We were both transferred to the same open ward and he assaulted [raped] me...Staff said about the harassment that they couldn't do anything until after something happened. I don't know if it was a common response to a lot of other patients but they were certainly flippant about complaints, particularly in the locked ward'

The doctor's response to this sexual assault is also of concern.

> 'I told my treating doctor eventually because I feared that I might be pregnant. He did not pursue at all the nature of what happened, who was involved...the biggest insult was that he put me on the pill and he wrote on my file that I was promiscuous and flirtatious. I think to cover up the assaults, so that was very upsetting too'.

Furthermore, in the cases of both these women and the other three (3) who had similar experiences, neither the woman or the male perpetrator were removed from the ward, adding to the woman's fear and distress. Moreover, only one (1) woman was provided with the option of counselling, albeit, after she requested it and rang a sexual assault service herself.

The experience of another woman is shared in some detail below, as it typifies the experiences of all the women who were either sexually assaulted while in hospital or witnessed such assaults occurring. This woman on her first admission to a psychiatric hospital was raped by another patient. In response to the woman reporting this, the head psychiatrist said:

> 'don't worry too much about it because this sort of thing does happen, we can't help it because we can't hear the screams through the thick walls.'

When the woman 'speaking above' was transferred to another hospital she was 'terrified' and told the admitting psychiatrist of her recent sexual assault. He assured her that this couldn't occur in his hospital and gave her a beeper which made her 'feel safer'. However she was 'horrified to wake at 2.00 a.m on her first night there and find a man [patient] standing at the end of her bed'. When she reported this the next day to the psychiatrist 'he got angry with me, he didn't want to know about it'. Twelve months later when she found herself back in hospital:

> 'there was a little girl in my room and every morning the patients were taking it in turns with her. As many as six or seven at a time...I went to the head nurse and I said do you know what is going on? She said 'mind your own business'...In private with my own psychiatrist, and mind you I was running a risk because I'm manic depressant, I could be having another attack couldn't I? So I said to him did you know this was happening? And he said 'it is being looked into'. But up until I left it was still going on'.

'I was concerned about the man involved because he was harassing me in the locked ward. I did tell the staff about it but they didn't really take any action. We were both transferred to the same open ward and he assaulted [raped] me...'

Every time this woman tried to talk about her feelings of being raped in hospital, she has had the following response from psychiatrists:

> 'when I got angry about it...they said I was getting a little bit uptight about it, because I actually talked about it and they put me on more medication.'

Her feelings are that:

'Of course it is the responsibility of psychiatric services to provide support to women who have been sexually assaulted...none of them are interested, it is too hard, I'm sure of that'. I wrote a letter to a community based psychiatric service about what happened, but there is no complaint process. It is like the chicken being told to complain to the fox'.

'when I got angry about it...they said I was getting a little bit uptight about it, because I actually talked about it and they put me on more medication.'

Unfortunately the above experiences were mirrored for women who were sexually assaulted or harassed by a staff member.

'Last time I was in hospital I was actually sexually assaulted by a nurse. I couldn't sleep and I asked for some extra medication and he told me to come into the medication room and he squeezed my breasts and kissed me and then he started rubbing his groin in my face. I reported it to the Director of Nursing at the hospital. They just looked at me as though they were shocked and I was very angry about that. (the psych nurse that assaulted me was not removed from the ward. He was on night duty and he was there the next night.) I got a taxi home that night and told Dad what happened and he wrote a letter, but they didn't actually do anything about it'.

Thus the womens' feelings about the lack of safety within hospital were exacerbated by what they described as a general 'trivialising' of both their expression of fear of sexual assault while in hospital and their report of sexual assault to staff.

Women shared 'feeling unsafe' and/or 'freaked out' having male patients in the bed next door in high dependency units. Equally, all but one woman interviewed felt 'unsafe' and/or 'insecure' having men sleeping in the same ward. Issues raised in relation to mixed wards were:

- that, particularly in the early stages after admission, women feel particularly vulnerable and thus unsafe with men in the same ward;
- that previous experience of sexual assault most commonly results in women having a heightened distrust of men. Sharing wards with men exacerbates these fears and can trigger memories;
- lack of choice in terms of mixed or single sex wards is another indication to women of the lack of understanding by psychiatric service providers of the impact of sexual assault on women.
- staff numbers generally and/or the number of staff present on the wards did not protect women from male patients.

'I have always been put in mixed wards. My preference would be a women only ward to start off with the first few weeks. Because when I cut myself up my past the sexual assaults come back. It is very hard then to mix with guys'.

'To begin with I was in a women's ward, then they put me in a single room which was fine. Then they put me in a mixed ward and I couldn't hack, it was awful. A stupid

place to put me I thought. I was having trouble with men any way and they put me in a mixed ward. I felt horrified and I decided I was going home there and then...I didn't feel the staff did anything to make the patients feel safe. I hate hospital, I never feel safe'.

'I think it is bad management on their behalf, the dormitories are opposite each other, just a hallway separating the women from the men...I feel very insecure having men sleeping so close to me'.

'I wasn't given a choice of single sex or mixed wards, it was a mixed ward. I would prefer just female'.

Women talked about staff spending the majority of their time at the nurses station, either attending to 'the bureaucracy they have to do' or 'sitting around laughing amongst themselves'. This limited number of staff actually on the ward exacerbated women feeling unsafe:

'I make sure that I stay around the nurses or I know that the nurses are quite close, then I feel safe'.

Other safety issues that women spoke about were: 'how badly lesbians get treated in the psych system by staff and patients'; 'threats, aggression and violence that were not warranted'; and 'being physically hurt by staff'.

Diagnostic issues

The exploration or evaluation of diagnoses and treatment modalities within psychiatric hospitals is not the focus of this report. However, from the experiences of women shared so far in this report, there are clearly diagnostic and treatment issues for women who have experienced sexual assault.

Women continually talked about how their mental health problems were defined by psychiatrists in a way that did not reflect their experience or reality. As their experiences were not taken into account, variable diagnoses were reached. Understanding the experience of each woman would allow access to the common denominator, which for these women was the sexual assault.

'The psychiatrist had his own ideas on what is going on and seems fairly resistant to anything I say, but like what he said was not what it was like'.

'I was only diagnosed about three months ago at my most recent admission. Before that they had always said it was a personality disorder. They didn't know, they just gave it four different labels. The very first psychiatrist I ever came across, I was really scared because I thought that psychiatrists were for real nutters. He said there is something wrong with your personality and I thought oh no, I'm going to be like this for ever. That wasn't a very sensitive way to do it'.

'Don't write sexual assault down as a symptom. That is why I am depressed'.

'It is pretty rough when they keep changing what they are going to call you. And then

when they don't react to you the person, but are reacting to whatever label they have given you, it is fairly devastating'.

Most of the women were clear that even when experiencing acute mental health problems, there were parts of them that were still fully functional and intact. This particularly related to them knowing what was the fundamental problem or trigger for their problem. Therefore, they emphasised the importance of professionals asking what they believe is happening to them, listening to this and incorporating this information in a meaningful way to the diagnostic process. As one woman said:

> 'The support offered was very symptomatic, reactive support. They had this thing called clinic every week where you front up in front of panel of doctors, registrar, resident, social workers, nurses and students. A whole group of people. And you sit down and they talk about you and to you. That was really, really difficult to deal with. That is how they make their decisions whether you go home, stay or what treatment you have...what would have been useful was if someone had actually just listened to me and let me say what I had to say'.

For this woman the impact of not participating in the diagnostic process resulted in her:

> 'feeling that the system has reinforced what I feel about myself, that I am a bad nasty person and it is my fault and it is too distasteful to talk about it [sexual assault] so we will talk about how to cope. That the system doesn't let me, or anyone else in this situation deal with it. They smother it...instead they say we will up your medication or get you doing this activity or whatever rather than listening and responding to what you say at the time'.

Currently, there is conflict and debate within service providers and consumers about who is defined as 'seriously mentally ill' and what diagnostic groups are, or should be, eligible for treatment by psychiatric services. This issue is not the focus of this report. However it is an important and relevant issue to women who have experience of both sexual assault and psychiatric services as studies indicate that women who have a history of sexual assault are more likely to be given a personality disorder diagnosis (Putman et al, 1986; Bryer et al, 1987;McElroy, 1992;).

The diagnostic and treatment effects of this issue were articulated by a woman interviewed in the following way:

> 'Going into hospital with bio-chemical problems and then having them taken away, that was all from my point of view that they were interested in. As soon as they discounted chemical imbalances and actual medical illness there was no interest whatever...the amount of attention and care that I received just disappeared...Its the medical model. If it can't be blamed on the chemistry, nowadays you are chucked out. They just don't want to touch you, personality disorder is seen as a very long, intensive process'.

A woman who was discharged from hospital after being given a

'The psychiatrist had his own ideas on what is going on and seems fairly resistant to anything I say, but like what he said was not ***what it was like'.***

'... They smother it...instead they say we will up your medication or get you doing this activity or whatever rather than listening and responding to what you say at the time'.

personality disorder diagnosis described her experience as:

'When I was hospitalised the only analogy I can think of was that they popped my hood up, took the engine apart, decided they couldn't fix it and gave it all back to me in a garbage bag'.

Another theme that emerged was many women's hurt at feeling that hospital practice is a process where you are 'only a number, there is no individuality' and that 'service providers respond to your symptoms, not to you the person'. Added to this are feelings about the 'power of labels'.

'It is like all of peoples expectations go if you have a psychiatric history. It is like all of a sudden you are dissociated with ever being capable of making a decision'.

'Different stigmas of blame are attached to different diagnoses by psychiatrists and consumers. Personality disorders are the bottom feeders without a doubt because other people are seen as legit because they are ill, they have a biomedical disorder. Personality disorders seem unexplainable and very foreign because you are not mad and you are aware of what you are doing. But you feel the same stigma and the same guilt and pain as everybody around you would feel if they were doing the same things and suddenly found themselves plunging a knife into their leg'.

Treatment issues

Diagnostic issues interact with, and flow onto, the types of treatment that are provided for women in hospital. Particular issues about treatment that concerned the women were:

- the primacy of medication as the treatment modality;
- the lack of information and/or understandable information provided about medication and its side effects;
- the virtual lack of availability of individual counselling on issues women regard as central to their mental health;
- the lack of involvement of women in the treatment process.

Examples of how women described these issues include:

'In hospital no-one actually ever sat down and talked about the 'whole thing', lets look what is going on here...It was all more deal with the symptom, that was what it felt like.. The support that they offered was medication...That is how the system works, if you just behave yourself and shut your mouth, take your medication. But it didn't actually solve anything, you still have this poison inside of you. And you go home and you try to function and you try to go to work and (crying) you would fail'.

'When I would get to see the psychiatrist he would just talk about the medication, prescribe more, or ask what the side effects have been, do blood tests and things like that'.

'I never believe that doctors explain properly. Because a lot of people like myself aren't very smart in the brain, and they have a tendency to say things above your head'.

'A lot of psychiatrists give you no information and just say, 'here's the medication, take it"'.

'They ask questions like "do you hear bells, do you have spiders crawling on you?" I was depressed because of the sexual assault, but they wouldn't listen and so the treatment program consisted of medication, whereas all I needed to do was to talk about my feelings that were surfacing'.

'It is like all of peoples expectations go if you have a psychiatric history. It is like all of a sudden you are dissociated with ever being capable of making a decision'.

'I was given medication because I was upset, but they didn't pursue why I was upset. I needed to talk about the sexual assault'.

'For me, it was a very medical unit and everything was based on blood tests and things like that. It wasn't based on asking how you felt, so certainly they were just not interested in anything emotional'.

'There is a big barrier between you and them, a power barrier...you get really really frustrated because you think just tell me what is going on. That makes you feel quite powerless...a lot of them give you no information and just say here's the medication, take it'.

'You never have any right to say 'I don't think that I need this'. Often they don't tell you when they increase the medication and the first that you know about it is when you roll up for your dose and you say 'what are these?' They are always reluctant to talk about it. You are supposed to have the right to get a second opinion, but that is all a load of rubbish because they just give you an injection'.

One woman described the impact of not being a partner in the process of her diagnosis and treatment as leaving her 'feeling emotionally scarred and embittered'. This was because:

'I wasn't listened to, there was no emotional support. Embittered I guess by the lack of honesty. Yeah what's amazing is the lack of honesty. No one honest about my treatment, about my illness, about how they perceived me, about my diagnosis, everyone was told my diagnosis before I was'.

Other comments around this were:

'They never told me what they were labelling me, I found out some time later...they didn't tell me anything, they treated me like a bloody child really'.

'Hospital is like a zoo, I didn't feel it is a caring place. In hospital the counselling is provided by your medical officer, but she just sussed me out to see what medication I needed. Like she just wants to know if you are hearing voices or seeing things. They like to know your delusions...they don't ask you what you think might be causing the anxiety. They are just interested in getting you functional enough to get you out of there...Functional meaning that you are not violent to yourself or other people and having the same plot as everyone else'.

'I guess it is the clinical attitude. I mean you feel reluctant to show emotion, to cry for example or to get angry because you are labelled as being disturbed and given more medication. That seems to be the common practice. That was why in group therapy I was always aware that some sort of doctor or psych nurse was watching. I remember crying once in group therapy and every one was encouraging me and saying "you are letting things out, you're doing well" and my medication was put up because she said that I was disturbed and obviously not coping very well'.

As can be recognised throughout this report, the women interviewed talked in an articulate and constructive way about the problems they had experienced within psychiatric services. However, when talking about their capacity to have their needs met within the hospital environment, there was a general sense of defeat conveyed. This sense is illustrated by the following quotes:

'There is no power to complain against the doctors. Besides they have got the psychiatric thing haven't they? So they are going to use it. They say 'she is schizophrenic so she doesn't know what she is talking about, she imagined it'. Well I didn't'.

'Maybe to some extent I have to submit to the regime if I am to survive'.

'I have never been able to say to the psychiatrist that they haven't got to the issue that is my problem, because when it comes to doctors I always think they are above me, and I am very scared to say a lot of things that I should'.

'I wasn't listened to...Yeah what's amazing is the lack of honesty. No one honest about my treatment, about my illness, about how they perceived me, about my diagnosis, everyone was told my diagnosis before I was'.

The fear of retribution was also talked about by women as a major reason for them not confronting professionals with their concerns:

'I think that a project like this is rare, it is good to bring it to the attention of professionals, direct quotes especially just so they can really see how services affect people. How we are treated and mistreated. I think that it really needs to be said and come out by people, like myself, I've been too scared often to seek publication of certain pieces, specific areas of abuse because I have been scared of the repercussions. Scared that I could be treated differently...Fear of repercussions if you speak out too loudly. Also

might be discharged before you are ready because you are seen as a management problem. I guess I am talking about being powerless'.

Women were all consistent in the type of hospital care that they would find useful. This is captured by the following quote:

'some sort of assurance that when I get out that I would have a doctor that would see me through my illness and would provide therapy and address the issues, the reasons for becoming psychotic. Not just be adjusted and hurried out of hospital and thrown back into society and still feeling suicidal'.

'They never told me what they were labelling me, I found out some time later...they didn't tell me anything, they treated me like a bloody child really'.

Participant feedback

Feedback from the women about the impact of participation in this project was provided at three (3) separate times throughout the project: at the time that the women first discussed their potential participation with the researcher; at the completion of the taped interview; and when women made comments on the draft report about four months after the interviews. To provide a context for this feedback, some of the principles and strategies of the study are reiterated.

A starting point in this study was a respect for women to feel safe and supported if they chose to participate in the research. Secondly, the recognition that interviews could be potentially distressing for women. Therefore interview and support processes, as outlined in the methodology section, were carefully developed in consultation with consumers and service providers. These processes were based on providing women with choice and the option of support at each stage of the interview and preceding it.

Parallel to these considerations was the aim that the women's participation in the interview process would be positive and valuable for them. This aim was based on the following:

Firstly, by allowing them to have a voice about their experiences and the meaning they attach to these, this process could be validating for women.

Secondly, by providing women with choices throughout the interview process, that this 'control of the process' could result in women feeling more able to be assertive about their needs and reality in the future.

Thirdly, by sharing their stories women could feel less isolated and more powerful in confronting issues and concerns talked about in the interview.

Fourthly, that by sharing their stories and having them documented, women may feel in a stronger position to decide whether in the future they wish to remain silent.

Reflection on the research process indicates that women were able to make choices that were healthy for them. A total of thirty-three (33) women initially agreed to participate in the project. Of these, two (2) women decided not to proceed after an initial meeting with the researcher. Both of those women said that they did not feel strong enough at the time to cope

with the anger generated when they talked about their experiences. Another woman who was interviewed rang to request that the tape be destroyed. She said that she was 'disappointed that she had all these feelings' and 'felt that she was not ready yet to deal with all the pain'. Two (2) other women requested to stop the interview because they were feeling overwhelmed with the feelings. Both of these women chose to continue the interview at a later stage, when they felt more ready to deal with their feelings.

Finally, a number of women chose not to be interviewed close to Christmas, but rather in the new year as they generally felt more vulnerable at that time and thus might not be in the best position to cope with feelings which arose during the interviews.

The consistent response of women at the end of the interview was that it had been a valuable experience. Comments made that capture the essence of feedback about the interview process were: 'I'm feeling good because you listened to me and I was able to say it in my own words'; 'I feel that this may help some other women in the future'; 'I have actually found the interview helpful it helped me articulate stuff I have had difficulty articulating, I feel good'; 'I felt like you really understood that people who have been abused as we have, just need to know that it is safe and that it is okay to talk about it now because it has never been okay before', and it was 'good knowing that there is a support person there' 'because sometimes you talk and then you are just left'.

Other factors which women mentioned assisted them to feel comfortable before and during the interview were that the information sheet had allowed them to understand clearly before the interview what the research was about; 'that the interview process was nice and relaxed'; that the use of open-ended questions enabled the woman to control what information she shared and that the choice of a support person allowed the woman to feel safe and supported. The women also said that they felt good about participating in the project as it was important to them to 'bring out in the open the impact of sexual assault and organisations not looking at it properly [without fear of repercussions] because it means that maybe something will be done for people/woman like me'.

There has also been anecdotal feedback from several services involved in the project. Some services reported that some of the women who were interviewed have become more assertive about acceptable boundaries of conversation and physical contact, and within services they are more supportive of each other than prior to this project. Furthermore, participation in this project has been seen as the impetus for the formation of a woman's discussion group at several services.

The draft report was circulated to all women interviewed for their comments and input. Ten women contacted the researcher and provided feedback. Each of these women expressed their excitement that their experiences were documented in a way that others could read and others could learn from. At the same time, they were all 'moved' or 'upset' reading other women's stories. The personal effect of the process was captured by the following two quotes:

> 'As I read it, it had a very powerful effect on me. It validated me and has had a healing effect. I felt incredibly sad when I read other situations women have been in - it is really bad...But it had a positive effect because I know that I am not alone. Also the commonality of experience made it more real.'

'Most impressed, excellent. I cried when I read other women's stories. It really shows what incest does to people. Put it together really well. Thank you for saying what it is like for people like us...I have never had someone who has said things for me in a way that my self is protected'.

The following comment from one of the women states what all women, in their own way, expressed:

'I hope that the research gets somewhere because people like us, we are human too and we need to be understood. We don't need to be brushed under the carpet like the sexual assault never happened. We are human too and I hope that the research does help'.

chapter three

summary of themes

> *...even the acknowledgment of the reality of the abuse [sexual assault] can profoundly shift the attitudes of both patient and professional...the clinician is then able to sympathise with the patient's effort to cope with overwhelming circumstances and to help the patient understand their impact (Chu & Dill, 1990, p891).*

This section provides a summary of the issues, understandings, concerns and impacts expressed by the women in the preparation of this report.

The circumstances of sexual assault

- Most of the women had been sexually assaulted by more than one perpetrator and one-third had been sexually assaulted both as a child and an adult.
- The most common perpetrator of child sexual assault was a family member, while the perpetrator of adult sexual assault was most commonly an acquaintance.
- Many of the women had experienced sexual assault as in-patients within psychiatric hospitals or had witnessed other patients being sexually assaulted.

The impact of sexual assault

- Women talked about the devastating impact of sexual assault on their lives which had affected to a different extent the women's capacity to function at different times in her life. This impact has been lasting and, for the women interviewed, this disruption particularly related to their ability to establish and maintain social relationships, undertake employment, and to their health generally. Those women who had been sexually assaulted as children reported that their emotional growth had been stifled.

- The women who had been sexually assaulted whilst in-patients in psychiatric hospitals or as a psychiatric patient had suffered the general impact of sexual assault as well as a loss of trust in the ability of psychiatric services to care for and protect them at their most vulnerable times (emotionally and/or medication related). These women reported a significant decline in their mental health as a result.
- For most of the women, sexual assault either as a child or adult had been so traumatic that they had needed to repress the memories. For these women, the recall of traumatic memories was triggered by an event or time of significant vulnerability such as a miscarriage, adult sexual assault and/or serious physical illness. Recall of traumatic memories included flashbacks, memories and remembering of disjointed pieces of information. The women talked about the impact of these memories on their mental health as profound.
- Each of the women interviewed reached a point in their lives when recurring memories of sexual assault became so psychologically intrusive and distressing that they could no longer be ignored or suppressed. Disclosure at this time was usually to a mental health professional due to the woman feeling that the impact of these memories was affecting her mental health.

The effect of an unsatisfactory response to disclosure

The clearly significant and destructive impact of sexual assault on the mental health and lives of the women interviewed was exacerbated by the responses to their disclosure of sexual assault. The impact of these negative responses on the child or the woman was overwhelmingly a sense of invalidation and of re-abuse. This most often led to women remaining silent for years about the sexual assault/s, feeling angry, isolated and a reinforcement of feelings of guilt and shame.

- The expectations the women had of the responses to their disclosure of sexual assault included that the person would intervene and prevent further sexual assault; that the girl or woman would be 'given permission' and encouraged to share her feelings about the sexual assault/s; and that mental health professionals would provide or arrange follow up counselling to assist the woman to talk about her feelings about sexual assault and to resolve related issues, including mental disturbance.
- The most common responses to disclosure that women experienced either as children or as adults were denial, anger or trivialisation.
- The women consistently reported that the impact of mental health professionals' silence to their disclosure of sexual assault was most often a feeling of re-abuse, a questioning of their own experience and a related decline in their mental health.
- Self mutilation had been an attempt to release the pain of sexual assault to which no-one would adequately respond.

The impact of these negative responses on the child or the woman was overwhelmingly a sense of invalidation and of re-abuse.

- The women who had experienced sexual assault as a child often had chosen not to disclose the sexual assault for years or decades. This occurred to a lesser extent with women who had been sexually assaulted as adults.
- The reasons women gave for non-disclosure included: threats of retribution from the perpetrator; the strong sense that talking about sexual assault was socially taboo; fear of how the person disclosed to would respond; confusion, particularly as a child about what sexual assault meant; the feeling that somehow it must have been their fault and the internalising by children and women of feelings of shame and guilt.
- The consistent theme from the interviews was that when the women's disclosures of sexual assault were responded to in validating and helpful ways, this resulted in the women believing that there was an improvement in their mental health. Conversely, responses that dismissed the relevance of sexual assault to a woman's well-being, reinforced women's distress and resulted in women's mental health problems continuing and/or escalating.
- For some of the women, the psychiatrist's response to their disclosure of sexual assault was to diagnose a psychiatric illness. This denial of the women's reality, and the imposition of an explanation that made little sense to a woman's understanding of herself, resulted in the women feeling angry, withdrawing and in a number of cases, attempting suicide.

The women's experiences of psychiatric and sexual assault services

- Each woman interviewed believed that there was a connection between the impact of sexual assault and their mental health problems. This connection was articulated in terms of memories of sexual assault or recent sexual assault being the catalyst for them first seeking help from a psychiatric service; memories of sexual assault becoming so overwhelming that they found themselves immobilised, out of control, self mutilating or losing control of reality; the experience that no amount of medication had blocked memories of sexual assault; that when they had resolved and integrated issues of sexual assault into their lives their mental health problems had dissipated, and in some cases, had meant that they no longer required medication.
- They felt that it was absurd that some professionals had said that it is inappropriate to raise or follow through issues of sexual assault with a woman, at an acute stage of her mental health/psychiatric problem although some women said that right at the time of admission may not be the most appropriate time for raising issues.
- Women interviewed were emphatic that despite the turmoil and pain generated by memories of sexual assault, they had to work through the issues related to these memories. Women said that the only effective way to do this was by talking about the issues and having their experiences and the impact of these validated and resolved.
- The inadequacy of service providers' responses to women's reality and needs was a recurring theme. Furthermore, women talked about fears around deinstitutionalisation, and their need to access psychiatric services including in-patient beds when they required them.

- Women felt that it was important that they did not jeopardise their access to services and that this could occur if they criticised current service provision. The women feared that if they spoke out at all about inadequacies of service provision by individuals or institutional practices then they might be denied access to a service, discharged early or isolated within the service.
- All the women said that services should be provided that assisted them to work through issues related to sexual assault.
- There were different responses from women on how these services should be provided. Some women talked about the need for all professionals within these services to be provided with training so that they better understand the impact of sexual assault and how to positively respond to a patient disclosure.

Some women were hesitant about the ability of in-patient services to develop appropriate understanding and skills in relation to sexual assault.

- The majority of women talked about their experience of having their medication increased if they started to talk about sexual assault.
- The women consistently reported that within a hospital setting, nurses (particularly females) were the only professional group with which they had sufficient on-going contact to allow the development of trust and communication.
- The women who had experience of a psychiatric hospital (public or private) talked about the inadequacy of current policies and practices to prevent sexual assault occurring; provide appropriate support if it did occur and remove the perpetrator to an area where he could not repeat the offence. Women felt that sexual assault of patients was not seen by services as a priority within their responsibilities and duty of care.
- The women reported that the most common responses they experienced when they reported sexual assault or the fear of it happening were denial or trivialisation and consequently no support was offered concerning the impact of this/ these assaults, nor steps taken to ensure that it was not repeated.

Hospital based services most often see patients merely in terms of a biological disorder, with treatment focussed on the use of drugs. Psycho-social factors such as the impact of sexual assault is rarely responded to in an effective way, with the availability of counselling extremely limited within the public system.

Women found the more institutional inpatient psychiatric agencies less able to hear and respond.

- Hospital based services most often see patients merely in terms of a biological disorder, with treatment focused on the use of drugs. Psycho-social factors such as the impact of sexual assault is rarely responded to in an effective way, with the availability of counselling extremely limited within the public system.

- Community-based mental health clinics still see women from a biological disorder perspective, but the social implications were more likely to be considered and treatment inclusive of medication, counselling and skill development be made available. This was attributed by some of the women to the use of multi-disciplinary teams.
- Non-government community-managed mental health services respond to individual women from a psycho-social perspective. It is in this setting, the least institutionalised of the three sectors, that women feel most listened to and their concerns addressed.

Seventy-five per cent of the women interviewed had used the crisis care or counselling services of a Centre Against Sexual Assault (CASA). Most of these women found a positive response from CASA workers to their disclosure of sexual assault/s and talked about the importance of having someone to listen to them, believe them and actively respond to the issues that their experiences presented for them. Women in this group consistently described the impact of these services in terms of major improvement in their mental health. However this situation is reversed for those women who found the services provided by the CASAs unhelpful. These women suggested that they found a reluctance by many CASAs to work with women who have a psychiatric history. The impact on women who felt that a CASA did not meet their needs was devastating. Women indicated that this sense of devastation resulted from their expectation that as a specialist sexual assault counselling service they would finally be listened to and assisted to work through issues around sexual assault. When the CASA failed to do this they felt there was nowhere else to go. The inappropriateness of short-term counselling and being shifted between counsellors were identified as issues by several of the women interviewed.

Helpful responses

While women interviewed had experienced a myriad of unhelpful and invalidating responses to disclosures of sexual assault, there had been some helpful responses.

In the interviewsthe women suggested that the basis of any effective response by a professional is to listen and offer:

- feedback to the woman that indicates a belief and understanding of the woman's reality and reassures the woman that she is not to blame for the sexual assault/s;
- opportunity for women to start talking about sexual assault experiences, given the years of silence that surround them;
- information about legal and medical options;
- resource materials that enable the woman to understand that she is not isolated in her response to the affects of sexual assault. The book *The Courage to Heal* (Bass & Davis, 1988) was repeatedly mentioned by the women as particularly useful;
- the choice of one-to-one and telephone counselling and support groups;
- strategies that women could use to minimise the impact of memories when they occur;
- referral lists, and advocates for women, as requested.

chapter four

recommendations

This report documents the experience of psychiatric services by thirty (30) women who have also been sexually assaulted at some time in their life. There was a chilling consistency with the way that the women described the on-going impact of sexual assault on their mental health and the inadequacy of mental health services to respond to what they regarded as central to their mental health problems. There was also a consistency in the words and ideas articulated by the women interviewed about the changes to mental health services that they believed would be positive for women's safety and for the resolution of sexual assault issues.

The range of issues and concerns raised by women are substantial and from the basis of the recommendations contained herein.

Education and training

From this study, it would appear that within most psychiatric services there is ignorance and fear about how to appropriately respond to a woman when she discloses sexual assault.

Recommendations:

It is recommended that:

- Additional undergraduate and post-graduate education and training are clearly required to assist mental health providers in their understanding of the specific needs of women service users. Education and training programs should aim to ensure that service providers understand these specific needs and the best ways to respond to them, giving recognition of the psychological, social and environmental factors which are part of women's reality.

  Training should include:

  — an explanation of the impact and sequelae of sexual assault;

  — an understanding of the importance of validation and the impact of non-validation of women's experiences;

  — the need to respond to women's distress in a supportive way due to sexual assault being a sensitive issue for women;

— the need to offer women the option of follow-up counselling from an appropriately skilled person.

- The Health & Community Services staff training and development unit, in conjunction with other relevant service providers, such as CASAs, develop 'responses to sexual assault' training modules, based on the findings of this report and the Good Practices in Women's Mental Health Project for all staff in psychiatric facilities throughout Victoria.
- These training modules be trialled in a city and country region and revised, based on evaluation of the pilot.
- An implementation strategy for the 'responses to sexual assault' training modules be developed by the staff training and development unit. This strategy to be targeted at all workers, including non-direct staff with training facilitated by both H&CS staff and CASA workers as appropriate.
- Ongoing training and standards monitoring in relation to the prevention and response of staff to allegations of sexual assault to occur in all mental health services.
- A professional development working party be established to identify the training needs of psychiatrists in relation to diagnostic and treatment issues relevant to women who have been sexually assaulted.
- The content of professional development training modules on prevention and appropriate responses to sexual assault be added to the pre-service curriculum of relevant courses such as: medicine; nursing (general and specific); social work; occupational therapy.

Access to counselling

When women who are receiving a service from mental health services make allegations of sexual assault, counselling from a professional within mental health services who has the necessary skills should be provided. Where there is not access to such skills, referral to an appropriate counselling service should be promptly arranged.

It would appear from the women's stories that their access to counselling at CASA's was limited due to some workers not having adequate understanding or skills to effectively work with women with a psychiatric in-patient history.

Recommendations:

It is recommended that:

- The CASA Forum develop policies and procedures which aim to assist women who have experienced, or are experiencing mental illness to access services which can best meet their needs. These policies should be incorporated into the 'CASA Best Practice Manual.'
- A working party be established with representatives of CASA's, mental health service providers and consumers to establish processes that will ensure effective liaison and coordinated and cooperative procedures between mental health and CASA services so that women are provided with continuity of care.

- The CASA Forum seek funds to provide training to CASA workers about mental health problems, and appropriate responses to these.

Enquiries relating to sexual assault during admissions

Many of the women interviewed believed that current problems within psychiatric services in relation to 'silence' around sexual assault will not be alleviated simply by ensuring that a woman's experience of sexual assault is asked routinely during the taking of a history. The women were clear that it is the response of the professional to a women's disclosure of sexual assault that is critical.

The women talked about admission to a service as a stressful time. For some, the thought of being asked about a history of sexual assault as part of the initial history taking would only add to the stress of this time.

Others were clear that the asking of such questions and an appropriate response from the professional could assist a speedy transition back to a state of mental health.

They thought that the asking of such questions at admission time would be a positive indicator to them that the discussion of sexual assault issues was acceptable.

Clearly the variety of responses from women suggest that this issue is problematic and needs further investigation.

Recommendation:

It is recommended that:

- Any decision to routinely ask a woman about her experience of sexual assault during history taking be made within the context that staff making the enquiry have the skills to follow up immediately and can offer a choice of options and counselling to the woman.

Safety from sexual assault within psychiatric services

Recommendations:

It is recommended that:

- Health and Community Services mental health service managers, planners and service providers recognise the right and need of women to feel safe when they are a client/patient of a mental health service (particularly psychiatric in-patient services) and that they develop policies and practices that aim to prevent the sexual assault of patients. Policies and procedures which ensure the sexual and physical safety of female patients and prevent sexual assault occurring within all mental health services should include:
  - — the provision of a choice of women only or mixed wards;
  - — all allegations of sexual harassment and/or sexual assault of a female client by another client to result in the immediate removal of the offending client from the current ward.

— that any alleged male perpetrators be placed in a single sex ward;

- Mandatory reporting of sexual assault in Health and Community Service facilities is replaced by a process which supports, over time, the woman in making informed choices as to the response she requires including:

  — sexual assault counselling from a trained professional within the services

  — referral to a CASA

  — reporting the offence to police

  — legal representation.

- The assault and the woman's emotional response to the assault is recorded in the file, for the purpose of ensuring that this information be available for future diagnostic and treatment assessments.

The involvement of women in diagnosis and treatment

This report has shown that the lack of active involvement by women in the process of diagnosis and treatment can result in women being given variable diagnoses, none of which resonates with their own feelings and experience. Women with a diagnosis of personality disorder (frequently made of women who have been sexually abused) can feel stigmatised and can be denied access to psychiatric services.

Recommendations:

It is recommended that:

- Sexual assault is recognised as contributing to the emotional state and behaviours of women who require assistance from psychiatric services and that an appropriate treatment plan is formulated collaboratively with the woman in response to her needs.
- Counselling regarding the assault would be a vital component.
- Psychiatrists listen to and understand the experience of each woman which would allow access to the common denominator, which, for these women was sexual assault.

chapter five

literature overview

The entire construct of the 'medical model' of 'mental illness' - what is it but an analogy? Between physical medicine and psychiatry: the mind is said to be subject to the same disease in the same manner as the body. But whereas in physical medicine there are verifiable physiological proofs....in mental illness alleged socially unacceptable behaviour is taken as a symptom, even as proof, of pathology (Kate Millett, 1991, p311).

INTRODUCTION

As this is an exploratory research study, findings emerge from the stories that women shared in interview. To maintain the primacy of women's experiences and the meaning that they attach to these experiences, a literature chapter is not included in this report. However, a review of the literature from the fields of medicine, psychiatry, psychology, sociology, anthropology, nursing, sexual assault, social work and feminist studies was conducted. This literature provided part of the researcher's understanding of current theories and practices, but did not from an analytical framework for the study. A brief overview of relevant literature in the various disciplines involved in the construction of mental illness and sexual assault is provided in this section. This is provided for reader's reference.

Historically medicine, and psychiatry in particular, have maintained their control over the defining and regulation of mental illness. However at the same time there has 'been the establishment of a myriad [of] different theories and therapies, each firmly supported by the scientific discourse that buttresses the rhetoric of therapeutic efficacy' (Ussher, 1991, p98). In addition to these, sociology, feminism and the anti-psychiatry critique have developed tools that enable us to recognise that: our knowledge and beliefs in the 'facts' about mental illness; the way in which we label and treat it; and how we experience a mental health problem will depend on who we are speaking to and which discipline is the dominant discourse at the time. These critiques have unlocked the 'neutral' and 'objective' claims of

psychiatry and exposed the social, political and historical basis of the labelling of mental illness, and the accompanying diagnostic categories.

Thus we now have available a range of theoretical positions and competing discourses that enable the examination of the validity of competing claims. However, theories 'provide only a partial explanation for madness [mental illness], spinning their webs of theories to persuade, to convince, and to regulate both knowledge itself and the individuals governed by it' (Ussher, 1991, p13). What we also need to hear is the needs that women have identified, both the individual woman and women as a group. It is women's experiences, shared in Part 2, that from the bulk of this report.

Incidence and impact of sexual assault

Over the past few years, there has been an increase in community awareness about:

- the occurrence of sexual assault, (CASA House, 1993; Australian Institute of Criminology, 1986) particularly child sexual abuse (Russell, 1986; Siegal, 1987; Finkelhor, 1990);
- and a recognition that the majority of victims are women and children (Victorian Community Council Against Violence, 1991);
- that perpetrators of sexual assault are almost all male (Butler, 1985).

Furthermore, Finkelhor found that most childhood sexual assault is 'experienced at the hands of a person known to the child [and that] many of the victims never disclosed the experiences to anyone' (Finkelhor et al, 1990, p27).

A review and synthesis of recent empirical studies on the impact of sexual abuse on children by Kendall-Tackett et al (1993) demonstrates the depth of clinical and epidemiological research interest in this area in recent times. They conclude that the review 'confirms the general impression that the impact of sexual abuse is serious and can manifest itself in a wide variety of symptomatic and pathological behaviours' (Kendall-Tachett et al, 1993, p173). Furthermore, the impact of sexual assault is not static, but chronic and on-going (Burgess & Holstrom, 1970; Mullen et al, 1988; Russell, 1986).

Possible link between sexual assault and mental health problems

The long term influence of sexual assault on the mental health of victims/survivors is also increasingly referred to in the literature. These studies, like those mentioned above, mainly use traditional scientific methods and do offer some important insights. It should be noted here that the smaller number of qualitative studies reported in the literature is not necessarily related to the rigour of these studies or the contribution that they have to make to our understanding of a particular problem or area. Rather, it probably reflects the 'gate keeping role' of both funding bodies and editors of professional journals, (the former having the power to determine the types of research to be supported financially and the latter the power to judge what is accepted as 'real' research and knowledge.

Nevertheless, studies carried out on:

- patients (Carmen et al, 1984; Bryer et al.,1987; Jacobson & Richardson, 1987; Brown & Anderson, 1991; Palmer et al., 1993; Swett & Halpert, 1993; Yellowlees & Kaushik, 1994);

- victims (Herman et al, 1986; Silverman et al, 1988; Mezy & Taylor, 1988; McLeer et al, 1992);
- convenience samples such as students (Finkelhor, 1979, 1984; Briere & Runtz, 1988); and,
- random community samples (Bagley & Ramsay, 1986; Burnam et al, 1988; Mullen et al, 1990; Bifulco et al, 1991; Pribor & Dinwiddie, 1992; Bushnell et al, 1993) all point to an association between sexual assault and subsequent psychopathology.

The search for proof of a causal connection (central to bio-medical research) between sexual abuse and later mental health problems and/or identification of factors that mediate this process is the focus of a number of studies (Conte & Schuerman, 1987; Carmen & Rieker, 1989; Briere, 1992; Mullen et al; 1993). In a recent study Mullen et al concludes that 'a history of childhood sexual assault does correlate with an increased risk for a wide range of mental health problems to which it is associated, even when allowance is made for the effects of family dysfunction' (Mullen et al, 1993,p730). His most poignant comment, in relation to this project is that 'it is the meaning of those elements [child sexual assault and disrupted development] within the lived experience of the victim that determines the outcome' (Mullen et al, 1993,p730).

Disclosure of sexual assault

Disclosure of sexual assault is another area referred to in the literature. Studies show that many patients do not volunteer that they have experienced sexual assault or deny this if asked due to fears such as retaliation, shame and denial (Jacobson & Richardson, 1987; Summit, 1989; Jacobson, 1989;). Professional failure to ask about sexual abuse can confirm patients' belief in the need to deny the reality of their experience (Bryer et al, 1987). Equally patient disclosure does not guarantee that this will be recorded or incorporated into the clinical understanding of the patient. Many mental health professionals do not believe the disclosure (Brewin, 1992), regard it as unimportant (Briere & Zaidi, 1989) or do not know how to respond.

The question of routine enquiry into a history of sexual abuse is thus problematic. If women are to be questioned about their experience of sexual abuse the clinician needs to be able to respond appropriately, offer support and incorporate this information into an understanding of the patient's presentation and development of a therapeutic response (Josephson & Fong-Beyette, 1987; Jacobson & Richardson, 1987).

Sexual assault and mental health professionals

A further area of research interest is the sexual exploitation/assault of women by mental health professionals. Despite this being an area shrouded in professional silence studies by De Young, 1981; Mowbray et al, 1984; Herman et al, 1987; Armsworth, 1990 indicate that prevalence is significant. Some authors 'have attempted to explicate general client and therapist characteristics that increase the likelihood of abuse occurring in the therapy hour, [e.g. Bouhoutsos et al 1983; Holroyd & Brodsky, 1977; Pope & Bouhoutsos, 1986]', (Armsworth, 1990, p541).

Equally, there has been some research into the occurrence of sexual assault of clients within psychiatric institutions (Nibert et al, 1989), although this is also an issue that has been predominantly ignored.

Psychiatric diagnosis and treatment

Debate about clinical practice and treatment modalities does not only occur between disciplines. There has been divisive and acrimonious debate within psychiatry, for example, over the effectiveness of psychotherapy and psychoanalysis (Halasz, 1994, p10). Equally, criticism of the Diagnostic and Statistical Manual (DSM-III-R) and the International Classification of Diseases (ICD) with its pathologising assumptions is broadly located, as is debate within psychiatry about the appropriateness of certain diagnostic categories (Kaplan, 1983; Tomm, 1990; Harding J. & Stiles J., 1991). In relation to sexual assault, the most comprehensive and cogent criticism of current diagnostic categories and their inadequacy is provided by Judith Herman. She argues that 'established diagnostic categories....have generally failed to recognise the impact of victimisation' (Herman, 1992, p3) and argues for the inclusion of complex post-traumatic stress disorder (PTSD) into DSM V. The conceptual framework that Herman suggests brings together the psychological and physiological impact of trauma (sexual assault) and incorporates the need to look at context and meaning (past, recent, present and future) for the individual.

Virtually all the literature referred to above use the methods of natural science to explore what is believed to be an underlying pathology of mental illness. These scientific methods are 'based on empiricist tradition, backed by the powers of reason and the rationalist philosophers, [and] claim possession of "true knowledge"' (Halasz, 1994, p8). Thus research methods are claimed to be objective and neutral and it is claimed that they do not reflect the value and interests of the researcher. Yet as Halasz goes onto say 'on the surface, the image of science and scientists as a dispassionate group following a purely logical enterprise in the pursuit of truth, is, on deeper reflection, a falsehood'. Despite this, the science based biomedical model continues to dominate mental health research. Thus most of the studies reported so far in this report are driven by a desire to refine and add to scientific theories on the cause and treatment of mental illness in relation to organic (the brain) or genetic factors.

Feminist analysis of sexual assault

Feminist analysis of sexual assault uses similar starting points to feminist theorising of mental health/illness. Acknowledgment and identification of sexual assault as a major social problem has only been a relatively recent development. A range of theories have been proposed to explain the cause and incidence of sexual assault. These include psychoanalytic theories (Freud, 1981); victim precipitation theory (Amir, 1971; Snowdon, 1984) and the analysis of power in sexual assault (CASA House, 1990, McCarthy, 1993). The power analysis of sexual assault which argues that sexual assault is about violence, not sexuality, is the current accepted theory in non-medical areas world wide. Within Victoria, this theoretical position is implicitly endorsed through the funding of Centres Against Sexual Assault by the State and Federal government.

Within this analysis, sexual assault is regarded as social, not a natural fact. Sexual assault is seen not as a problem of individual pathology or the 'deviant' rapist but rather an extension of the patriarchal culture that we live in. A culture that is based on the uneven distribution of power between men, women and children (CASA House, 1991 p7,8).

From the preceding overview it can be seen that most studies on women, mental health and

sexual assault could be loosely grouped in the following manner. They attempt to:

1) identify a relationship between sexual assault and a whole range of diagnostic mental disorders; or

2) establish factors that mediate a woman's experience of sexual assault and the later development of mental illness; or

3) challenge the basis of psychiatric knowledge and its constructed theories and practice as a means of explaining the greater incidence of sexual assault and mental health problems of women.

While each of these literature groupings has a contribution to make to our understanding of women's mental health problems and a possible relationship of these with experience of sexual assault, inevitably they compete with each other for a position of pre-eminence. Sadly at this time there is little evidence of what would seem most beneficial for the mental health of women generally, and specifically women who have also experienced sexual assault. That is the cooperative development of interdisciplinary theories and practice.

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appendix1

STEERING COMMITTEE MEMBERS

Ms Jan Southgate (Chair)

Co-ordinator: South East Centre Against Sexual Assault

Ms Anne Ball

Social Worker:Waverley Mental Health Community Centre

Ms Glenda Bawden

Chief Social Worker: Monash Medical Centre

Dr Helen Driscoll

1993 - Senior Lecturer in Child Psychiatry: University of Melbourne and Consultant: Royal Children's Hospital. 1994: Private practice

Ms Jenny Gee

Co-ordinator: Mental Health Legal Centre

Ms Kim Glover

Counsellor/advocate: North East Centre Against Sexual Assault

Ms Lesley Hewitt

Lecturer: Department of Social Work and Human Services, Monash University

Ms Helen Leeson

1993 - Clinical Nurse Educator: Human Relations, North East Metropolitan Psychiatric Services (NEMPS). 1994 - Senior Consultant:Psychiatric Services Training and Development Unit

Ms Belinda Mackie

Psychotherapist: Williams Rd Family Therapy Centre

Dr Gita Martyres

Consultant Psychiatrist: St. Vincent's Hospital /Private practice

Ms Kate O'Donnell

Counsellor/Advocate: South East Centre Against Sexual Assault

Ex officio

Ms Carolyn Graham

Researcher

appendix2

INFORMATION SHEET FOR POTENTIAL PROJECT PARTICIPANTS

My name is Carolyn Graham. I work as a researcher for the South East Centre Against Sexual Assault, which is part of Monash Medical Centre. We have received funding to explore the experience of the psychiatric system by women who have been sexually assaulted. Therefore I want to talk to women who have both been sexually assaulted and have been a patient or client of a psychiatric service. This might include services such as psychiatric day and residential programs, psychiatric hospitals and mental health community services.

Why should you be involved in the research?

I hope that by listening and recording women's stories, I will be able to describe different issues and problems that women may have encountered, with either psychiatric and/or sexual assault services. This research will give you the opportunity to tell your story in your own words. By sharing your experience, you may help other women in a similar situation to you, in the future.

What does the research involve?

I want women to feel able to describe in a safe environment their experience. The main focus will be on whether you have ever been asked by a psychiatrist about sexual assault and, if so, what treatment or support was provided to you after you disclosed the assault.

The interview will take approximately one hour to complete, will be conducted at a service of your choice and will be audio taped. While participation in a taped interview is preferable, you will be given the choice to write about your experiences. You will be required to sign a form that gives your consent to be interviewed, and under what conditions. If you wish to stop the interview at any time, then I will terminate it immediately.

I understand that the experiences that you share with me during an interview may be upsetting to you. Therefore, a support system will be available for you to use. You can choose: i) a worker from a service that you use, either to sit with you during the interview, or to be available within the building during the interview time; ii) to finish the interview at any time and to request support from the worker that you have chosen; iii) after the interview to talk about feelings you have as a result of the interview with your support worker; iv) to gain follow up help from a professional service that you are currently using. Or alternatively, I will give you the name and phone number of a local 24 hour sexual assault crisis service that you could phone if you were feeling upset as a result of the interview.

The findings of the research will be distributed in a report format, and may be used for media releases. It is also possible that at a later stage, women's stories may be published as a small book. If this was to occur, your separate consent for your involvement in the book would be sought.

All information that you share with me will be confidential. I will not use your name, or any other identifying information, in any published or unpublished material. Also any records of our interview will be stored in a locked filing cabinet, and I will be the only person that will be allowed to access them.

If after the interview you decide that you do not want any information that you shared with me to be used in the research, you can contact me up to six weeks after the interview and request that the information be destroyed.

How do you become involved in the research?

If you are willing to be involved in the study, or you would like more information, please return the attached sheet, or if you prefer, contact me directly on (03) 575 7741. I will then get in touch with you to organise a suitable time for an interview and to arrange a support system for you.

Yours sincerely

Carolyn Graham
South East Centre Against Sexual Assault
Monash Medical Centre

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appendix3

PERMISSION TO CONTACT

My first name is..... and I am willing to be contacted by Carolyn Graham (the researcher) on the following number(s):

Telephone: ( ) (Home) ( ) (Work)

Times I prefer to be contacted are:

PLEASE TICK

Daytime:	Work	Home	Other
At Night:	Work	Home	Other

Please note that when you are called, the researcher will ask to speak to you and will not say what the call is in regard to until you come to the phone.

appendix4

INTERVIEW PROCESS AND INTRODUCTORY COMMENTS TO WOMEN PRIOR TO THE START OF THE INTERVIEW

a) Understandings that need to underpin all interactions with women

- Fundamental to the study is the respect for women's right to feel safe and supported, and as far as possible to ensure that participation in the research is a positive, not a negative experience for women.
- That the issues to be talked about in the interview will be sensitive to women. Thus there will be a need to create clear boundaries between the role of the interviewer and the support person.
- That some women who agree to be interviewed may not have had any counselling about sexual assault, while others may have.
- That women have maximum control of the process, both in terms of the conduct of the interview and the parallel support process.
- That women's confidentiality to be preserved at all stages.

Introductory meeting with women following initial phone contact

Aim: to provide women with the opportunity to meet with the researcher, 'check her out', ask questions and discuss the research and interview process.

Ensure that the support person is available at the time of this first meeting, in case the woman chooses to continue straight into the interview.

Areas to be covered during the initial meeting to include: (note that the first five points have been explained on the information sheet and reiterated on the phone by the researcher)

- Introduction of myself and thanks for meeting with me;
- Provide an overview of why the project was established, who is going to be interviewed, what will happen with the information that the woman shares with me, that a report will be published and how this project hopes to make a difference;
- Provide opportunities for the woman to ask questions;
- Discuss who the woman would like to be her support person and ensure that she understands how she can use the support person. Clarify that I am not a counsellor, thus the reason for the support person;
- Explain why I wish to audio record the interview (so I have a record of their words and the context of these) and ask if she minds me tape recording the interview;
- Clearly state the purpose of the interview and outline the sorts of things I would be interested in the woman sharing during the interview;
- Provide the woman with the opportunity to continue straight into the in-depth interview if she prefers to make it just the one meeting, or alternatively the opportunity to say that she does not wish to continue her participation.

INTERVIEW

Ensure that the support person will sit on the introduction to the interview and the signing of the consent form. Secondly that she will be available throughout the interview and afterwards.

What to introduce the interview with

I am doing some research that aims to find out from women how some psychiatric services deal with sexual assault, and in particular what you have found helpful and unhelpful.

We hope that by you, and other women sharing your story and me documenting your experiences, that mental health service/s in the future can more easily meet the needs of women who have been sexually assaulted.

I believe that because you have used psychiatric services and are aware of what seemed to work for you, that you are in the best position to help this research. Therefore, I appreciate you agreeing to participate today and to share with me some of your experiences and how you felt about these. However before we start I need to explain a few details to you so you know exactly what will happen today and with the information that you share with me.

Using the 'Consent form' reiterate

a) The purpose of the study is to: document women's experience of how psychiatric services deal with sexual assault, and the impact of this on women.

b) The interview format: I have some areas that I am hoping that we will cover, but rather than me directing a whole lot of questions to you I am hoping that most of the areas that I hope to cover will just come out as you talk about your experiences and those that have particular meaning to you. The areas that I would find useful for you to talk about are:

- some basic personal information such as your age and psychiatric or mental health services that you have used;
- if you have disclosed sexual assault and if so, what have been the responses of people to this;
- whether you have any thoughts on a possible connection between sexual assault and mental health problems and how you feel other people think about this;
- how useful you have found psychiatric services and other referral and support agencies work around sexual assault issues;
- and finally some feedback on how the interview process has been for you.

c) That she has the right to stop the interview at any time.

d) That the role and availability of the support person is available to her, regardless of whether she stops the interview or not.

e) How the information is to be stored and how no identifying information will be used in any presentation about the research.

f) That a report is to be written that will share women's experiences under thematic headings.

Allow the woman to ask questions and then ask her to sign the 'consent form' and her support person.

appendix5

INTERVIEW GUIDE

Note: The questions outlined below are there purely as a guide to the researcher during the interview. The questions aim to identify the 'band of experience' that I am interested in and to provide a guide on how to sensitively probe areas that women choose to talk about. Thus it is anticipated that many of these questions will not need to be asked, as women will cover the general areas in the course of her 'story telling'.

(Note: Need to continually try and differentiate which type of service/s women are talking about during the interview).

A) General and psyche background

1 Perhaps we can start by you telling me how old you are.

2 To help me understand your experience of different psychiatric services (for example psych hospital, private psychiatrist etc) could you tell me what psychiatric services that you have used and when?

3 What was happening in your life at the time you had your first contact or referral with a psychiatric service?

4 What did the doctor say your problem was? (Probe: Did you understand the language that they used? What did this mean to you?)

5 What did the doctors provide in terms of treatment? (Probe: drugs, contraception, counselling, referral, hospitalisation, discharge?)

B) Disclosure of sexual assault and perceived responses

6 Have you have ever been able to tell anyone about being sexually assaulted? (explain here what I mean by sexual assault/sexual abuse)

7 If answer YES, Who are the people you have told? What are the feelings that you when you first disclosed? Which feelings were strongest at the time? (Probe: Have you ever told a worker within a psychiatric service about the sexual assault/s? What was their reaction? Do you feel that your sexual assault experience/s was believed?)

7b If answer NO then ask: What stopped you from telling? (Probe: felt unsafe, didn't think would be believed, didn't seem important, never an opportunity to establish a relationship of any value with psyche staff etc).

If relevant ask: What would have helped you to disclose?

8 If they say they have not been believed at any time when they disclosed S/A then ask: Has the feeling you have not been believed had any effect on you? If so what?

C) Self and others perception of possible relationship between sexual assault and mental health/illness

9 How, if at all, do you think that having experienced sexual assault has effected/is effecting your life? (physically, psychologically, emotionally, sexually; or health, work)

10 Has it ever been suggested to you there might be a relationship between the sexual assault experiences and your mental health? (Probe: in what way?)

D) How psychiatric services work with sexual assault: theory and practice

11 At the time of the assault/s and in the subsequent years, what have you found useful in dealing with issues around the assaults? Is there anything else you would have found useful?

12 Do you think it is an appropriate role of a psychiatric service to provide support to you about sexual assault? If answer YES (Probe: what do you think would be the most appropriate support that they can provide?)

13 Did you/do you feel safe while in a psychiatric hospital or other psych service. What made you/ makes you feel safe/unsafe? (Probe: what do you mean by safe?)

14 Did you/ do you feel that efforts were made to make you feel safe? In what ways? (Probe: What would make you feel safe from sexual assault when using a psychiatric service?)

15 What sort of accommodation in hospital would you have found most helpful? Would/ was it important to have the choice of a women only or mixed ward when you were in hospital? What difference would this have made/make to you?

16 Have you ever been offered a choice of a male or female worker within a service (eg contact nurse, psychiatrist etc)? Do you have a preference? Why?

17 What are your three biggest worries now?

E) Other sexual assault referral agencies and support agencies

18 What services have you been referred to by psychiatric services? What were these? (Probe: Did you follow the referral up? If so, was it helpful to you? In what ways? If you didn't follow the referral up, why not?)

19 Was there anything that was not helpful to you that the referral agency did or said?

20 Have you had counselling in relation to the sexual assault? Was talking about it useful? In what ways?

21 What helped you most, or would have helped you to work through your feelings about the sexual abuse?

F) Research process and language

22 Did you understand the language that doctors, nurses and other workers used when talking to you? (Probe: What did it mean to you? What made it easier or more difficult for you to understand what was being said to you? Did you feel that you could ask questions?)

23 Did you understand the language that sexual assault workers used when talking to you? (Probe: What did it mean to you? What made it easier or more difficult for you to understand what was being said to you? Did you feel that you could ask questions?)

24 How have you felt about the interview process for this project? (Probe: What is the impact on you of participating in the research process?)

25 If you were me, how would you have approached these interviews? (Probe: in terms of process, content and interview style).

Thank the woman for her participation. Provide her with the opportunity to ask any questions of me. Give her the name and number of the closest CASA and of Telsasa. Recheck if she wishes to talk to her support person when I leave.

appendix6

CONSENT FORM

I,..... of.....

have been asked to participate in the research study entitled

'Women who have been sexually assaulted - their experience of the psychiatric system' being conducted by South East Centre Against Sexual Assault (Monash Medical Centre).

I give my consent by signing this form on the understanding that this research study will be carried out in a manner conforming with the principles set out by the National Health and Medical Research Council, and further that:

1. I understand the general purposes, methods, demands and benefits and possible risks, inconveniences and discomforts of the study as outlined in the 'Information Sheet for Potential Project Participants' that has been given to me.
2. My participation in the research study is voluntary, and that I am free to withdraw at any time, and will still receive appropriate treatment for my condition, as will be the case if I do not volunteer to enter the study.
3. The confidentiality of my medical history will be safeguarded.
4. I have been given the opportunity to have a member of my family, a friend or a psychiatric service worker present while the project was explained to me.

Signature: ..... Date: .....

WITNESS: I,.....of.....as an independent witness, confirm that the aims and procedures of the study and any risks involved have been explained to the person consenting, whose signature I witness. In my opinion, he/she is acting rationally and voluntarily.

Signature: ..... Date: .....

Investigator: I, Carolyn Graham, have fully explained the aims, risks and procedures of the above named study to the person named herein.

Signature: ..... Date: .....