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Identifying Ways Of Enhancing The Psychological Functioning In Victims Of Sexual Offences From Clinical And Justice System Management Perspectives

by

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BA (Psych) Hons, MPsych (Forensic)

A thesis submitted in fulfilment of the

requirements for the award of

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USE OF THESIS

The Use of Thesis statement is not included in this version of the thesis.

ABSTRACT

Research efforts in the field of sexual victimisation have traditionally focussed on identifying ways to increase reporting rates. While reporting rates still remain low with estimates in the 10-15% vicinity (Australian Bureau of Statistics, 1996; Australian Institute of Criminology, 2000), there is thought to have been an increase and stabilisation of reporting rates in recent years (Australian Bureau of Statistics, 1998, 2002; Roberts & Gebotys, 1992). Brought on by this increase and stabilisation of reporting rates, is a need to expand the research focus to include the effective *management* of victims of sexual offences. Management can take place on two main levels: on a clinical level (for those who access support services) and on a justice system level (for those who report to the police). The purpose of this research was to examine the circumstances of 132 women and men who had been victims of sexual offences at some time in their lives, from both clinical and justice system perspectives. This was achieved by combining quantitative and qualitative methodologies to examine the complex nature of participants' psychological functioning, and the interaction between indicators of their psychological functioning and various dynamic and static predictor variables. Multiple regression analyses indicated that between 48% and 73% of the variance in the four indicators of psychological functioning (depression, anxiety, posttraumatic stress, and self-esteem) was accounted for with the predictors. Dynamic variables including frequent rumination of why the offence occurred, shame-proneness, perceived control, and coping strategies were consistently more strongly related to outcome measures than the static variables. These findings provide a basis for optimism regarding clinical and justice system interventions with people who have experienced sexual offences, since dynamic factors are inherently modifiable. Practical implications that allow justice and clinical management efforts to focus on the high-impact areas identified in this research are discussed. Current psychological functioning did not differ between victims who had reported their offences to the police and those who had not, though several key themes were identified by victims in terms of therapeutic and anti-therapeutic elements of the Justice System process. From a therapeutic jurisprudence perspective, these experiences are valuable in being able to guide those who work with victims of sexual offences within the Justice System. Further, reasons why some participants reported their victimisation to the police and others did not, along with

participants' personal definitions of justice, may provide useful indications as to how the justice system may better meet the needs of victims of sexual offences.

DECLARATION

I certify that this thesis does not, to the best of my knowledge and belief:

1) incorporate without acknowledgement any material previously submitted for a degree or diploma in any higher institution of higher education;
2) contain any material previously published or written by another person except where due reference is made in the text; or
3) contain any defamatory material.

ACKNOWLEDGMENTS

Thank-you to my Principal Supervisor, Associate Professor Alfred Allan, for his expertise, encouragement, and guidance, not only throughout this PhD research but throughout my Masters degree as well. His enthusiasm for this project never failed, and that helped me immensely when things were looking dim during the early phase of data collection. Thank you also to Dr. Andrew Guilfoyle, for his ideas, guidance, and support; his contribution to this thesis is greatly appreciated.

I wish to acknowledge the many sexual assault and sexual abuse victims/survivors who trusted me and told me their stories for the sake of this research in hope of improving the situations of those who follow in their footsteps. I hope they were able to gain something positive from participating, I know many told me so at various times throughout the project, and that alone made it a worthwhile exercise and kept me motivated. In listening to their stories and thinking about them now, I continue to be amazed and inspired at their strength and courage, and I wish them all the happiness they deserve.

Thank-you also to the Director of Public Prosecutions in Western Australia, Robert Cock, for his support of this project, and the coordinators of the counselling agencies who allowed me to advertise this research in their agencies. A very special thank-you to Margaret Price of the Wanneroo Times Conununity Newspaper, for all her time and help in preparing articles to recruit participants for this research. Without her assistance, I doubt whether we would have been able to continue the project.

Lastly, I wish to acknowledge my dad, Bill Gall, for the immense support he has given me throughout my entire life and my University studies, first at Queen's in Canada and then at ECU here in Perth, Australia. It is my dad who is responsible for my ambition, my strong values of education, and the confidence that enables me to do what I want to do, and I thank him dearly for all his wisdom and all his support. Knowing that he believes I can do anything I set my mind to has encouraged me to venture into new things and new places and to set high goals. This thesis is dedicated to my dad. I know he may not read it, but I know he'll enjoy the spirit of it - the hard work, perseverance

and sacrifice that it took, and the eventual joy and satisfaction of achieving something. Thanks Dad, you're the best.

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CHAPTER 1
Introduction

Sexual offences in both childhood and adulthood constitute a social problem that is far too common. The prevalence of sexual offences has been estimated through numerous studies. With respect to sexual offences in childhood, a random-digit telephone survey in the United States of America (USA) reported that 34% of women indicated that they had experienced at least one incident of sexual abuse before 18 years of age (Wyatt, Loeb, Solis, & Carmona, 1999). Further, a Canadian study found that 11.9% of high school girls reported sexual abuse "while growing up" (Wolfe, Scott, Wekerle, & Pittman, 2001). Official male sexual abuse prevalence rates tend to be somewhat lower than official rates of sexual abuse of female children. For example, in a national telephone survey in the United Kingdom (UK), 16% of men indicated they had been sexually abused as children (Finkelhor, Hotaling, Lewis, & Smith, 1990), whereas a community study in Canada found a prevalence rate of 7% for boys (MacMillan, Fleming, & Trocme, 1997). In Wolfe and colleagues' (2001) study, 5.6% of high school boys reported sexual abuse "while growing up". These figures suggest that between 11.9% and 34% of girls and between 5.6% and 16% of boys are sexually abused as children. That is, as many as 1 in 3 girls and 1 in 6 boys may be sexually abused during childhood. These rates suggest that sexual abuse is much more prevalent in girls than in boys, however, Smallbone and Wortley (2001) studied incarcerated sex offenders in an Australian prison and found that while 52% of the offenders' victims in *official* (justice system) figures were boys, offenders reported that 74% of the total number of *actual* victims were boys. This finding suggests that fewer sexual abuse cases involving male victims may be reported to the police and therefore it is possible that the prevalence rates commonly reported may consistently underestimate the prevalence of sexual abuse of boys.

With respect to sexual offences in adulthood, according to the Australian Bureau of Statistics Women's Safety Survey (1996), 1.5% of women 18 years and over experienced sexual assault in the 12 months preceding the survey and 15.5% experienced sexual assault since age 15. Regarding prevalence rates of male sexual assault, a UK study revealed that 3% of men reported that they had experienced an incident of sexual assault in adulthood (Coxell, King, Mezey, & Gordon, 1999). These figures suggest that 1 in 6 women in Australia and 1 in 33 men in the UK experience sexual assault in adulthood.

Examining the prevalence rates of children and adult sexual victimisation in isolation, however, obscures the fact that many victims are sexually victimised on more than one occasion, often both as children and adults. Revictimisation is the term used in this thesis to describe the situation where a person is sexually victimised in childhood and again in adulthood. The research literature indicates a strong relationship between childhood sexual abuse and sexual revictimisation in adulthood. For example, Gidycz, Coble, Latham, and Layman (1993) reported that 32.1% of child sexual abuse survivors experienced adult sexual victimisation compared to only 13.6% of those without a child sexual abuse history. While the link between child sexual abuse and later *sexual* victimisation has been strongly supported in the literature, susceptibility to other forms of abuse (physical and emotional) has also been identified. For instance, Briere and Runtz (1987) found that 49% of women who had experienced child sexual abuse also reported being physically abused in their adult relationships compared with only 18% of women without a history of child sexual abuse.

Although the above prevalence rates suggest that sexual offences in childhood and adulthood are a common social problem, research also suggests that the majority of victims of sexual offences do not report their victimisation to the police (e.g. only 15% of sexual offence victims reported to the police in a survey by the Australian Institute of Criminology, 2000)[1]. The number of sexual offences reported to police has nonetheless increased in the last two decades and appears to have stabilised (Australian Bureau of Statistics, 1998, 2002; Roberts & Gebotys, 1992). Highlighted from this surge in

[1] Canadian research shows an even lower rate; The Violence Against Women Survey (Statistics Canada, 1993) estimated that only about 6% of sexual assaults are reported to the police.

accessing the justice system (encompassing the police and the courts), is a need to expand psychologists' traditional focus of increasing reporting rates to include the effective *management* of victims of sexual offences. Management of victims can take place on two main levels: on a justice system level and on a clinical level.

The first level deals with victims in the *justice system* process, with the aim of making the process maximally therapeutic[2] for those who report their victimisation to the police. A justice system that involves a therapeutic process for victims might also increase reporting of these crimes. The reasons for maximising the therapeutic value of the justice system are therefore twofold: first, to maximise the psychological functioning of victims, and second, to maximise the proportion of victims who report sexual offences to the police, and thus help reduce the likelihood of more offences and increase the provision of services to victims who report.

This approach of making efforts to develop the justice system into a more therapeutic process is the basis of the perspective of *therapeutic jurisprudence*, which according to Wexler and Winnick (1991)

> looks at the law as a social force that, like it or not, may produce therapeutic or antitherapeutic consequences. The task of therapeutic jurisprudence is to identify -- and ultimately to examine empirically -- relationships between legal arrangements and therapeutic outcomes. (p. 8)

A therapeutic jurisprudence perspective aims to increase therapeutic elements of legal processes and reduce anti-therapeutic elements. However important this aim of increasing the therapeutic nature of the justice system is, therapeutic jurisprudence does not suggest that therapeutic considerations are more important than considerations of due process and other justice values (Wexler & Winnick, 1996). Therefore, while making efforts to make the justice system experience more therapeutic (or less anti-therapeutic) for victims of sexual offences is important, defendants' rights must not be forgotten or compromised. Therapeutic jurisprudence was initially applied to the mental health field (Wexler & Winnick, 1996), however, it has expanded to a variety of other fields including correctional law (Cohen & Dvoskin, 1996), juvenile law (Shiff &

[2] In this thesis, the term 'therapeutic' is referred to in the way that Slobogin (1996, p. 767) defined it: "beneficial in the sense of improving the psychological or physical well-being of a person."

Wexler, 1996), personal injury (Shuman, 1996), and sexual victimisation (Feldthusen, Hankivsky, & Greaves, 2000). While researchers and clinicians in the therapeutic jurisprudence field have generated theories to enhance the therapeutic potential of justice system processes (Wexler & Winnick, 1991), researchers must work toward providing directions that are supported by empirical research. To this end, qualitative research conducted by Feldthusen and colleagues (2000) involved observing victims of sexual offences in civil litigation and government compensation procedures. They found that victims were often dissatisfied with justice procedures. This finding provides a stimulus for further research in the sexual victimisation arena on the justice system level.

Accordingly, the second level of management of victims of sexual offences encompasses the *clinical* level. Here the aim is to enhance the psychological functioning of victims who access counselling or therapy services, regardless of whether they have reported the offences to the police. Whilst research describing the psychological *impact* of sexual offences is plentiful (e.g. Dinwiddie et al., 2000; MacMillan et al., 2001; Mullen, Martin, Anderson, Romans, & Herbison, 1996; Resick, 1993), there remains a dearth of information to guide the *advancement* of healthy psychological functioning in people who have been sexually victimised (Cruz & Essen, 1994).

Since many victims do not report sexual offences to the police (Australian Bureau of Statistics, 1996; Australian Institute of Criminology, 2000), research must examine those who report to the police as well as those who do not, rather than the common practice of studying only one of the two groups or not collecting such information about samples at all (e.g. Arata, 1999; Frazier, 1991; Hill & Zautra, 1989; MacMillan et al., 2001; Mullen et al., 1996; Regehr, Regehr, & Bradford, 1998). Therefore, what is needed is an examination of the justice system process for victims of sexual offences, coupled with a thorough empirical investigation of the factors that affect the therapeutic process for victims of sexual offences, regardless of whether they report the crime to the police. This thesis was designed to meet these current needs.

Structure Of The Thesis

The next chapter of this thesis, Chapter 2, examines the role of the justice system in cases of sexual offences, reviewing rates of reporting to the police and research findings regarding the experiences of victims who access the justice system by reporting their victimisation to the police. Chapter 3 reviews several pertinent research findings to describe the impact of sexual offences and the methods by which clinical practice currently aims to reduce harmful consequences. Chapter 4 more specifically sets up the scene for the present study, as it reviews research about the prediction of psychological functioning in the wake of a sexual offence. In Chapter 5 the aims of the study are presented.

The methodology of the study is described in Chapter 6.

The results of the research are presented in Chapter 7 through to Chapter 9. Chapter 7 identifies some main themes regarding victims' experiences in dealing with sexual offences and their experiences in the justice system. Chapter 8 identifies several variables that could be quantified to contribute to the set of predictor variables. These variables are included in Chapter 9, which utilises several dynamic (generally modifiable) and static (generally unmodifiable) predictor variables to examine their influence on five measures of psychological functioning (depression, anxiety, posttraumatic stress, self-esteem, and anger). The ultimate aim is to identify the most explanatory model of psychological functioning, and to identify the key variables for focus in the practice of justice/clinical services.

Discussion of the research results and the use of the explanatory model as applied to past research findings, clinical and justice implications, methodological issues, and directions for future research are presented in Chapter 10, resulting in some brief conclusions from the project.

CHAPTER 2
The Role Of The Justice System After Sexual Victimisation

The Western Australian criminal justice system is an adversarial system based on English law (Law Reform Commission of Western Australia, 1999). The law is codified; sexual offences are defined in Chapter XXXI of the Western Australia Criminal Code (*Criminal Code*, 1913). Sexual offence cases involving adult victims are generally held in an open court, by a Judge and jury. The State serves as the prosecutor of criminal cases, on behalf of society rather than the victim, since "it is the Crown (or State) which is nominally the primary 'victim' of any criminal wrongdoing" (Law Reform Commission of Western Australia, 1999, p. 198). The victim's role is only as a witness (Law Reform Commission of Western Australia, 1999), though he or she is permitted to submit Victim Impact Statements for sentencing purposes (see *Sentencing Act*, 1994), and he or she is entitled to the Criminal Injuries Compensation scheme (Law Reform Commission of Western Australia, 1999). Victims do not have separate legal representation in Western Australia (Keating, 2001).

The Australian Institute of Criminology indicated that only 15% of surveyed victims of sexual offences had reported the incident to the police (2000). The Australian Bureau of Statistics Women's Safety Survey (1996) reported an even lower reporting rate for sexual assault in Australia. Only 10% of women who had ever experienced a sexual assault reported the last incident to the police. Reporting rates in the survey differed according to the relationship between the offender and the victim. For instance, of women who were sexually assaulted by a stranger, 24.5% told the police about the last incident, compared to 16.6% of cases of sexual assault by a previous partner, 3.6% by a boyfriend/date, and 6.7% by another known man. From the above figures, it appears that the reporting rate for sexual assault may be somewhere in the vicinity of 10-15%, and

the likelihood of a victim reporting an incident of sexual assault may depend, in part, on the nature of the victim-perpetrator relationship.

Common Reasons For Not Reporting To The Police

There are many studies that canvass the reasons why some victims do not report sexual offences (e.g. Australian Bureau of Statistics, 1996; Collings, 1987; Dussich, 2001). The findings of the Women's Safety Survey (Australian Bureau of Statistics, 1996) provide a useful summary of the reasons that have been identified in Australia. The survey reported that the main reasons why women did not report the last incident of sexual assault were:

- would deal with it herself (39.1%),
- did not regard it as a serious offence (14.4%),
- shame/embarrassment (12.5%),
- did not think police could do anything (9.5%),
- thought she would not be believed (6.5%),
- fear of perpetrator (6.1%),
- did not want perpetrator arrested (2.0%), and
- other reasons (9.4%).

Common Reasons For Reporting To The Police

While research regarding the reasons why some victims do *not* report sexual offences to the police are abundant (e.g., Australian Bureau of Statistics, 1996; Collings, 1987; Dussich, 2001), the reasons why other victims *do* report sexual offences to the police are relatively under-researched. However, one study that did canvass victims' reasons for reporting to the police indicated that 42% of victims who reported to the police did so mainly because they wanted to prevent the perpetrator from offending against them again, or against other people (Bachman, 1993). Further, 29% of the victims reported the incident mainly to catch or punish the perpetrator, and 16% of the victims reported mainly because they needed help after the offence incident. The dearth of research in this area is disappointing, because it appears as if identifying the reasons why victims report sexual offences to the police may provide a wealth of information that may ultimately be useful in making the justice system a more therapeutic process for victims.

Experiences Of Victims Who Have Reported To Police

While there is evidence to suggest that taking legal action in response to sexual victimisation can be therapeutic for victims (Feldthusen et al., 2000; Holmstrom & Burgess, 1983), the same research also provides evidence to suggest that legal processes can be anti-therapeutic, and indeed traumatic, in many other instances.

Holmstrom and Burgess (1983) were among the first researchers to study the experiences of victims of sexual offences as they made their way through the criminal justice process. Even though their research took place in the USA over 20 years ago, it is still widely referred to today. The similarity between the findings of their research and research conducted more recently (e.g. Madigan & Gamble, 1989) suggests that, in practice, little has changed for victims of sexual offences who participate in the justice system process. For example, one of the strongest and most common complaints of victims over years of research is that they do not feel they are kept adequately informed about the progress of their cases (Holmstrom & Burgess, 1983). Holmstrom and Burgess noted that victims generally wanted information and felt that they did not get enough. When they did receive information and explanations, they tended to appraise the professional's behaviour in a more positive light. Similarly, in a report by the Dublin Rape Crisis Centre and School of Law at Trinity College (1998), not being kept informed about the progress of the case after reporting a sexual offence has been a major complaint of victims and has been thought to add considerable distress on top of an already stressful process.

Another common complaint has been that the length of time between reporting to the police and going to court is too long, leading to increased distress and relationship and occupational difficulties (Holmstrom & Burgess, 1983; Madigan & Gamble, 1989). Holmstrom and Burgess observed court appearances of numerous victims of sexual offences and concluded that court delays are typical. The number and length of delays observed by Holmstrom and Burgess led them to state that "nothing could be more revealing of the lowly position rape victims occupy in the criminal justice system than the waiting time they must endure" (p. 127). Victims noted that such delays were tiresome, discouraging, and led to financial losses due to babysitting costs and time off

work for themselves and their support people. Delays also led to reduced support for some victims because their support people could not, or did not want to, continue taking time off work to attend court when further delays were probable. Delays ultimately meant sacrifice of the victims' quality of life, at least until the cases were completed. As Holmstrom and Burgess (1983, p.154) stated, "As long as the justice process hangs over the victim's head, it is a disruption to the victim's life, a piece of unfinished business." It must be acknowledged that many of the problems that sexual offence victims experience in the justice system may not be objectively different from the problems other victims experience (Keating, 2001). However, victims of sexual offences and other types of interpersonal violence may be more adversely affected by delays and postponements as a result of the personal nature of the offences and the potentially more severe impact of the offences on their daily lives.[3]

It is generally during the lengthy interim period between reporting to police and going to trial, when victims first discover that they have become merely witnesses to a crime (Holmstrom & Burgess, 1983). Victims learn that criminal offences are legally prosecuted by the State, not the victims. They therefore find that they have little input into what happens to their case (Holmstrom & Burgess, 1983). Further, Holmstrom and Burgess observed that victims go through the trial process with very little support, since they do not have a legal representative (in the USA; also the case in Australia), and they do not have one particular person who knows everything about the case and keeps the victim informed. The Dublin report indicated that victims who had separate legal representation reported being more satisfied with the trial process than victims who did not have such representation (Dublin Rape Crisis Centre and School of Law Trinity College, 1998).

The experiences of victims attending court were described in detail by Holmstrom and Burgess (1983), and it appeared that many procedures outside of the actual courtroom led to immense distress for many victims. For example, victims described the court environment as intimidating, due to the hostile manner and threatening behaviour of the

[3] This is not to say that victims of less personally invasive offences, such as theft, are never as adversely affected as victims who experience sexual offences, rather that, on the whole, there is probably greater likelihood that victims of sexual offences will experience greater distress and disruption to their lives.

perpetrator and/or the perpetrator's family and friends. Victims were dissatisfied with having to wait in the court corridor (often with the perpetrator and the perpetrator's friends and family) and having an open court, which meant that members of the public could watch the trial (Holmstrom & Burgess, 1983).

Issues of respect for the victims were also raised in the sample of victims in Holmstrom and Burgess' (1983) research. It appeared that victims felt disrespected when the District Attorney (DA) spent only a short time preparing their cases. Holmstrom and Burgess observed that in some instances, the DA received the case only one hour before the hearing. Further, victims reported being made to feel as it *they* had committed a crime, rather than being the victims. This feeling may originate from the justice system's structural bias in favour of the defendant (Victorian Law Reform Commission, 2001), thereby translating into a system that is naturally biased against the victim. While the defendant remains innocent unless/until proven guilty, the victim necessarily remains wrong unless/until proven right. As a result of this bias, efforts to make the justice system therapeutic for victims may be difficult. Another example of disrespect involves court postponements. Postponements were reported by victims as even more discouraging and exhausting when they were not informed about it until arriving at court. Victims described taking a lot of energy to prepare emotionally for court, only to arrive at the court to find out that it had been postponed again. The experience of feeling let down was described by many victims in Burgess and Holmstrom's research.

Madigan and Gamble (1989) concur with many of the observations reported by Holmstrom and Burgess (1983) and even go so far as to say that the justice system constitutes a "second rape" for many victims. A prime example Madigan and Gamble give to illustrate this statement is the interviewing style of police officers towards victims. Some police officers have indicated to Madigan and Gamble that the victim's character and morals are as important in the investigation as the sexual offence incident itself.. These attitudes that some police bring with them to their interactions with victims can make victims feel humiliated and as though they are assaulted all over again. Madigan and Gamble further assert that police screen cases as legitimate or not, based on myths and stereotypes that only certain types of people can be sexually assaulted, rather than on objective issues. Other observations that Madigan and Gamble made that

are similar to those of Holmstrom and Burgess are that delays are common and wreck havoc in the life of the victim, and that not being told about court postponements until they arrived at court made victims feel let down.

Lees (1996) found that most women who had gone to trial as the victim of a sexual offence found their experience testifying humiliating and distressful. Many of these women had stated that it was distressing being limited to answering questions posed by the barristers and not being allowed to fully explain what had happened to them or how they felt during the sexual offence. The Law Reform Commission of Western Australia (1999, p. 7) agreed with Lees' observations when it stated, "The absurd insistence on a 'yes' or 'no' answer to a question has left many witnesses with a jaundiced view of the judicial process." Further, Allan (2001, p.5) suggested that, "the minimisation of the role of victims, by for example restricting what they can say in court, makes them feel alienated from criminal proceedings."

However, despite the numerous difficulties that victims reported about the justice system process in Holmstrom and Burgess' (1983) research, it was also clear that the justice system had the potential to be therapeutic. For example, it was found that Judges were able to add therapeutic value to a trial process with as little as a few words to victims. One Judge was observed to say to the victim, "We are grateful that you are willing to come to court" (Holmstrom & Burgess, 1983, p.160). Further, victims were typically pleased about the way the police had treated them upon reporting their sexual victimisation. It therefore appears that the personal manner of police is acceptable to some victims, but some of the processes and procedures in place (i.e., delays) are far from adequate (Holmstrom & Burgess, 1983).

Recommendations To Improve The Justice System Experience For Victims

Resulting from their in depth research with victims of sexual offences through the justice system, Holmstrom and Burgess (1983) put forth several recommendations with the aim of more respectful treatment of victims in the justice system process. First, victims should be assigned one specially trained person to deal with them from the beginning to the end of the process. The function of this person would be to accompany the victim to

various appointments with police, prosecutors, to trial, and he or she would also be responsible for keeping the victim informed regarding his or her case. Second, there should be systematic research to evaluate how the procedures in the justice system affect victims. Third, they argued that roles within the justice system need to be reconsidered. They suggested that if the justice system is truly adversarial in nature, then victims should also have the right to their own counsel, rather than just the defendant. Fourth, victims should be given more information, more explanations, and more advice from people working in the justice system. Fifth, victims should be given more privacy. For example, victims and their support people could have waiting rooms at court that are separate from the perpetrator, the perpetrator's family and friends, and other members of the public. Sixth, the police interviewing style should be altered to portray more respect for victims reporting sexual offences (i.e., less victim blame). Seventh, there should be better continuity of services for victims, particularly continuity of service *personnel.* For example, having one police officer and one prosecutor follow a victim's case from start to finish, rather than victims having to tell their stories over and over to new personnel. Eighth, the process should be shorter, with fewer delays. Ninth, earlier screening of cases by the DA's office, so that victims do not wait for several months assuming their cases will go to trial and then later told that their case will not go ahead.

It should be noted that many of these recommendations by Holmstrom and Burgess (1983), for example, better continuity of staff, less intimidating police interviewing styles, separating waiting rooms at court for victims, and keeping victims better informed, would not necessarily require any change to legislation and do not appear as if they would have any impact on defendants' rights.

As a further example of recommendations to make the justice system more therapeutic for victims, The Parliament of Victoria, Drugs and Crime Prevention Committee (1996) (hereafter referred to The Drugs and Crime Prevention Committee) in Australia recommended allowing victims the option to give their testimony by way of alternative arrangements such as closed-circuit television (CCTV). While pre-recorded evidence has been used in cases of children and adults in special circumstances, such as mental impairment, the Committee recommended an evaluation with the view of extending this procedure to all complainants of sexual offence, regardless of age or circumstance. The

Drugs and Crime Prevention Committee recommended that sexual offence victims be given the choice of alternative procedures for giving their testimony, in order to reduce the negative impact of giving evidence. The New Zealand Law Commission (1996) broadened the scope even further by recommending that all witnesses in criminal trials (sexual offences or otherwise) be given the option of pre-recording their evidence. The arguments in favour of such recommendations include reduced distress to the complainant, an increase in the accuracy of complainants' testimony (presumably due to reduced stress in giving testimony and/or decreasing memory loss over time), quicker resolution of cases, and an improvement of trial procedures (for example, inadmissible testimony can be edited out before the jury hears it).

Victim representation is another issue that has been raised with the view to making the justice system more therapeutic for victims (Holmstrom and Burgess, 1983; Victorian Law Reform Commission, 2001). At the present time, victims are not officially represented in Australia, rather, they are considered only as witnesses to the alleged offence. The potential benefit of having a victim representative is primarily that victims would be more informed of their rights, and consequently would have better practical access to exercising their rights (Victorian Law Reform Commission, 2001). Further, having such a representative is also thought to make the process less traumatic for victims (Victorian Law Reform Commission, 2001). Some European countries (i.e., Belgium) have already effected changes to provide victims with separate legal representation (Dublin Rape Crisis Centre and School of Law Trinity College, 1998), and as stated previously, this appears to have increased victims' satisfaction with the justice system.

Problem-oriented courts (also referred to as specialised courts) have also been a topical issue recently. The Victorian Law Reform Commission (2001) noted that problem-oriented courts are becoming more common in Australia, with drug courts in most States, and a domestic violence court in South Australia. Although sexual offence courts are slow to develop, the State of Florida in the US developed such a court in 2001 (Victorian Law Reform Commission, 2001). One main benefit of problem-oriented courts for sexual offences is that staff working within the court system develop high levels of understanding and expertise in dealing with particular victims. It appears that

the shift toward problem-oriented courts in many countries may result in sexual offence courts becoming more common.

What most of the recommendations seem to be suggesting is more respect for victims and the option for victims to be more involved in the process. To identify how victims might fit in the justice system better, a brief overview of the history of the Western criminal justice system and alternatives to the current justice system will now be discussed.

Models of Justice

In ancient Western history, crime was considered a harm done to victims and their families, in the context of their community (Van Ness & Heetderks Strong, 1997). The parties involved in dealing with crimes were the victims and their families, the offenders, the community, and the government. The goal was to repair the harm done and provide restitution to the various parties (Van Ness & Heetderks Strong, 1997).

The Norman invasion into Britain, however, signified an end to looking at crimes in this way (Van Ness & Heetderks Strong, 1997). This period saw the victim of crime removed from importance, with the King becoming the principal crime victim. Restitution was not paid to the victims anymore; instead, it was paid to the King in the form of fines (Van Ness & Heetderks Strong, 1997). This new model of justice included the King (as the government) and the offender as the only parties in dealing with the crime (Van Ness & Heetderks Strong, 1997). The emphasis was on the offender as a lawbreaker, and the importance of legal guilt and punishment was forefront. This *retributive model of justice* formed the basis of the current criminal justice system (Van Ness & Heetderks Strong, 1997).

Processes within the retributive model serve to reduce victims and offenders to passive participants; offenders have little incentive to become active in the process, and victims are relegated to the position of witnesses (Van Ness, 1996). Zehr (1990) points out that in the retributive justice system, crime is the violation of rules, where the State is the victim, and the parties involved are the State and the offender. By focussing on the

wrong done, this produces blameworthiness with guilt at the forefront. The wrongdoer is made to address the wrong done to the State by being punished by the State (Zehr, 1990). Punishment by the State serves to reinforce the State's power and authority and ignores the harm caused by the crime (Llewellyn & Howse, 1999). Within the retributive model are various sentencing philosophies that fluctuate. The main sentencing philosophies are just deserts, offender rehabilitation, victim rehabilitation, and victim rights (or victim participation) (Sebba, 2000).

The just deserts model of sentencing aims to punish the offender, based on the seriousness of the crime rather than the particular needs of the offender (Sebba, 2000). The seriousness of the crime is assessed by the amount of harm objectively seen to have been inflicted by the offender (Sebba, 2000). Therefore, this model does not view the victim in terms of the extent to which the victim suffered subjectively. However, the offender rehabilitation model of sentencing focusses on the particular needs of offenders with the ultimate aim of successfully integrating the offender back into society (Sebba, 2000). Due to the perception that the rehabilitation of offenders is largely unsuccessful, support for this model of sentencing is often inconsistent (Sebba, 2000). The victim rehabilitation model is a more recent development within the retributive system, whereby victims are allowed to submit Victim Impact Statements to the court (for the victims' own benefit), efforts are made to reduce the negative experience of the court (e.g., testimony by CCTV), and compensation and support services are provided to victims (Sebba, 2000). This model aims for a more positive outcome for victims, but victims do not have an active role in the legal decision-making. Developing in response to the victim rehabilitation model was the victim rights or victim participation model (Sebba, 2000). In this model, the victim is invited to be an active party in the process and the response to the offence is based, in part, on the subjective level of harm suffered by the victim (Sebba, 2000). The victim participation model is the closest model (within the retributive system) to resemble restorative justice, however, restorative justice moves far beyond simple victim rights since the aim of restorative justice is not retributive.

Restorative justice is an alternative to the current retributive system. However, it is not a new movement (Llewellyn & Howse, 1999). Perhaps ironically, restorative justice has many similar elements as the justice model of ancient history just described, where the

focus was repairing the harm done as a result of the crime (Van Ness & Heetderks Strong, 1997). Therefore, a move towards restorative justice is really a "return to the roots of justice" (Llewellyn & Howse, 1999, p.5). Zehr (1990, p. 181) described restorative justice in the following manner: "Crime is a violation of people and relationships. It creates obligations to make things right. Justice involves the victim, the offender, and the community in a search for solutions which promote repair, reconciliation, and reassurance." In this way, all parties are encouraged to play an active role in the restoring process. Whereas the retributive justice model views crime as a violation of rules, the restorative justice model views crime as a harm done to victims and the wider community (including the offender) (Zehr, 1990). Whereas the retributive model views punishment as the outcome to the wrong, the restorative justice model views the outcome as a process of problem-solving. The problem-solving process leads to the offenders taking responsibility for their actions and the (re)establishment of social equality (Llewellyn & Howse, 1999).

Ashworth (2000) pointed out that there are three aims of *restorative justice*. First, restorative justice has a goal of restoring the victim with efforts made by the offender, such as an apology or compensation of some kind. Second, restorative justice also aims to restore the wider community. Third, restorative justice allows participation of the victim in the process in order to help determine the response to the offence.

Typically, efforts in restorative justice have developed into victim-offender mediation (Goodey, 2000), where the mediator, the offender, the victim, and usually other people such as family members of the offender or victim, or other community members, sit face to face to discuss the impact of the offence upon the victim, and to identify ways to restore justice to the victim. The offender accepts responsibility for the harm caused to the victim as a result of the offence (Morris & Maxwell, 2000), and there are opportunities for the offender to apologise to the victim. The victim can gain some understanding of what happened and why the offence occurred (Morris & Maxwell, 2000). A high level of satisfaction has been reported by victims and offenders in restorative justice programs in Australia (Victorian Law Reform Commission, 2001). Erez (1990; 2000) and Wexler and Winnick (1996) suggest that participation and input into the process (i.e., having a *voice*) can be therapeutic for the victim. The procedural

justice literature suggests that victim participation in the process will provide victims with *process control* (Tyler, 1988), which will enhance their satisfaction with the justice system, regardless of the objective outcome (Lind & Tyler, 1988).

From a therapeutic jurisprudence perspective, victim input will not only be helpful to the victim, but to the offender as well (Erez, 2000). Victim input should help offenders form a better understanding of the impact of their actions upon their victims (Wexler, 1996). On this premise, it is suggested that increased empathy of the victim's situation should promote better rehabilitation of the offender.

However, since most restorative justice programs have been used in cases of less serious offences than sexual offences (Victorian Law Reform Commission, 2001), it is unknown how such schemes would fare with victims of more serious crimes involving interpersonal violence such as sexual offences. Since ongoing fear and anxiety have been reported as long-lasting effects of sexual offences (Steketee & Foa, 1987), it cannot be assumed that victims of sexual offences would be as enthusiastic about participating in restorative justice processes and facing their perpetrators (Crawford & Goodey, 2000).

However, Young (2000) noted that traditional views of restorative justice (i.e., face to face mediation) are generally only applied to minor offences, when in reality it is the victims of more serious offences, such as sexual offences, who need restoration the most. Therefore, looking at restorative justice in a broader manner may be beneficial. Indeed, as Young points out, the meaning of restorative justice has typically been applied in a manner that is too narrow and therefore restrictive. For example, restorative justice processes do not necessarily have to entail the victim meeting face to face with the offender. Looking at restorative justice in a broader manner and identifying ways to restore justice to victims in sexual offences represents a challenge to those working in the justice system. However, it also appears imperative that if the goal is to restore justice to victims, research must start to examine what *justice* actually means to the victims themselves.

CHAPTER 3

The Psychological Impact Of Sexual Victimisation And Subsequent Clinical Management

The Psychological Impact of Sexual Victimisation

A review of the available research reveals that there is no set of symptoms that every victim experiences (Frazier, 1991; Weaver & Clum, 1995). Having said this, the research is also clear that there are several complex emotional, cognitive, social, and behavioural effects of sexual victimisation that have been found to be extremely common in many, but not all, victims of sexual offences (MacMillan et al., 2001; Resick, 1993). The aim of this chapter is to provide a concise summary of these effects. A more comprehensive evaluation of the effects of sexual victimisation is beyond the scope of this chapter, but can be found in the work of Dinwiddie and colleagues (2000), Mullen and colleagues (1996), MacMillan and colleagues (2001), and Resick (1993). For the purpose of clarity, the effects of *adult* sexual victimisation will be discussed in terms of immediate (less than 2 weeks post-offence), short-term (between 2 weeks and 1 year post-offence), and longer-term (more than 1 year post-offence) effects. In contrast to adult offences, *childhood* sexual offences are not easily described using these three time periods since immediate and short-term effects are largely understudied. (Due to the nature of the crime, victims of childhood offences are often not identified until years after the offences have ceased.) However, a substantial amount of research has reported the long-term effects of childhood sexual offences, and it is these effects that will be described here.

Sexual Victimisation In Childhood

Identifying the negative effects associated with childhood sexual abuse is difficult because child sexual abuse often occurs in the context of a negative family environment in general (e.g., parental substance use problems) (e.g. Rind, Tromovitch, & Bauserman, 1998). That is, the negative consequences of sexual abuse may be due to the negative family environment, and sexual abuse may be merely one example of that environment. However, research by Higgins and McCabe (2000) found evidence that experiencing child sexual abuse provides a substantial degree of long-term negative consequences on its own, that is, even when family environment is controlled. Twin studies have also found that a significant relationship between child sexual abuse and psychopathology still remains even after family environment is controlled (Dinwiddie et al., 2000; Nelson et al., 2002).

Common differences found between people in community samples who have been sexually abused as children and those who have not been sexually abused as children include a higher incidence of depression, anxiety, eating disorders, substance use problems, self-harm behaviours, suicidal ideation, and suicide attempts among child sexual abuse victims (Davidson, Hughes, George, & Blazer, 1996; Mullen et al., 1996; Romans, Martin, Anderson, Herbison, & Mullen, 1995). Specifically, Romans and colleagues found that 8.7% of sexually abused female participants reported deliberate self-harm behaviours, compared to only 0.4% of non-abused female participants. Molnar, Berkman, and Buka (2001) also reported increased rates of suicide attempts in sexual abuse victims. They found that the odds of suicide attempts were 2 to 4 times higher for female victims, and 4 to 11 times higher for male victims, compared to their non-abused counterparts. Other reported effects of child sexual abuse include relationship problems (Finkelhor, Hotaling, Lewis, & Smith, 1989; Gibson & Hartshorne, 1996; McCarthy & Taylor, 1999), feelings of isolation and stigma (Coffey, Leitenberg, Henning, Turner, & Bennett, 1996), poor self-esteem and difficulty trusting others (Cole & Putnam, 1992; Mullen et al., 1996), sexual problems (Mullen et al., 1996), more self-reported health symptoms, and more self-reported doctors visits (Newman et al., 2000). Further, a study of twins reported a higher prevalence of depression, conduct disorder, panic disorder, alcoholism, suicidal ideation, and suicide

attempts in twins who reported child sexual abuse history, compared with their non-abused co-twins (Dinwiddie et al., 2000).

There is some suggestion in the research literature that the relationship between child sexual abuse and psychopathology is stronger for women than for men. In their community study in Canada, MacMillan and colleagues (2001) found that women with a history of child sexual abuse had higher rates of anxiety disorders, major depressive disorder, substance use disorders, and antisocial behaviour, than women without a history of child sexual abuse. For men, only alcohol dependence was significantly more prevalent in men with a history of child sexual abuse than men without a history of child sexual abuse. More research comparing the impact of sexual victimisation on men and women is needed to determine whether differentiation of treatment approaches for male and female victims is warranted.

The pathways from childhood sexual abuse to the damaging effects are hypothesised to occur in a number of potential ways. Childhood sexual abuse appears to result in a loss of self-regulation ability, perhaps as a result of *splitting* from emotions to survive the abuse. This appears to leave people less able to regulate the intensity of their emotions (Van der Kolk & Fisler, 1994). This reduction in self-regulation ability may result in aggression against other people, or self-destructive behaviours, including eating disorders and substance use problems (Van der Kolk & Fisler, 1994).

Another hypothesised pathway from childhood sexual abuse to the damaging consequences is through the changes in the body's biological make-up (De Bellis & Putnam, 1994). People who have experienced chronic psychological trauma tend to show differences in their endogenous opioid systems compared to people who have not experienced chronic trauma (Van der Kolk & Fisler, 1994). These differences may lead victimised people to deal with future stress in a different, less effective manner. Indeed, coping strategies including substance use, self-hann, and eating disordered behaviours are not uncommon amongst sexually victimised populations (Romans et al., 1995). These chemical differences also appear to lead to increased vulnerability to other problems such as depression (Weiss, Longhurst, & Mazure, 1999).

Effects such as shame and reduced self-esteem may develop as a result of the nature of sexual abuse and the secrecy that often surrounds it. For example, perpetrators often tell their victims that they (the victims) are to blame for the abuse (Cruz & Essen, 1994). Societal reactions to sexual abuse, such as reluctance to discuss the issue, may also contribute to the sense of shame and lower self-worth that sexually victimised individuals often report experiencing (Ward, 1995).

Sexual Victimisation In Adulthood

While it may appear logical that there would be a difference of impact on people who have experienced a *completed* sexual assault compared to people who have experienced an *attempted* sexual assault, there is evidence that contradicts this view. For example, Becker and colleagues' (1982) research found that completed and attempted rape victims did not reveal differing levels of psychopathology in the immediate or short-term periods (up to a year post-offence). However, they did note that victims of attempted rape engaged in more safety-assuring behaviours than victims of completed rape (e.g., learning self-defence, changing locks). It is suggested that perhaps the victims of completed rape felt more helpless than those who managed to escape from a completed rape, and therefore felt less able to take measures to increase their safety.

Immediate effects (less than 2 weeks post-offence).

Victims reporting high levels of posttraumatic stress symptomatology at one week post-offence are generally considered within the *normal* range of responding to a traumatic event. Indeed, Rothbaum and colleagues (1992) reported that almost all victims exhibited posttraumatic stress symptomatology at one-week post-offence. Further, over 55% of victims of sexual assault in Becker and colleagues' (1982) study reported fear, anger, embarrassment, humiliation, sleep difficulties, and gastro-intestinal irritability. While only a quarter of the victims in their study felt self-blame regarding the offence, other studies have reported much higher levels of self-blame (e.g. Frazier, 1990; Mezey & Taylor, 1988). Self-esteem is also often reduced after experiencing a sexual offence (Mezey & Taylor, 1988). Lastly, depressive symptomatology is extremely common immediately post-offence: All victims in Mezey and Taylor's research were considered either moderately or severely depressed in the immediate period after the offence.

Short-term effects (2 weeks to one year post-offence).

Rothbaum and colleagues (1992) reported that 65% of victims met the criteria for Posttraumatic Stress Disorder (PTSD) at 1 month post-offence, and this number decreased to 47% at 3 months post-offence. They also noted that those who had not improved by the 3-month assessment period tended to develop chronic PTSD symptoms. Therefore, it appears that the first 3 months may form the crucial period in the development of chronic PTSD after experiencing a sexual offence and consequently may be a critical period for intervention. Further, although almost all victims of sexual offences exhibited posttraumatic stress symptomatology in the immediate phase, more than half of victims' symptoms subsided substantially by the 3-month assessment point. Frazier, Conlon, and Glaser (2001) found similar results: 63% of the victim sample met criteria for PTSD at 2 months, whereas only 48% met the criteria at 12 months post-offence.

At one-year post-offence, over 45% of Becker and colleagues' (1982) sample still reported a fear of people behind them, sexual problems, and nightmares, while over 75% still had fears regarding crowds, being outdoors, being indoors, or being alone. Steketee and Foa (1987) reported that while depression in their sample subsided within the 3 month period post-offence, anxiety and fear persisted. Indeed, there is no shortage of research evidence to suggest that depression may be a relatively short-term problem amongst victims of sexual offences, compared to anxiety and fear (e.g. Kilpatrick, Veronen, & Resick, 1979; Mezey & Taylor, 1988). However, Nadelson, Notman, Zackman, and Gornick (1982) reported that 41% of their sample still reported episodes of depression related to the rape 15-30 months post-rape. Further, Ellis, Atkeson, and Calhoun (1981) found significantly more depression in sexual offence victims 3 years post-offence, compared to non-victim controls. As such, the evidence regarding depression is inconclusive as to the long-term course.

Longer-term effects (more than one year post-offence).

Research into the long-term effects of sexual assault is relatively uncommon; most research in the sexual assault field has focussed on the immediate and short-term periods. Nonetheless, research that has examined long-term effects has produced interesting results. Long-term effects are extremely varied and include startle-reflex

abnormalities (Morgan, Grillon, Lubin, & Southwick, 1997), reduced self-esteem (Resick, Jordan, Girelli, Hutter, & Marhoefer-Dvorak, 1988), suicide attempts (Davidson et al., 1996), sexual problems (Van Berlo & Ensink, 2000), fear and anxiety (Resick, 1993), and guilt and shame (Doyle & Thornton, 2002).

One finding that is consistent in the literature is that significant symptomatology remains in many victims of sexual offences, even several years post-offence. Cohen and Roth's (1987) study examined current psychological functioning in 72 victims of rape whose offences were an average of 8 years ago. It was found that over 50% of the sample were revealed to fit the *caseness* criteria on the Symptom Checklist-90-Revised (SCL-90-R), meaning that they displayed a significant level of psychological distress across several indices. Further, the level of symptomatology was generally unrelated to the length of time since the offence, providing further support for the suggestion that there is little improvement in symptomatology over longer-periods of time.

Revictimisation

As defined in Chapter 1, revictimisation in this thesis refers to sexual victimisation in childhood and again in adulthood. The effects of revictimisation have been researched quite extensively in recent years, and the findings are consistent that revictimisation is associated with poorer psychological functioning on a number of measures, compared to experiencing sexual victimisation in either childhood or adulthood alone (Arata, 2002). For instance, Murphy and colleagues (1988) found that revictimised women reported higher levels of general distress on the SCL-90-R, as well as higher levels of somatisation, obsessive-compulsivity, depression, anxiety, hostility, and interpersonal sensitivity, compared to non-revictimised women. Further, Gidycz and colleagues (1993) found that revictimised women indicated higher levels of depression and anxiety than nonrevictimised women. PTSD and dissociation have also been found to be more prevalent in people who have been revictimised compared to non-revictimised individuals (Arata, 2002).

Addressing The Negative Consequences Of Sexual Offences In Clinical Practice

Although there is plenty of literature covering aspects relating to the *impact* of sexual offences (e.g. Dinwiddie et al., 2000; MacMillan et al., 2001; Mullen et al., 1996; Resick, 1993), there is less material available to guide the clinician in dealing therapeutically with people who have been sexually victimised. As Cruz and Essen (1994, p.xiv) stated, "The mental health profession is surprisingly ill-equipped to deal effectively with this pervasive problem. There are very few treatment guidelines that clinicians can use as a comprehensive tool." Four books published in recent years will be reviewed here for the purpose of providing the context of current clinical practice in the field of sexual victimisation. This review can be used to compare what is currently happening in clinical practice to what should be happening on the basis of the research findings discussed later.

The four books that will be reviewed here are Koss and Harvey (1991), Paludi (1999), Cruz and Essen (1994), and a book edited by Petrak and Hedge (2002). Koss and Harvey (1991), Paludi (1999) and Cruz and Essen (1994) were the most recent treatment-oriented books found in a medium-sized Canadian University library. Unfortunately they consist of only very brief explanations of what clinicians should do in practice. Petrak and Hedge's (2002) book was the only sexual victimisation treatment-oriented book in the bookstore at the same University. It is much more comprehensive than the first three books. There was no literature on childhood or adulthood sexual victimisation available in an urban retail bookstore in the same city as the University. These four books were chosen on the basis of what clinicians who are hoping to treat sexual offence victims might find in their search for guidance in this area of clinical practice. Since these are the best resources found among a university library, university bookstore, and retail bookstore, one might expect these four resources to be as much as what would be readily available to clinicians treating sexual offence victims specifically. However, it is acknowledged that there are numerous other, more general, clinical materials that may be useful in treating people who have been sexually victimised, but it is beyond the scope of this study to review those generalised materials.

Koss and Harvey (1991) outlined six steps that need to be taken to move from being a *victim* to a *survivor*. First, clients need to have control over their memories and the remembering process, rather than being controlled by their memories. Second, integration of the memory and feelings needs to occur. Third, clients need to be able to tolerate the feelings attached to the offence. Fourth, symptoms such as anxiety, depression, and sexual dysfunction need to be dealt with so that they are more tolerable to clients. Fifth, clients need to be reconnected with others and have the capacity for relationships. Sixth, clients need to assign a tolerable meaning to the offence and to the self as a survivor. After going through these steps, signs of recovery should be noticed, including improved self-esteem, and being able to hold the perpetrator responsible for the offence rather than having feelings of self-blame.

Paludi (1999) proposed that there are four general modalities for treating adults who were sexually abused as children. The first modality is anxiety management training. This modality includes techniques such as progressive muscle relaxation, deep breathing, verbal cueing, and metaphoric imagery. The second modality is the identification of feelings and salient therapeutic issues. *Control issues* were identified as potentially important issues to work on, but there was no guidance in terms of the specific aspects of control the clinician might address, or indeed how to approach working with control issues. The third modality is the ventilation and assimilation of affective issues. The fourth and final modality is the resolution of behavioural issues, such as sexuality and relationship difficulties.

Cruz and Essen's (1994) book provided the following goals of therapy with adults who have been sexually abused in childhood: decrease cognitive distortions, self-blame, and affective responses, and increase self-esteem and level of functioning. Unfortunately, level of functioning was not further defined. The strategies recommended to achieve the above mentioned goals are to refocus the blame for the abuse onto the perpetrator, depathologise the client's symptoms (reframe the symptoms as understandable reactions to abuse), and normalise the client's feelings. Other issues that are identified as potential target areas are body-image, relationship building skills and intimacy issues, sexuality issues and sex education, parenting information and skills, communication skills, boundary and limit-setting skills, and problem-solving and decision-making skills. They

further suggest that the client needs to grieve the losses of the trauma, losses such as childhood spirit and educational achievements. Many other suggestions discussed in Cruz and Essen's book deal with developing a positive therapeutic relationship with the client.

In Petrak and Hedge's (2002) book, the following issues were suggested by Naugle, Resnick, Gray, and Acierno (2002) as issues to focus on in counselling: anxiety management, problematic cognitions (typically involving safety, trust, power, esteem, and intimacy), and ineffective behaviours, such as avoidance of anxiety provoking situations. Various treatment modalities for dealing with the focus areas were provided and include progressive muscle relaxation, breathing control skills, and exposure therapy for addressing anxiety management, cognitive restructuring and guided self-talk for addressing problematic cognitions, and role playing and covert modeling for addressing ineffective behaviours.

In another chapter in Petrak and Hedge's (2002) book, Kennerley concluded, as a result of factor analysis, that common beliefs and assumptions held by victims of childhood sexual abuse about themselves fell into five clusters: badness, helplessness, uncleanness, being a misfit, and being nothing. These areas provide focus areas on which to focus in counselling. Kennerley (2002) also asserted that clinicians working therapeutically with victims of sexual offences must work with the client's subjective experience of the offence, rather than the objective characteristics of the offence. For instance, a victim who was subjected to penetration will not necessarily suffer more psychological harm or perceive the offence in a more devastating manner than a victim who was not subjected to penetration.

The paucity of literature to guide the clinician in dealing with male victims of sexual offences is strikingly evident. In Petrak and Hedge's (2002) book, Bennice and Resick (p. 69) stated that "therapy procedures that have been developed and assessed for female sexual assault survivors should be considered for male clients as well" but they failed to give a reason or any evidence for making the assumption that the needs of male and female victims of sexual offences are the same.

In conclusion, it appears that there is little in the way of literature to guide clinicians working with victims of sexual offences. While some general areas have been identified as targets for intervention (e.g. control issues), clinicians appear to be largely left to develop their own theories and strategies in dealing with victims of sexual offences, with little evidence from research.

CHAPTER 4

Predicting Psychological Functioning In People Who Have Experienced Sexual Offences

While the impact of sexual offences on victims described in the previous chapter is a vital area of research, there is a need for research to progress beyond this point to provide better guidance to clinicians. Merely studying the effects of sexual offences will not provide enough information for clinicians to effectively advance the therapeutic process for victims who seek professional assistance, nor will it provide enough information with which to make the justice system a more therapeutic process for victims.

Researchers in the sexual victimisation field (e.g. Frazier & Schauben, 1994) have called for examinations into modifiable factors to improve victims' psychological functioning after sexual offences. Although these researchers do not refer to these modifiable factors as *dynamic factors* as such, it would appear that this is an appropriate term to use. This would follow the tradition of the offender rehabilitation field in forensic psychology whereby factors examined for their influence on outcomes are often classified as *dynamic* or *static*, depending on whether they are generally modifiable or unmodifiable, respectively (Hanson & Harris, 2000; Webster, Hucker, & Bloom, 2002). By adopting these terms and therefore also the approach, it permits a systematic approach to examining predictors of outcome, which becomes useful when looking for areas in which to intervene after sexual victimisation. Researchers need to identify ways of reducing the damaging consequences of sexual offences. If research is able to determine the factors that predict better or worse psychological functioning, clinicians will be better able to focus their interventions on these priority areas. In this way, the therapeutic process can be improved for victims of sexual offences. This chapter will provide a review of the research with regard to prediction of psychological functioning

following sexual offences, and in doing so, it will also identify some limitations in the research to date.

This chapter is structured into three main parts: 1) Research with static factors as predictors; 2) Research with dynamic factors as predictors; and 3) The relative importance of static and dynamic factors.

Research With Static Factors As Predictors

Static factors commonly referred to in the research literature with respect to sexual victimisation include victims' demographic information (e.g., gender, age), victim-offence characteristics (e.g., age of victim at time of offence, whether the victim reported the offence to police), and offence details (e.g., offence severity, which is often discussed in terms of the level of force used by the perpetrator, the nature of the acts such as whether intercourse occurred, presence of a weapon, and level of injury to the victim) (e.g. Cohen & Roth, 1987; Dumnore, Clark, & Ehlers, 1999; Weaver & Clum, 1995).

On one hand, some research has found evidence of a link between poorer psychological functioning and static factors including offence severity in samples predominantly consisting of female community members (e.g. Cohen & Roth, 1987; Ellis et al., 1981; Wyatt, Notgrass, & Newcomb, 1990), length of time since the offence in a meta-analytic study of predominantly clinical samples (Weaver & Clum, 1995), history of justice system involvement in a sample accessed through police and hospital services (Dunmore et al., 1999) and socioeconomic status of the victim in a sample of community members (Cohen & Roth, 1987). On the other hand, there is also research that showed no consistent evidence of a link between psychological functioning and several static variables in samples recruited primarily from clinical, college, and navy sources. These variables include offence severity (e.g. Dunmore et al., 1999; Frazier, 1991; Gold, Milan, Mayall, & Johnson, 1994; Merrill, Thomsen, Sinclair, Gold, & Milner, 2001), gender (Briere, Evans, Runtz, & Wall, 1988; Oddone Paolucci, Genuis, & Violato, 2001), socioeconomic status of the victim (Oddone Paolucci et al., 2001), length of time since offence (Cohen & Roth, 1987; Dunmore et al., 1999), age at time of offence

(Oddone Paolucci et al., 2001) and relationship to perpetrator (Dunmore et al., 1999). These inconsistent findings cast doubt on the sort of conclusion that can be made in terms of the degree to which static variables surrounding sexual victimisation are associated with psychological functioning.

While the research with static predictor variables provided a good base from which to initiate empirical study in the area of sexual victimisation, the need to study dynamic predictor variables eventually arose in the hope of being able to therapeutically intervene in the coping process of victims of sexual offences.

Research With Dynamic Factors As Predictors

Research with dynamic predictor variables has provided valuable insight into coping processes in the general population, and some of these predictors have also been examined in the coping processes of victims of sexual offences. The main dynamic variables in the literature are as follows: specific attributions for the sexual offence, general attributional styles, coping strategies, perceived control, social support, and searching for meaning (rumination) (e.g. Frazier, 1990; O'Neill & Kerig, 2000; Regehr et al., 1998; Tangney, Wagner, & Gramzow, 1992; Ullman, 1996; Ullman, 1997).

Specific Attributions

The explanations of the cause of a behaviour or event are referred to as attributions, and they have been shown to affect one's emotions, cognitions, and future behaviour (Weiner, 1979; 1986). Kübler-Ross (1969) examined instances where people had personally experienced negative events and she concluded that people appear to need to explain the reasons for the events' occurrence. This view is consistent with that of Pennebaker (1997) who suggested that this need to explain events is a manifestation of people's basic need to achieve closure.

Kübler-Ross (1969) also observed that people's need to make some sense of events is so strong that they will sometimes blame themselves rather than not having any reason at all. This claim is consistent with the previously noted findings that self-blame after sexual victimisation is common (Frazier, 1990; Meyer & Taylor, 1986). In one way

self-blame appears to be functional in that people's belief in a just and predictable world can be maintained (Kübler-Ross, 1969). However, Lefcourt (1976) suggested that self-blame is not always functional and may only exacerbate any negative perceptions of the self and contribute to the lack of a sense of control the person may already be feeling. This may especially be the case regarding sexual offence victimisation, as victims who blame themselves (i.e., I shouldn't have walked alone) may develop lower self-esteem (Hoagwood, 1990) and other negative consequences compared to victims who attribute the sexual offence to bad luck (i.e., being in the wrong place at the wrong time). Indeed, Meyer and Taylor (1986) found in a sample of recent sexual assault victims recruited from a rape crisis centre, that self-blame was associated with increased post-assault depression, whereas societal blame was not associated with psychological functioning. The finding that self-blame attributions in sexual assault victims are harmful to adjustment has been supported in other research with female college students (e.g. Arata, 1999). However, a distinction between two types of self-blame is crucial in understanding the role of self-blame in the therapeutic process.

Blaming oneself for negative situations can take the form of guilt or shame (Tangney, 1990). The terms guilt and shame are sometimes used interchangeably, however objectively they have quite distinct meanings (Niedenthal, Tangney, & Gavanski, 1994). Guilt refers to self-blame due to some perceived *behavioural error*, whereas shame refers to self-blame due to perceived *characterological flaw* (Tangney et al., 1992). While guilt focusses on one's own behaviour and perceives some wrong action, shame focuses on one's own character and perceives a flawed, defective, or inferior person. Guilt and shame regarding a sexual offence are often also commonly referred to as behavioural self-blame and characterological self-blame, respectively (Janoff-Bulman, 1979).

Janoff-Bulman (1979) was among the first to hypothesise about the differential impact of characterological and behavioural self-blame in sexual offence victims. She hypothesised that while characterological self-blame would be harmful, behavioural self-blame would be adaptive because of the modifiable nature of behaviour, as opposed to the relatively unmodifiable nature of one's character. That is, if victims blame their behaviour for the sexual offence, they would be able to prevent future offences by

modifying their behaviour (e.g., not walking alone at night, not being so trusting of people). In this hypothesis, it appears that having a sense of control about the avoidability of future sexual offences is assumed to lead to better adjustment.

In testing the basic hypothesis that characterological self-blame is harmful whereas behavioural self-blame is adaptive, the relationship between these two types of self-blame and psychological functioning in victims of sexual offences has been investigated by several researchers. Research is quite consistent in reporting that characterological self-blame appears harmful to the therapeutic process. Specifically, in samples consisting almost exclusively of female clients of sexual assault centres and shelters for abused women, characterological self-blame has been associated with depression (Frazier, 1990; Meyer & Taylor, 1986; O'Neill & Kerig, 2000; Regehr et al., 1998), fear (Meyer & Taylor, 1986), and obsessive compulsivity (O'Neill & Kerig, 2000). Further, characterological self-blame was related to global distress consisting of general psychopathology, social maladjustment, posttraumatic stress symptoms, and physical symptoms in a sample of female university and medical centre staff (Koss, Figueredo, & Prince, 2002).

However, inconsistency in the research lies in the association between behavioural self-blame and psychological functioning. While some studies found no evidence of any sort of association between behavioural self-blame and psychological functioning in samples consisting primarily of female sexual assault centre clients and college students (Hill & Zautra, 1989; Regehr et al., 1998), other studies with similar samples found behavioural self-blame to have a detrimental effect on psychological functioning (Frazier, 1990; Meyer & Taylor, 1986; O'Neill & Kerig, 2000), and yet elsewhere it has even been associated with positive psychological functioning in a sample of female university and medical centre staff (Koss et al., 2002).

Clearly, the research evidence to date supports the part of Janoff-Bulman's (1979) hypothesis that proposes that characterological self-blame is harmful in sexual offence victims. However, there is no consistent evidence to suggest that behavioural self-blame is any more adaptive than characterological self-blame, and indeed some research has shown that it is just as harmful.

General Attributional Styles

In contrast to specific attributions, general attributional styles are personality characteristics or tendencies to attribute negative events to particular sources (Alexander, Brewin, Vearnals, Wolff, & Leff, 1999; Tangney, 1991). In this way, having a tendency to attribute negative occurrences to one's own character would be thought of as displaying a certain amount of shame-proneness (Tangney et al., 1992). Likewise, having a tendency to attribute negative occurrences to one's own behaviour would be thought of as displaying a certain amount of guilt-proneness (Tangney et al., 1992).

Just as specific attributions for sexual offences have been studied for their relationship to psychological functioning, so too have general attributional styles. However, to the present researcher's knowledge, the general attributional styles of shame-proneness and guilt-proneness have not been examined in sexual offence victims specifically. Therefore, research that examines these general attributional styles in the general population will be discussed here to provide a basis for studying these concepts in sexual offence victims. Since guilt-proneness and shame-proneness are consistently inter-correlated (Tangney, 1991; Tangney et al., 1992), examinations of association of one variable with psychological functioning should be analysed whilst controlling for the other variable. Even so, the research findings have been inconsistent.

Some research has found that both guilt-proneness and shame-proneness are related to poorer psychological functioning. For example, Harder, Cutler, and Rockart (1992) measured psychological distress in college students with the Symptom Checklist-90 (SCL-90) and found that shame-proneness (with guilt-proneness controlled for) was associated with global distress severity, depression, obsessive-compulsiveness, interpersonal sensitivity, phobic anxiety, and psychoticism. Guilt-proneness (with shame-proneness controlled for) was associated with global distress severity, somatisation, interpersonal sensitivity, anxiety, hostility-anger, and psychoticism.

On the other hand, other research with college students has found that only shame-proneness is consistently related to poorer psychological functioning. For example, in Tangney, Wagner, and Gramzow's (1992) study, shame-proneness (with guilt-proneness

controlled for) was positively related to all scales of the SCL-90, as well as other scales that measured depression and anxiety. Guilt-proneness (*without* controlling for shame-proneness) was also related to several scales of the SCL-90, as well as depression and anxiety, however, when shame-proneness was controlled for, guilt-proneness was no longer associated with any negative outcomes on any of the measures. This finding suggests that guilt may only be harmful when it is fused with shame, but more research is necessary to draw firmer conclusions.

These findings clearly indicate a need for more research into the relationship between the general attributional styles of shame-proneness and guilt-proneness and psychological functioning in the general population. However, there also exists a need to assess the relationship between these general attributional styles specifically amongst people who have experienced sexual victimisation, given the interesting findings to date about the relationship between specific attributions for sexual offences and psychological functioning, as described earlier (Frazier, 1990; Koss et al., 2002; Meyer & Taylor, 1986; O'Neill & Kerig, 2000). Since self-blame was shown to be common amongst victims of sexual offences recruited from sexual assault centres and police services (Frazier, 1990; Mezey & Taylor, 1988), the general attributional styles of shame-proneness and guilt-proneness may be particularly salient features to examine in the therapeutic process of sexual offence victims.

Coping Strategies

It makes intuitive sense that the way in which people cope with adverse events would affect their adjustment to those events, and indeed, there is no shortage of research evidence to demonstrate the impact of coping strategies on adjustment (e.g. Arata & Burkhart, 1998; Conway & Terry, 1992; Meyer & Taylor, 1986; Tix & Frazier, 1998).

There are several ways of classifying coping strategies into categories. Two main methods distinguish between problem-focussed and emotion-focussed coping (Folkman & Lazarus, 1985) and approach and avoidance coping (Cohen & Roth, 1987). As the names suggest, approach coping refers to coping activities that are oriented toward the problem, whereas avoidance coping refers to coping activities that are oriented away from the problem (Cohen & Roth, 1987). Problem-focussed coping is described as

dealing directly with the adverse issues in trying to improve the problem situation itself, whereas emotion-focussed coping is described as focussing on the emotions resulting from the adverse event, but not actually making efforts to improve the objective situation (Folkman & Lazarus, 1985). Numerous studies in various areas have been conducted to identify which coping strategies are more therapeutic than others (Charlton & Thompson, 1996; Collins, Baum, & Singer, 1983; Solomon, Mikulincer, & Benbenishty, 1989).

Solomon, Mikulincer, and Benbenishty (1989) found that emotion-focussed coping strategies were related to increased number of PTSD symptoms among soldiers. Similarly, Charlton and Thompson (1996) found that emotion-focussed coping after trauma (compared to problem-focussed coping) was related to higher distress measured by the SCL-90. From these studies, problem-focussed coping strategies appear more effective in dealing with adverse situations than emotion-focussed strategies. However, Collins, Baum, and Singer (1983) found that problem-focussed coping strategies actually led to more distress when there was no solution to the problem. Nonetheless, these findings indicate that problem-focussed coping may be effective in many circumstances but not all. On another level, approach coping may be more useful than avoidance coping, the latter of which has been associated with anxiety and depression (e.g. Coyne, Aldwin, & Lazarus, 1981) and psychosomatic symptoms (e.g. Benner, 1984).

In victims of sexual offences, a similar picture has evolved. Meyer and Taylor (1986) conducted a study of female rape crisis centre clients who had been raped in the two years before the study (average of 4 months) and found that the victims who made specific efforts to reduce stress (i.e., meditation) were less likely to report depression and fear. Further, staying home and using other types of withdrawal coping strategies were related to more depression and fear. This finding suggests that approach-oriented strategies may be more therapeutic than avoidance-oriented strategies. Similarly, in a study of female community members, Cohen and Roth (1987) found approach strategies to be less harmful to adjustment after rape than avoidance strategies, in their sample of women who had been raped an average of eight years before the study. Similar results eventuated in a sample of female navy recruits who had been sexually abused as

children (Merrill et al., 2001), as approach coping strategies (which they referred to as constructive strategies) were associated with decreased symptoms, while self-destructive strategies (i.e., drinking a lot) and avoidance strategies (i.e., slept a lot and tried not to think about it) were strongly related to increased symptomatology.

These findings together suggest that approach strategies may be more helpful than avoidance strategies. However, the victims in these studies were far beyond the immediate post-offence period. Suls and Fletcher (1985) suggested that avoidance coping may actually be effective when the threat is short-term or unavoidable. Similarly, Lyons (1991) argued that in the initial stages of the coping process, avoidance can be functional. Research evidence, however, has demonstrated that even in the immediate post-offence period, avoidance strategies were still associated with higher levels of symptomatology in a sample of sexual assault centre clients (Frazier & Burnett, 1994).

The research in the sexual victimisation field thus far has provided a useful base from which to examine coping strategies in sexual offence victims. It appears, however, that investigating coping by looking only at dichotomous variables (i.e., approach-avoidance) may be too simplistic in what appears to be a complex process. It is therefore suggested that research needs to take a broader approach to assessing the impact of coping strategies on psychological functioning after sexual victimisation. This would entail breaking coping strategies down into more categories to examine the differential impact of each category on psychological functioning. Frydenberg and Lewis (1997) provide an example of how to break down coping strategies in their Coping Scale for Adults: dealing directly with the problem, nonproductive coping (e.g., drinking alcohol), sharing, and optimism.

Perceived Control

The term "locus of control" was coined by Rotter (1966), referring to an attitude, belief, or expectancy about the influence of one's own actions on events in their lives. People were described as having an internal locus of control if they believed that reinforcements they received were based largely on their own actions (Rotter, 1966). On the other hand, people who believed that reinforcements they received were based on factors out of their control, such as chance, luck, and fate, were described as having an external locus of

control (Rotter, 1966). People were therefore classified along the internal-external continuum.

Since then, several other terms such as personal control (Cooper, Okamura, & McNeil, 1995), perceived control (Rector & Roger, 1986), and control expectancies (Solomon et al., 1989), have been used to illustrate and measure the same general concepts (Charlton & Thompson, 1996; Rotter, 1966) The following passages discuss the relevant research with respect to the issue of control, while retaining the particular control terms used in the publications. When referring to the present researcher's ideas about control, however, the term *perceived control* will be used. The term *perceived control* is preferred over other terms due to the flexibility with which the term can be used. For example, as discussed in the following passages, control can be discussed with reference to personal versus interpersonal perceived control, providing more than one continuum with which to classify people. Additionally, it is argued that including the term *perceived* (as in *perceived personal control* rather than merely *personal control*) is important, since it makes it clear that what is being referred to is people's *beliefs or perceptions* about the amount of control they have, rather than the objective situation of how much control they actually have in their lives.

Perceived control has been the subject of numerous studies to assess its impact on psychological functioning in the general population (e.g. Grace & Schill, 1986; Solomon, Mikulincer, & Avitzur, 1988; Strickland, 1978). The research below suggests that people with more perceived control appraise adverse situations as more manageable and in turn adjust more effectively with adverse situations. It appears that perceived control can affect people's cognitive appraisals of adverse situations and consequently the coping strategies that are implemented, which in turn can affect adjustment. For example, Solomon and colleagues (1988) found that soldiers with an external locus of control, measured by Rotter's Locus of Control Scale, appraised their combat experience as more threatening than those with a more internal locus of control. This external appraisal was associated with increased PTSD symptoms. Further, in Strickland's (1978) review of studies that examined the role of locus of control in coping, it was found that people with an internal locus of control used more problem-focussed coping than those with an external locus of control. It appears that people with

more perceived control may use more effective coping strategies, which in turn may lead to better adjustment.

Perceived control has also been shown to be an important variable in relation to adjustment to sexual victimisation. For example, higher perceived control (measured by an adapted version of the Perlin and Schooler's Self-Mastery Scale) was associated with decreased symptoms (indicated by the Hopkins Symptom Checklist) in a study of sexual assault victims recruited primarily from women's shelters (O'Neill & Kerig, 2000). Similar results were found by Regehr, Regehr, and Bradford (1998) where locus of control (measured by the Internal Control Index) was associated with lower levels of depression in their sample of rape victims recruited primarily from a sexual assault centre.

However, there lies a problem with the research currently available in relation to perceived control and its relation to adjustment after sexual offences. The problem is that perceived control has, to a large extent, been viewed as one concept without subdivisions, even though people may have different control expectancies for different aspects of their lives. For example, one's control expectancies for personal aspects (i.e., career achievement) could be largely different than for social aspects (i.e., relationships). Indeed, research in areas other than sexual victimisation suggest that perceived personal and interpersonal control are different concepts, and can have differential relationships with psychological functioning (Paulhus & Van Selst, 1990; Rector & Roger, 1986; Spittal, Siegert, McClure, & Walkey, 2002).

The distinction between perceived personal and interpersonal control may be particularly important when it comes to sexual victimisation, since it is an act of an interpersonal nature. It is quite possible that someone could feel a large amount of control with respect to their personal pursuits (e.g., career), yet a complete lack of control with respect to their relationships with other people. It is also possible that this personal-interpersonal distinction may account for the lack of association between locus of control and child sexual abuse victimisation found in some research (e.g. Porter & Long, 1999). It is therefore suggested that studying the broad concept of perceived control without any distinctions may not provide the whole picture with respect to the

relationship between perceived control and psychological functioning in victims of sexual offences.

Social Support

An area with a great deal of inconsistency in the research literature is the area of the impact of social support on adjustment to sexual victimisation. While some research with female community members has found that social support is an important part of the therapeutic process after sexual victimisation (Ullman, 1996), most research has, perhaps surprisingly, found no association between social support and adjustment after sexual victimisation in women recruited from victim centres and hospitals (Davis, Brickman, & Baker, 1991; Popiel & Susskind, 1985). The marked differences in these findings are presumably due to the nature and source of the social support studied; merely disclosing the offence to another person or attending counselling does not necessarily mean that one is being supported.

Past research has been able to indicate the situations where victims are more likely to access support and the types of support that victims report as helpful and unhelpful. For example, Golding, Siegal, Sorenson, Burnam, and Stein's (1989) community survey indicated that victims who had been sexually victimised by a stranger and physically threatened to a greater degree accessed supports (physicians, rape crisis centres, friends and family, and police) more than victims of sexual offences where there was less physical threat and whose perpetrators were known to them. Further, rape crisis centres were rated by victims as most helpful, whereas physicians and police were rated as least helpful.

What appears missing from the research literature is knowledge about the roles that specific types of social support play in victims' *psychological functioning*. For example, the relative therapeutic value of attending counselling versus sharing sexual victimisation experiences with a supportive friend.

Rumination

Although not a very widely studied area, research examining the association between rumination about the sexual offence and psychological functioning has been interesting

so far. Rumination is defined in this thesis as frequently thinking about *why* the offence occurred, or in other words, searching for some sort of meaning for the offence. It appears that searching for meaning was important to many sexual offence victims in a sample of female college students (Frazier & Schauben, 1994). So far, research suggests that more frequent rumination is associated with poorer psychological functioning. For instance, Silver, Boon, and Stones (1983) reported that incest victims from the community who ruminated (searched for meaning) more frequently had significantly higher psychological distress (measured on the SCL-90), more impairment in social functioning, lower self-esteem, and lower self-reported resolution of the offence. Similarly, Ullman (1997) found that increased searching for meaning was associated with an increase in psychological symptoms and poorer self-rated recovery in a female community sample. More research examining the associations between rumination and psychological functioning would enable stronger conclusions with which to guide intervention efforts.

The Relative Importance of Static and Dynamic Factors

The dynamic factors discussed thus far appear to play a role in the psychological functioning after sexual victimisation. This appears promising, since dynamic factors are technically modifiable and could therefore serve as target areas in clinical interventions. However, the findings that suggest that static factors may also play a role in psychological functioning after sexual victimisation cannot be ignored. The next step in the research field is an examination of the relative contribution of dynamic and static factors. To date, such research suggests that dynamic factors play a larger role in adjustment to sexual victimisation than static factors. For instance, in a meta analytic study consisting primarily of clinical samples, Weaver and Clum (1995) found no consistent link between victim demographic information and psychological functioning but they did find an association between length of time since the offence and psychological functioning. However, the overall pattern that evolved was that dynamic factors contributed more than twice as much to psychological distress than static factors. While this finding provides some optimism (since dynamic factors are modifiable and therefore serve as priority areas in counselling to improve outcomes), there is not enough information about the relative contribution of static and dynamic factors to be

able to conclude that dynamic factors are overwhelmingly more important. Further investigation in this area would be a valuable addition to the research literature to guide theory and practice in the sexual victimisation field.

CHAPTER 5

Aims Of The Thesis

The aims of this thesis were established through a process of identifying what evidence the research literature currently provides and what the next steps should be in order to further the knowledge in the field of sexual victimisation. Areas of knowledge that were deemed important to develop were those that would contribute to enhancing the management of victims of sexual offences on clinical and justice system levels. The aims are divided into two categories based on whether they are addressed by quantitative or qualitative methods.

Aims Addressed By Quantitative Methods

1) To describe the symptomatology of the sample of participants to allow comparisons with past research.

2) To assess the relationships between static factors and psychological functioning. Of particular interest here is whether participants' psychological functioning differs according to whether they participated in the justice system.

3) To assess the relationships between dynamic factors and psychological functioning. Particular importance is placed on a) behavioural self-blame and characterological self-blame, due to the inconsistency in the research literature regarding these factors to date (Hill & Zautra, 1989; Koss et al., 2002; O'Neill & Kerig, 2000), and b) shame-proneness, guilt-proneness, perceived personal control, and perceived interpersonal control, due to the absence of research on these variables in the sexual victimisation literature.

4) To develop an optimal explanatory model of participants' current psychological functioning, utilising a combination of static and dynamic variables. The relative importance of dynamic and static variables is of particular interest.

Aims Addressed By Qualitative Methods

5) To describe the factors participants report as being influential in coping with sexual offences, including any factors discussed by participants that might predict their psychological functioning, for use in quantitative analyses.

6) To describe the needs of sexual offence victims in the justice system, by canvassing the reasons some participants reported to the police, the reasons other participants did *not* report to the police, and participants' personal definitions of *justice.*

7) To describe the factors participants report as being therapeutic and anti-therapeutic in their justice system experiences (this involves only those who reported their sexual victimisation to the police), to inform policy makers and those who work in the justice system.

Static, Dynamic, And Outcome Variables

The group of quantitative predictor variables examined in this study are categorised into static and dynamic factors. The static variables include the three categories of static factors that were identified in the literature review: 1) demographic information (Briere et al., 1988), 2) victim-offence characteristics (Oddone Paolucci et al., 2001), and 3) offence details (Cohen & Roth, 1987). The dynamic variables examined in this study were chosen because they were either a) reported in past research as having some type of relationship with psychological functioning in victims of sexual offences: attributions (O'Neill & Kerig, 2000), coping strategies (Meyer & Taylor, 1986), perceived control (Regehr et al., 1998), and rumination (Ullman, 1997), or b) in the case of shame-proneness and guilt-proneness, relationships have been found with psychological

functioning in college and general population samples (Harder et al., 1992), but not yet in victims of sexual offences.

The outcome variables in this study consist of five indicators of psychological functioning that were identified in the literature review as being common effects of sexual victimisation: depression (MacMillan et al., 2001), anxiety (MacMillan et al., 2001), posttraumatic stress (Rothbaum et al., 1992), self-esteem (Mezey & Taylor, 1988), and anger (Becker et al., 1982).

The variables in the three categories (dynamic, static, and outcomes) are listed below in Table 1. The variables refer to participant information unless indicated otherwise (e.g., "age" refers to the participant's age).

Table 1

Static, dynamic, and outcome variables examined in the present study

Static variables	Dynamic variables	Outcome variables
Demographic information	Attributions for offence	Depression
Current age	Shame/guilt-proneness	Anxiety
Gender	Coping strategies	Posttraumatic stress
Relationship status	Perceived control	Self-esteem
	Frequency of rumination	Anger
Victim-offence characteristics		
Age at time of offence		
Time since offence		
Offence as child/adult/both		
Reported offence to police		
Offence details		
Penetration occurred		
Oral sex occurred		
In-family offence		
In-home offence		
Multiple perpetrators		
Multiple incidents		

CHAPTER 6
Methodology

Participants

Participant Recruitment

Participants were recruited in Perth and surrounding areas in Western Australia. Advertisements were placed in local newspapers, magazines, and community newsletters, at community centres, women's health centres, counselling agencies, gym/recreation facilities, community libraries, university campuses, and the Sexual Assault Resource Centre. Further, the Office of the Director of Public Prosecutions (DPP) of Western Australia sent information about the research to some victims of sexual offences whose cases were finalised in the year and a half data collection period. People who were interested in participating in the study contacted the researcher; if they were not interested, they simply took no action at all. The researcher was not given any names of any victims by any agency. It was felt that this type of recruitment was the least intrusive, and allowed people to make their own choices about participation. See Appendices A to D for letters, advertisements, and newspaper articles used to recruit participants.

The majority of participants (43.5%) were recruited from articles about the research in various community newspapers. Other participants were recruited from university campuses in the Perth area (11.4%), the Perth Women's Information Service monthly newsletter (8.3%), advertisements placed in community letterboxes by a distribution company (8.3%), the Sexual Assault Resource Centre (5.3%), the Perth Women's Magazine (5.3%), and women's general counselling agencies (4.5%). The remaining participants (13.4%) were recruited in other ways including community newsletters, referrals from other participants, and from the Office of the Director of Public Prosecutions in Perth. Participants who were recruited from advertisements in

counselling agencies indicated significantly lower levels of self-esteem (M = 21.5, SD = 5.7) than participants recruited from advertisements in the general community (M = 27.0, SD = 7.2), t (103) = 2.82, $p < .01$. However, no other differences with respect to recruitment location were found. Figure 1 displays the recruitment source for the 132 participants.

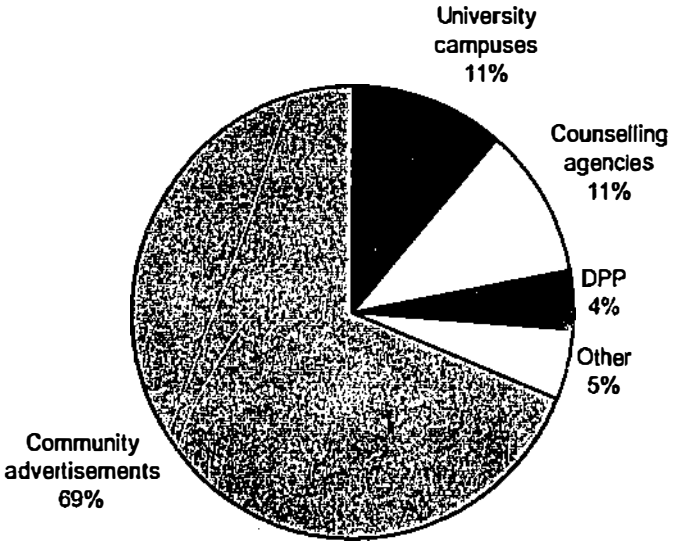

Figure 1. Participant recruitment source.

Description of the Sample

The sample consisted of 132 people who were at least 16 years of age at the time of participation and were sexually abused or sexually assaulted at some time in their lives (childhood and/or adulthood). In considering whether someone was a victim of a sexual offence, it was only required that the participants perceived themselves as having been victimised sexually (it was not necessary for the case to have been heard in court or for the perpetrator to have been found guilty). Aside from age (at least 16 years) and the

perception of having been sexually victimised, there were no other criteria for inclusion in the study.

The researcher initially set out to study only people who had experienced sexual victimisation in adulthood, however, a low response rate and lack of cooperation from police (regarding participant recruitment) forced a design change. People who were sexually victimised in childhood were thereafter included in the study design and from that point recruitment became much easier. The design change had two consequences. First, the sample of participants became more diverse which can make interpretation and generalisation more difficult. Second, it provided the opportunity to study and compare three groups of participants (victims of adult sexual offences, victims of child sexual offences, and victims of both) rather than just the one group (victims of adult sexual offences only).

Gender, age, and relationship status.

Female participants accounted for 87.9% of the sample (n = 116); 12.1% were male (n = 16). It was anticipated that few men would participate, however, given the scarcity of research involving men as victims of sexual offences, it was decided to attempt to recruit men nonetheless. The age range of participants at the time of participation was 16 to 69, with an average age of 38.6 years (SD = 12.1). Participants who were at least 40 years old accounted for 45.5% of the sample, while participants at least 30 years old accounted for 79.5% of the sample. Examination of relationship status indicated that 37 participants were married (28.0%), 37 participants were single (28.0%), 21 participants were divorced (15.9%), 16 participants were in de facto (common law) relationships (12.1%), 11 participants were in serious relationships (but not de facto) (8.3%), and 10 participants were separated (7.6%).

Sexual offence characteristics.

Each participant was placed into one of three categories, depending on the sexual offences they reported experiencing: 1) childhood sexual offences only, 2) adult sexual offences only, or 3) both childhood and adulthood sexual offences. Some cases were not easily or clearly assigned to one category, because the criteria for each category were not solely based on age. In these cases, the following general rules applied. Sexual offences

that began in childhood and continued into adolescence by the same offender (e.g., father) were assigned to the *childhood only* category. However, if the same perpetrator then sexually offended against the victim in adulthood, after years of non-offending, the case was assigned to the *both* category. Once-off sexual offences in adolescence were deemed as *adult* offences if the perpetrator was a friend or partner of the victim, but as *child* offences if the perpetrator was an older person in a position of trust, such as a parent or sibling, a friend of the victim's family, or a school teacher.

Seventy-seven participants reported being victims of childhood offences only (58.3%), 24 participants reported being victims of adult offences only (18.2%), and 31 participants reported being victims of both childhood and adulthood sexual offences (23.5%). Length of time since the most recent sexual offence incident varied from 3 weeks to 62 years, with an average of 21.4 years (SD= 14.4). Of the total sample, 4.5% of participants were victimised less than a year ago, 14.4% were victimised between one and five years ago, 9.9% were victimised between six and 10 years ago, and 71.2% were victimised more than 10 years ago. Penetration (vaginal/anal) occurred in 113 incidents (85.6%), and oral sex occurred in 60 incidents (45.5%). A minority of participants (11.4%) indicated that their victimisation consisted of fondling and/or kissing without penetration or oral sex.

The 132 participants in this sample reported being sexually offended by 274 perpetrators. Almost half of the participants (47%) had experienced sexual offences by more than one perpetrator over the course of their lives, and 36 participants (27.3%) had experienced offences by at least three perpetrators.

The relationships between victim and perpetrator (taken from a checklist completed by the participants) are described for child sexual offences and adult sexual offences separately, since the victim-perpetrator relationship patterns differ widely between the two situations. It is interesting to note that 36.3% of perpetrators were strangers to the victim before the day of the offence for adult offences, whereas this was the case in only 2.3% of childhood offence cases.

For sexual offences occurring against victims in adulthood, there were 102 perpetrators. Of these, 28 perpetrators were strangers to the victim (27.5%), which is the highest category of perpetrator relationship for the adult offences (see Figure 2). The remaining perpetrators (in descending order of frequency) were 27 acquaintances (26.5%), 12 partners (11.8%), 11 ex-partners (10.8%), 10 friends (9.8%), 9 people the victim had just met that day (8.8%), 3 fathers of the victim (2.9%), and 2 brothers of the victim (2%)[4].

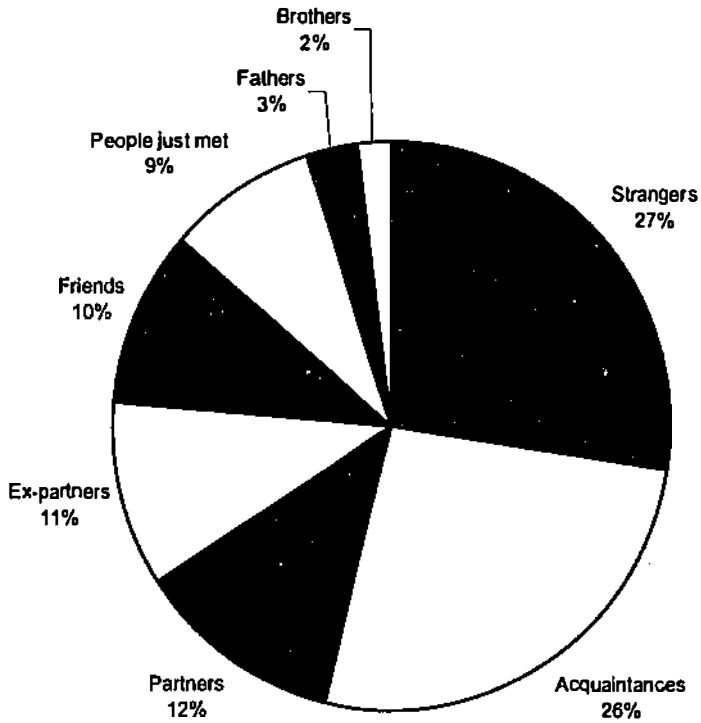

Figure 2: Relationship of perpetrator to victim in adult sexual offences (102 perpetrators in total).

[4] Percentages do not add up to 100% due to rounding.

For sexual offences occurring against victims in childhood, there were 175 perpetrators[5]. Of the 175 perpetrators, 38 perpetrators were natural fathers to the victim (21.7%), which is the most frequent category of relationship for the child offences (see Figure 3 below). The remaining perpetrators (in descending order of frequency) were 25 brothers (14.3%), 23 family friends (13.1%), 15 stepfathers[6] (8.6%), 10 grandfathers (5.7%), 7 neighbours (4%), 7 uncles (4%), 6 cousins (3.4%), 5 mothers (2.9%), and 5 victims' friends' family members (2.9%). The remaining 28 perpetrators (16%) fall into other categories including strangers, sisters, school staff., grandmother, siblings' friends or spouses, female babysitters, and acquaintances. Further, there were 6 participants (3.4%) who did not wish to specify their relationship to the perpetrators.

[5] To explain why the number of perpetrators for the adult and child categories (102 and 175) sum more than the total number of perpetrators (274), there were three cases where the victims' fathers abused them as children and sexually assaulted them many years later in adulthood, so they were counted in both categories, but only once in the total figure.

[5] Combining the two categories of natural fathers and step-fathers yields 53 perpetrators, which is 30.3% of all perpetrators for sexual offences in childhood.

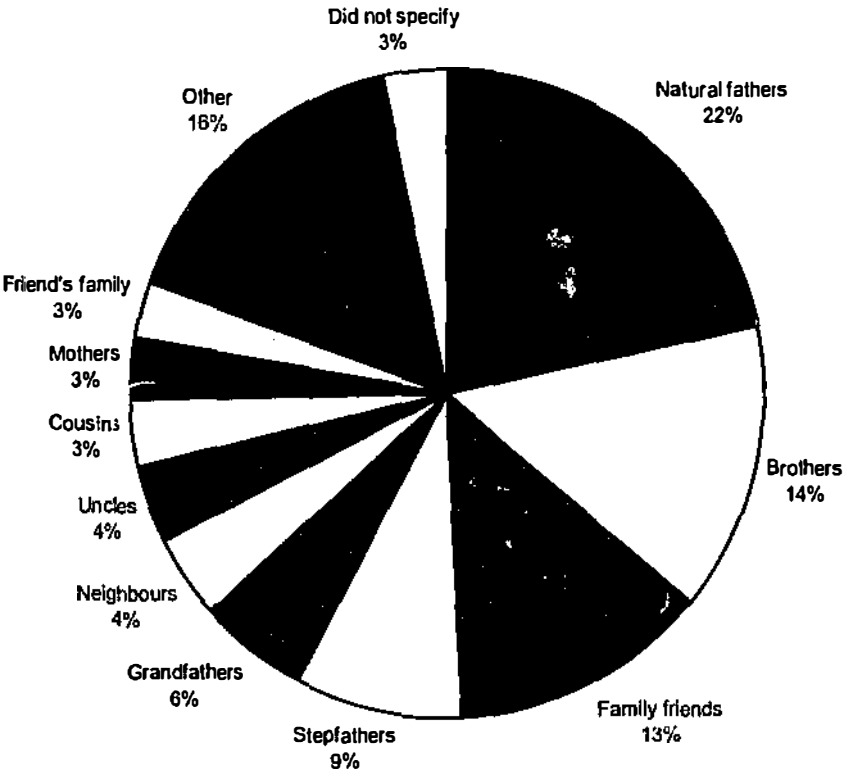

Figure 3: Relationship of perpetrator to victim in childhood sexual offences (175 perpetrators in total).

Of the 132 participants, 59 (44.7%) had some contact with the police regarding the sexual offence at one time or another. Participants were included in this group whether they made an *official* report to the police or just made informal inquiries. Of the 59 participants in this group, 53 (89.8%) made an official report to the police (40.2% of the whole sample). The remaining 6 participants in this group (10.2% of the justice system group or 4.5% of the whole sample) did not follow through with charges after initial inquiries to the police. The remaining 73 participants (55.3%) never had any contact with the police regarding the sexual offence. Figure 4 displays the three groups based on their level of contact with the justice system.

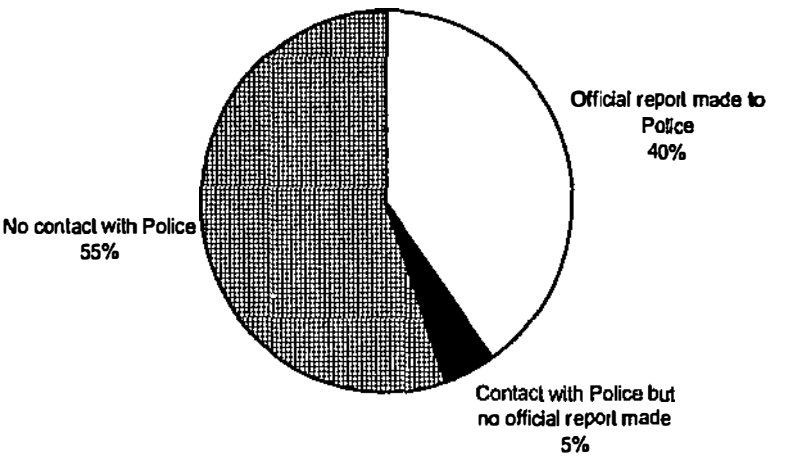

Figure 4: Percentage of participants who made official police statements, had contact with police but did not make official statements, and had no contact with police.

Measures

The package of questionnaires that participants completed is located in Appendix E, with the exception of the questionnaires that are subject to copyright. Questionnaires that are subject to copyright are not included in the appendix (to respect the copyright) but information is provided as to where the questionnaires were obtained for use in this research. The items in the questionnaire package were utilised in one of three categories: static predictor variables, dynamic predictor variables, or outcome variables. These variables will now be described.

Static Predictor Variables

Basic demographic details and information regarding the sexual offence were collected to describe the sample and to use as static predictor variables. These details included

age, gender, marital/relationship status, age at time of sexual offence, length of time since the offence, relationship to perpetrator at time of offence, whether the offence occurred in the victim's home or family, whether they were victimised multiple times or by multiple perpetrators, whether they reported the sexual offence to the police, and a checklist of what the sexual offence involved (fondling, oral sex, vaginal-penile penetration, vaginal-digit/object penetration, anal sex, and a blank space for others not specified).

Dynamic Predictor Variables

Spheres of Control Scale (SOCS).

The SOCS is a 30-item scale designed to measure perceived control in three domains: personal, interpersonal, and socio-political (Paulhus & Van Selst, 1990). Only the Personal Control and the Interpersonal Control subscales were used in this study, comprising 10 items for each scale (20 items in total), rated on a 7-point scale from 1 (disagree) to 7 (agree). Total scores for each subscale range from 10 to 70. Half the items were reverse scored. Items from the Personal Control subscale include: "I can usually achieve what I want if I work hard for it" and "I usually do not set goals because I have a hard time following through on them." Items from the Interpersonal Control subscale include: "In my personal relationships, the other person usually has more control than I do" and "I find it easy to play an important part in most group situations." Internal reliability was adequate in the personal and interpersonal control scales (coefficient alpha ranged from .69 to .75 in various samples) (Spittal et al., 2002). In describing and discussing the findings in this thesis, *perceived personal control* and *perceived interpersonal control* refer to their respective scales on the SOCS, whereas *perceived control* (without mention of personal or interpersonal) refers to the pooled personal and interpersonal scales (as perceived control in the general sense).

Coping Scale for Adults (Short Form) (CSA).

The CSA was developed in the Australian context and has been shown to have sufficient test-retest reliability and internal consistency (coefficient alphas for the subscales range from .69 to .92) (Frydenberg & Lewis, 1997). The CSA Short Form consists of 20 items, comprising 19 structured items and a final open-ended response question. It measures 18

distinct coping strategies that fall under four broad categories: 1) Dealing Independently with the Problem, 2) Nonproductive Coping, 3) Optimism, and 4) Sharing. Examples items include: "Develop a plan of action" (Dealing Independently with the Problem), "I get sick; for example, headache, stomach ache" (Nonproductive Coping), "Look on the bright side of things and think of all that is good" (Optimism), and "Talk to others and give each other support" (Sharing). The CSA is commercially available from ACER Press in Australia.

Test of Self-Conscious Affect (TOSCA).

The TOSCA is designed to measure shame-proneness, guilt-proneness, externalisation, detachment-unconcern, alpha pride, and beta pride (Tangney, Wagner, & Gramzow, 1989). It contains subject-generated items, and has been used widely as a measure of shame-proneness and guilt-proneness in research and has been shown to be appropriate for adults of all ages (Tangney et al., 1992). The TOSCA consists of 15 brief scenarios. Participants rate each of the corresponding responses on a 5-point scale from 1 (not very likely) to 5 (very likely) regarding how likely they are to react in the specified manner. For example, one scenario states: *You are driving down the road, and you hit a small animal.* The responses to this item are: a) You would think the animal shouldn't have been on the road (externalisation), b) You would think: "I'm terrible" (shame-proneness), c) You would feel: "Well, it was an accident" (detachment/unconcern), and d) You would probably think it over several times wondering if you could have avoided it" (guilt-proneness). Only data from the shame-proneness and guilt-proneness dimensions of this scale were utilised as predictor variables in this study. These two dimensions have been shown to have sufficient internal consistency in adult samples, with coefficient alphas ranging from .62 to .81 (Tangney et al., 1989). Permission to use the TOSCA in this research was granted by June Tangney.

Attribution scale for sexual offences.

Attributions of blame for the sexual offence were assessed using a seven-item scale devised by the present author for this research project. The seven factors of blame in this scale are: perpetrator, victim character, victim behaviour, bad luck, someone else besides the perpetrator, society, and other blame not specified. Participants rated each factor of blame on a 7-point scale ranging from 1 (don't believe at all) to 7 (believe strongly).

This scale is similar to Ullman's attribution scale (Ullman, 1997), except the scale in the present study included the "bad luck" attribution and used a 7-point rating scale rather than a 4-point rating scale.

Rumination of why the offence occurred.

Given that a standardised scale to assess rumination was not available, the frequency of ruminations about why the offence occurred was assessed in the current study with the following question: "How often do you think about *why* the sexual offence occurred?" with responses from 1 (Never) to 7 (Always).

Outcome Variables

The following measures were used as indicators of current psychological functioning.

Hospital Anxiety and Depression Scale (HAD).

The HAD is designed to measure depression and anxiety, each with 7 items (Zigmond & Snaith, 1983). Each item comprises a statement, about which respondents choose the response that best applies to their feelings in the past week, using a 4-point rating scale. Total scores for each subscale range from 0 to 21. Half of the items are reverse-scored. A sample depression item is: "I still enjoy the things I used to enjoy", with the following response choices: "Definitely as much", "Not quite as much", "Only a little", and "Hardly at all". A sample anxiety item is: "I feel tense or wound up", with the following response choices: "Most of the time", "A lot of the time", "From time to time (occasionally)", and "Not at all". Internal consistency for the depression and anxiety subscales is acceptable (coefficient alphas of .30 to .60 for depression and .41 to .76 for anxiety (Zigmond & Snaith, 1983). Convergent validity with other anxiety and depression scales is also adequate, with a coefficient of .67 between the anxiety scale and the Clinical Anxiety Scale (Snaith, Baugh, Clayden, Husain, & Sipple, 1982) and .74 between the depression scale and the Montgomery-Asberg Depression Rating Scale (Montgomery & Asberg, 1979). Convergent validity has been shown to be adequate with psychiatric ratings as well, with a coefficient of .70 for anxiety, and .74 for depression (Zigmond & Snaith). The HAD is available from Nfer-Nelson Publishing Company.

Rosenberg's Self Esteem Scale (RSES).

The RSES consists of 10 statements to which respondents circle "Strongly agree", "Agree", "Disagree", or "Strongly disagree" (Rosenberg, 1965). Total scores range from 10 to 40. Half of the items are reverse-scored. Statements include "I feel that I am a person of worth, at least on an equal basis with others" and "I feel I do not have much to be proud of". This scale has been used in several research areas including chronic fatigue (White & Schweitzer, 2000), rehabilitation counselling (Garske, 2000), arthritis (Sheasby, Barlow, Cullen, & Wright, 2000), and substance use treatment (Dodge & Potocky, 2000). It has been shown to have adequate internal consistency with coefficient alphas ranging from .77 (in Fleming & Courtney, 1984) to .92 (in Vispoel, Boo, & Bleiler, 2001). Convergent validity (.78 with self-regard), and test-retest reliability (.82 after one week) have also been shown to be adequate (Fleming & Courtney, 1984; Reynolds, 1988). Permission to use the RSES in this research was granted by the Morris Rosenberg Foundation.

State-Trait Personality Inventory (STPI).

The STPI consists of trait and state measures of anger, anxiety, depression, and curiosity (Spielberger, 1995). Only the *state* anger scale was used is this study. It comprises 10 statements which respondents rate on a 4-point scale from 1 ("not at all") to 4 ("very much so") regarding their current situation. Items include "I feel angry" and "I feel like breaking things." One item ("I am mad") was altered to "I am mad (infuriated)" due to the Australian jargon where "mad" sometimes takes on the meaning of "insane". The state anger scale of the STPI has shown to have high concurrent validity with traditional measures of state anger. For example, correlations with scores on the State-Trait Anger Inventory were between .95 and .97 in navy recruits and between .96 and .97 in college students (Spielberger, 1995). Internal consistency has also been shown to be high, with alpha coefficients of .9 in navy recruits, and .9 to .92 in college students (Spielberger, 1995). Permission for use of the STPI in this research was granted by Charles Spielberger.

Trauma Symptom Inventory (TSI).

The TSI is designed to measure symptoms of posttraumatic stress and other psychological effects of traumatic events (Briere, 1995). One benefit of this scale is that it yields levels of posttraumatic stress on a continuum rather than providing a diagnosis, which would only yield a dichotomous variable. There are 100 items that form 10 clinical scales: anxious arousal, dissociation, depression, sexual concerns, anger/irritability, dysfunctional sexual behaviour, intrusive experiences, impaired self-reference, defiensive avoidance, and tension reduction behaviour. Respondents rate on a scale of 0 (never) to 3 (often) the degree to which they had experienced each of the 100 symptoms in the last 6 months. Internal consistency in the standardisation sample was adequate as coefficient alphas ranged from .74 to .91, with an average coefficient alpha of .86 (Briere, 1995). Further, comparisons with similar scales on the Brief Symptom Inventory (Derogatis & Spencer, 1982) revealed reasonable convergent validity (coefficients ranged from .75 to .82). A composite posttraumatic stress score created by summing the following four scales and dividing the figure by four was used in the present study: 1) anxious arousal, 2) intrusive experiences, 3) defensive avoidance, and 4) dissociation. The TSI is commercially available from the Australian Council for Educational Research (ACER) in Australia, or from Psychological Assessment Resources (PAR) in the USA.

Interview Guide

While the interviews varied largely in content from one participant to the next, participants were given an A4-size card consisting of a list of some general topics that may surface in the interview. Two sets of topics were generated, one set for participants who had some contact with police about the sexual offence, and another set of topics for participants who had not had any contact with the police regarding the sexual offence.

Participants who had some contact with the police about their sexual offence were given the following set of topics:

- experience of giving a statement
- contact with police: positive/negative experiences
- experience of giving evidence in court

- contact with the court system: positive/negative experiences
- suggestions for change in the justice system
- the meaning of the word *justice*
- coping: things that worked, things that did not work
- prescription medication
- use of alcohol and other drugs
- support of family/friends/counsellors

Participants who did *not* have any contact with the justice system about their sexual offence were given the following topics:

- reasons why you did not report it to the police
- suggestions for change in the justice system
- the meaning of the word *justice*
- coping: things that worked, things that did not work
- prescription medication
- use of alcohol and other drugs
- support of family/friends/counsellors

Procedure

Data collection took place from March 2001 to July 2002. Potential participants heard about the study in the community and contacted the researcher by phone if they were interested in getting more information about the project (see the earlier section *Participant Recruitment* for recruitment methods). The researcher explained the details of the project, answered any questions or concerns, and then arranged a meeting if callers met the criteria and indicated that they wished to participate.

Five people contacted the researcher and said they would think about participating but to the researcher's knowledge did not end up participating in the project. However, it is possible that they re-contacted the researcher at a later date to participate, without the researcher being aware of the initial contact. Further, six people made appointments to

participate in the project but did not attend the appointment and therefore these people are not included in the sample of participants.

The researcher met with participants at mutually agreed upon locations. Most meetings with participants took place in the researcher's office on the university campus (39.4%) or at participants' homes (37.9%). The remainder of meetings with participants took place in public places such as meeting rooms in public libraries (20.5%), or at participants' workplaces (2.3%). The participants who chose to meet at a public place generally did not want to meet at their homes because they wished to remain anonymous (otherwise they would have had to give their address to the researcher), or because family or housemates were likely to be home at the time of participation. Participants who did not want to meet at the researcher's office on the University campus generally gave the reason that travelling to the campus was inconvenient as it was far from their homes. There were no differences on any of the outcome measures (depression, anxiety, posttraumatic stress, and self-esteem) with respect to the location at which participants chose to participate. Figure 5 displays the locations of participation.

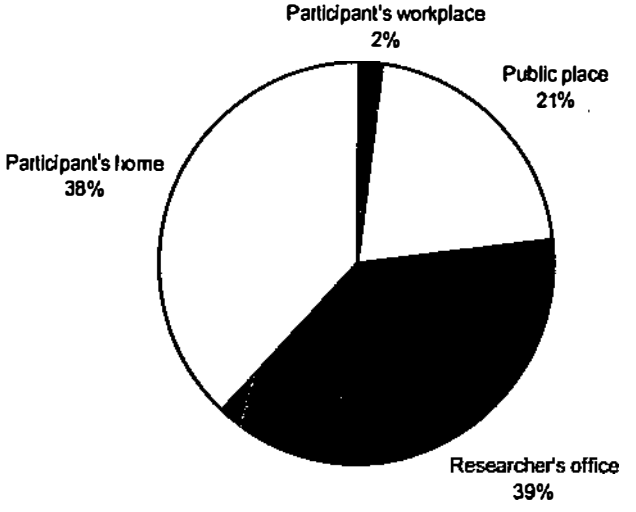

Figure 5: Location of participation

All meetings were once off and one-to-one. Participants were told that they could take a break at any time throughout their participation. They were also encouraged to tell the researcher if they wished to stop participating, for any reason, and that it was important that they not continue with the questionnaires or the interview if they did not want to. (Only one participant stopped the participation process; this situation is described later in this section.)

It took participants approximately 45 to 60 minutes to complete the questionnaires. Immediately after completing the questionnaires, participants were asked whether they would like to relate their experiences and views in a verbal discussion with the researcher. All 132 participants chose to do so, and some participants commented that the discussion/interview was the part of the study that they were most eager to do. Interviews ranged considerably in time, from 5 to 90 minutes, depending on how long participants wished to discuss their situations. Interviews were neither audiotaped nor videotaped, out of concern by the researcher that participants would feel less comfortable and/or would filter their discussions if they were being taped. Participants were encouraged to tell the researcher if a topic arose in the discussion that they did not wish to talk about.

Issues discussed in the interviews varied considerably from one participant to the next. Some participants started the interviews themselves by raising issues they felt were important to relate to the researcher. Other participants waited for the researcher to begin the interview and in such cases there were three ways the researcher started the interview:

1) If participants brought up a relevant issue on the telephone when they first inquired about the project, the researcher noted that issue and asked them to elaborate on it during the interview. A common example that arose during the initial telephone call was participants' frustration and disappointment with the justice system. In such cases, when the interview began, participants were asked to elaborate on their experiences in the justice system. Another common example was the degree to which the sexual victimisation had affected their lives. In these cases, participants in the interviews were

asked to elaborate on the effects of the victimisation on their lives, and the factors they felt were important in their coping process.

2) If the researcher was aware of some unique aspect of the participant's situation then she asked the participant to describe that situation or experience. For example, when interviewing male participants, if they had some contact with the police as a victim of a sexual offence, they were asked to describe their experience in the justice system from a male victim's perspective. Another example of unique situations involved a female participant who was in treatment for drug dependence and had a criminal record. The researcher asked her to describe her experience of telling the police about the sexual abuse from the perspective of someone who had a criminal record and a drug problem, both of which were known to police.

3) If none of the above situations occurred, the researcher started the interview by asking participants whether they had any contact with the police regarding the sexual offence. If participants responded in the affirmative, the researcher asked them to describe their experience in the justice system, from the time of initial contact to the police, through to the completion of the case. If participants responded in the negative, the researcher asked them to elaborate on their decision not to report the offences to the police.

Participants were also given the interview guide (described above), to use as a prompt if needed.

Notes were taken by the researcher during the course of each interview. Verbatim statements made by participants were noted during interviews, where possible.

A debriefing discussion then took place with the participants, during which they were provided with the Sexual Assault Resource Centre's pamphlet, which includes their 24-hour crisis telephone number. Participants were encouraged to access this 24-hour crisis service if they felt they needed to talk with a Counsellor immediately. Participants were also encouraged to contact the researcher if they became distressed and felt they did not possess adequate resources to manage the situation. An arrangement had been made for any distressed participants to be seen at the local Psychology Clinic within a couple of

days, if participants wished to do so. Participants were thanked for their time and valuable participation in this project and were encouraged to re-contact the researcher if they wished to receive results of the study, counselling referral information, or other such information.

After participation, any identifying information that participants had given the researcher (e.g., names and contact details) was destroyed. Each participant was assigned an identification number, which was marked on both the questionnaire and the notes taken from their interview. This number was simply based on the order of participation (e.g., the first participant was #001). In this way, participants were not identifiable, since all identifying information was destroyed immediately after the participation session, but the qualitative data were still linked with the quantitative data. The questionnaire data were entered into a statistical software package (SPSS Version 10). The interview notes were typed into a data processing package for storage and later retrieval and printing. Both the questionnaires and the printed interview notes were stored in a locked file cabinet in the researcher's office on the University campus, along with the computer disk containing the interview notes.

There were two incidents where the researcher needed to make external support arrangements for distressed participants. One participant had experienced domestic violence years previously, and completed only the first page of the questionnaire when she realised that it was going to be more difficult than she had expected. She described feeling that she had thought she had dealt with the domestic violence well, but was just realising (while doing the questionnaire) that she really had not dealt with the sexual aspect of the violence at all. She was teary and clearly in distress. The researcher gently advised the participant to stop completing the questionnaire. The researcher managed the situation over a 3-hour period and then offered the participant the option of a counselling appointment at the local Psychology Clinic. The participant attended an appointment at the Clinic the next day and continued with further sessions. She later expressed that she was glad she made the effort to participate in the project because she was then able to start dealing with the sexual aspect of the domestic violence.

The other participant who reported needing additional support described feeling good at the end of participation. However, she called the researcher the next day, explaining that she just received news that the perpetrator had just been given parole and she did not know when he would be released. Since she had not known that he had applied for parole, she described being "in a panic" and not being prepared for his release. With the participant's permission, the researcher contacted a local rape victim/victim rights advocate known to the researcher for helping other victims through various aspects of the justice system process. The victim rights advocate contacted the participant, discussed her concerns, and then took her to the police station to place her on the Victim Register, a process that informs victims of any changes in the perpetrator's legal situation, such as parole decisions. The participant contacted the researcher a few days later to say that she was feeling much less distressed, having spoken to the advocate. She stated she felt more in control of things, having been informed of the procedures in the justice system and knowing that she had initiated the parole restriction negotiation process.

Data Analysis

Quantitative Data

SPSS Version 10.0 was used to analyse the quantitative data. Descriptive statistics were used to establish sociodemographic characteristics of the sample and the characteristics of the sexual offence incidents participants reported.

In addressing Aim 1, descriptive statistics were used to describe the symptomatology in the sample of participants. Then a series of one-sample t-tests was used to test for significant differences between participants' scores and normative values. These t-tests allowed the researcher to report how the participants' scores compared with scores from people in control samples from the general population and other specific samples (e.g., clinical psychiatric outpatients, people who have experienced traumatic events versus those who have not, people who have been diagnosed with PTSD versus people who do not have a diagnosis of PTSD).

In addressing Aim 2, the relationship between static factors and psychological functioning was assessed using correlational analyses for two continuous variables, and t-tests for one continuous variable and one categorical variable.

Similarly, in addressing Aim 3, the relationship between dynamic factors and psychological functioning was assessed using correlational analyses for two continuous variables, and t-tests for one continuous variable and one categorical variable.

In addressing Aim 4, multiple regression analyses were used to assess the relationship between the predictor variables and the outcome variables (depression, anxiety, posttraumatic stress, and self-esteem).[7] Using Tabachnick and Fiddell's (2001) guide to the number of participants required per predictor variable ($N \geq 50 + 8m$, where m = the number of predictors [maximum 9 in this study], and N = the minimum number of participants required, N = 122), the sample of 132 participants in the current study was deemed sufficient.

Results of analyses of quantitative data are reported in Chapter 9.

Qualitative Data

The purpose of the qualitative data was to 1) identify new variables to include in quantitative analyses, 2) look for support (or non-support) of quantitative findings, and 3) identify information that is largely inaccessible by quantitative methods (e.g., therapeutic and anti-therapeutic experiences in the justice system). The qualitative data were examined by way of content analysis (Neuendorf, 2002), through which the main themes in the data were identified. The researcher was blind to the respondents' scale scores during the coding process. Comments made by participants in the interviews were noted and analysed by the researcher when they referred to issues that participants suggested or implied were related to their psychological functioning. These issues included justice system procedures that participants relayed as having a therapeutic or anti-therapeutic impact on their psychological functioning. Other issues that were noted

[7] It was not possible to analyse the data from the anger scale inferentially due to the reasons discussed in Chapter 9.

and analysed were factors found to be relevant to sexual victimisation in the research literature (e.g., self-blame, coping strategies, perceived control). The main themes that emerged from the qualitative data are reported in Chapter 7. Some aspects of the qualitative data that connected with psychological functioning and justice system issues were quantified in Chapter 8 and then linked with the existing quantitative data in Chapter 9.

CHAPTER 7

Results

Qualitative Data

Data described in this chapter are derived from interviews with the 132 victims of sexual offences who formed the sample of participants for this study, and other information gained during the data collection process (i.e., responses from agencies regarding advertising the study on their premises). Several themes emerged from the data regarding the therapeutic process and issues that affect the therapeutic process from the victims' point of view. Dealing with sexual victimisation from male perspectives is also described. Other themes that will be discussed in this chapter include justice system issues. These issues include the reasons for reporting the sexual offence to the police, the experience of giving a statement to police, the interim period between giving the statement and going to trial, and then the trial period itself. Victims' reasons for *not* reporting to the police are important and will also be discussed in this chapter. Verbatim statements by participants are accompanied by the participants' identification numbers (e.g., #006). Corresponding details of quoted participants are provided in Appendix F.

Before the first participant was recruited, some valuable information was gained in the process of advertising the project in community health agencies (e.g., general practitioners' offices, physiotherapy offices). The researcher was met with a valuable insight into how general members of the community view sexual offences. While some staff at the agencies appeared uncomfortable and quietly hesitant but nonetheless agreed to the researcher placing the advertisement on their community noticeboard, other staff were adamant that such an advertisement was not "appropriate" on their premises. Two such comments from separate medical office receptionists were "we don't see those people here" and (displaying the advertisement) "would be against the principles of the practice." Even the co-ordinators of several *counselling* agencies were not willing to

give their clients the opportunity to participate in this research, for fear it might be too difficult for them or because they are being "bombarded with research lately."

About Participation

The reasons participants gave for wanting to participate in the research are noteworthy. The vast majority of participants stated they wanted to participate "to help someone else". Many participants described feeling an intense and long-term desire to pass on their experiences to someone else, in the hope that their experiences might be able to help someone. They described feeling helpless that they did not know how to help others, and this research project was a way they felt they could fulfill their wish to help others, whilst remaining anonymous. Some participants said they had offered to volunteer at sexual assault/abuse agencies or other counselling agencies, but they had been told (in a variety of ways) that their help would not be useful. In particular, the older participants described feeling that their lives had been filled with pain and suffering in trying to deal with the consequences of sexual offences, and they wished to ease the pain and suffering of others if they could.

Many participants stated that they knew that participating would bring up bad memories for a few days around the time of participation, and many stated that they did not sleep well the night before participating, but their strong will to help others kept them determined to participate. A common theme, of hoping their own assault/abuse was not for *nothing*, that their experiences could at least be useful to *someone*, was evident. Several participants stated that while their primary reason for participating was to help other people, they also hoped for the chance of being able to gain insight into their own situations. Indeed, many participants stated after completing the questionnaires, that they were so delighted (and surprised) to see the progress they had made over the years, and yet others were glad to identify issues that they might still need to work on. After the interviews, some participants said it was the first time someone had really listened to them, and that it felt "wonderful".

The Therapeutic Process And Influential Factors Involved In This Process

One of the most common remarks made by participants was the expectation of family and friends to *get over it*. Participants consistently described this expectation as unrealistic and actively damaging to their therapeutic process. Participants suggested that the more their partners, friends, relatives, and colleagues expected them to get over the sexual victimisation quickly, the less chance the participants had of reaching their optimum level of psychological functioning. Comments from participants suggested that friends and family members appeared to allow only a month or so to recover from sexual assault in adulthood. For cases of childhood sexual abuse, participants over 30 years of age were generally expected to have long recovered from years of abuse.

"Friends weren't really supportive, they didn't know what to say, some friends I haven't spoken to since then because of how everyone dealt with the sexual assault ... it's like when someone dies ... some people don't know what to say. People expect you to 'just get over it' very soon after it happens, there's a lot of pressure to put on a brave face and pretend everything's ok." (#006)

Participants reported that comments such as "it was so long ago, just get over it" placed unrealistic expectations on them and may have inadvertently obstructed the therapeutic process. It appeared as though the reason was the damaging effect of not being *heard*.

"Many people say to just get over it, this is so unrealistic about how abuse affects people's lives, you just learn to live with it, you don't get over it." (#023)

Some friends and family members of participants appeared to impede the therapeutic process in other ways as well. For instance, participants reported having to take care of not only their own responses to the offence, but the responses of their loved ones as well. Since dealing with sexual offences is not a widespread topic of discussion in our society (compared with other painful issues such as dealing with the death of a loved one), it was clear from the speech of some participants that their loved ones often appeared to have good intentions, but did not know how to support victims positively.

"I told my boyfriend at the time about it [the assault] *but he couldn't handle it and it seemed he was more concerned with who the guy was who assaulted me rather than what I needed at the time. I felt I had to take care of myself and also him too. It was an extra burden. I wish I never told him" (#023)*

"[My husband] *expected me to get over the abuse, he said it was a long time ago and so I should be over it." (#043)*

"It's useful to talk to someone who has been through it. The home environment is hard when people you live with don't know about it, they can't understand why you act strangely sometimes." (#019)

While some participants told their family and friends about their sexual victimisation in the hope of receiving some support from these people, other participants chose not to tell certain family members or friends, in the hope of getting on with life. In this way, the participants in the latter group were, in a sense, pressuring themselves to cope with the victimisation quickly.

"What helped me was being forced to get on with life, focus on other areas besides the assault...I wasn't able to dwell on the assault and become depressed. I decided not to tell my parents about it ...so I would have to be normal around them. Also, taking care of my children, having other things to focus on, is good...I probably wouldn't have coped as well without them." (#004)

Participants portrayed a strong sense of shame and guilt surrounding the sexual offences. They also described feeling different and alone. They described these feelings as being strong barriers to the therapeutic process. One participant described his need to "forgive" himself to rid himself of the shame and guilt.

"The key is in forgiveness of yourself, even though you didn't do anything wrong you must forgive yourself because you assume as a child that you must have been doing something wrong to deserve that. I never told anyone about it for 21 years, there was a lot of shame and guilt there. I told my mum first...that was a start." (#034)

There were also several comments from participants about the search for reasons to explain why they were sexually victimised, and the need to place the blame somewhere. It appears from the comments of some participants that "why?" was always on the back of their minds.

"I read a lot of books [on sexual abuse], *I'm looking for the answer to 'why?'" (#030)*

"The 'why?' is always there, I always wonder why it happened." (#008)

A persistent theme in the interviews was participants' descriptions of not feeling confident in trusting their "gut feeling" anymore. They described not feeling comfortable about deciding whom to trust. This was especially true for those who were sexually victimised by people they trusted (the majority of cases). These feelings led to generalised feelings of distrust of their own feelings and of other people. Several participants suggested that not being able to trust others often prevented them from engaging in deep and meaningful relationships with their partners.

"I find it difficult to trust people, especially men...I found it hard to gain my gut feeling instinct back, I'm slowly regaining it though." (#006)

"I understand why people don't report [to the police], *by the time you worked passed the shock, you are into denial, angry, lost trust in everyone, have no gut feeling anymore." (#035)*

A widespread finding was participants' accounts of suffering from depression for many years before it was diagnosed and treated. Even once diagnosed, there was great reluctance to commence anti-depressant medication. Reasons for this revolved around victims' feelings that they were failures if they needed medication; they described feeling that they should be able to cope with things that come up in life on their own. There was also a sense of fear of losing control by taking medication. Difficulties with trust resurface.

"I was extremely reluctant to go on medication for years because I felt that would be giving in ... not being strong enough ... fear of losing control of what was happening to me ... and trust also ... feeling able to trust my GP and psychiatrist enough was hard." (#085)

"I have suffered depression most of my life. I had a breakdown 5 years ago, I took anti-depressants for the first time in my life, they were really good, it was a big decision to go on them, I was very concerned I would become addicted, I didn't want to be dirty. I also thought I should have been able to handle it on my own...I shouldn't need medication." (#033)

This feeling that they should be able to cope on their own often led participants to adopt coping habits that may have helped them deal with everyday life in the short-term but they also suggested that eventually these habits inhibited them from leading fulfilled lives.

"I tried to put it behind me...I didn't cope well, I isolated myself, I don't go out as much, especially at night, even though the assault didn't happen at night." (#001)

Coping habits such as using drugs (particularly alcohol and marijuana) were described by participants as being useful in the beginning, since it helped them feel relaxed when they were otherwise "constantly on-edge". Some participants also noted that the reaction to the sexual offence in terms of flashbacks and nightmares were often so terrifying and debilitating, they used drugs to calm themselves down. However, most participants indicated that this was only really useful in the short-term and that the drugs only served to dull the pain for the moment, rather than taking the pain away. Looking back on the situation, many participants stated that using drugs prevented them from working through the trauma of the sexual offences and that they wished they had gone to counselling earlier.

"I used drinking and drugs a lot after the assault...to get through things ... but it's not good 'cause you can't really deal with things that way." (#006)

"When I was younger I used marijuana a lot to cope with things. I eventually realised 6 years ago that I must stop using it because it was stopping me from expressing myself." (#034)

Participants continually noted that they often found themselves in situations that reinforced their sense of powerlessness and worthlessness, and this was particularly the case for participants who had been sexually abused in childhood. These situations included abusive spousal relationships, being taken advantage of by family and friends, and being sexually harassed in the workplace. Experiencing continual vulnerability appeared to imply to participants that the sexual victimisation was not in the past, but rather just the start to a very painful life. Particularly with romantic relationships did participants recognise the effects of early sexual victimisation. For instance, participants frequently described a string of relationships with abusive partners, feeling quite strongly that this pattern occurred because of their low self esteem as a result of sexual victimisation.

"Your self esteem is so low, you think you're not going to get anyone else." (#038)

"I feel very strongly that my experiences as a child led to my bad decisions regarding men. I was always looking for a man to protect me, and in doing that I chose men who were protective maybe from other people but they were too controlling of me and ended up abusing me as well." (#098)

In fact, one victim of sexual victimisation in childhood and adulthood (#027) noted that she was so used to being treated in a sexually and emotionally abusive manner that when she found herself in a healthy relationship where her partner respected her and did not force her to have sex, she found herself doubting whether he was actually physically and sexually attracted to her. This victim ended the healthy relationship because she did not feel comfortable in a relationship that was so unfamiliar.

Despite these problems, a widespread pattern in many participants' accounts was never having attended professional services for assistance in dealing with their sexual victimisation. A variety of reasons that prevented them from attending counselling were

given. First, some participants were not aware of counselling services available specifically for people who have experienced sexual victimisation. These participants were surprised when the researcher gave them a pamphlet on some of the services available. It seemed that it was the participants who were older and had experienced sexual abuse as children who were less likely to be aware of the available support services. Second, participants described feeling full of shame and too embarrassed to seek help. Third, a sense of fear of opening up something too dreadful to deal with was another concern about counselling. Fourth, the expectations of what would happen in the counselling process were a concern for some participants. For example, there were concerns that counsellors would make clients describe every small detail of the abuse when they did not want to do that. Other concerns were that counsellors would not believe them that the offences occurred, and that counsellors would tell them that they would have to forgive the perpetrator if they were to heal properly.

"There isn't enough information about services out there. I never knew about it [Sexual Assault Resource Centre; SARC] *when I needed it, people need to know about these things before it happens ... things like the QUIT line* [for smoking] *are just known about now* [participant's emphasis], *where is all the information about SARC? You have to call them to find out about it." (#031)*

"There are pamphlets around these days for everything ... head lice, heart attacks, everything ... but not for sexual abuse. [Pamphlets] *should be in GPs' offices, libraries, all police stations should have this document available." (#021)*

"I don't want to go [to counselling] *because I might remember more buried memories, and I don't want to know anymore." (#013)*

Although many participants had not attended professional services for assistance in dealing with their sexual victimisation, those who wanted such support described inadequate access to counselling support services. Specifically, they described having to wait several months on waitlists for public-funded counselling (even at times of crisis), and too few sessions to deal with the often long-term issues. For example, some public agencies were described as having a limit of 6 to 10 sessions, and even then, participants

felt there were too few professionals within these services who were trained and competent to deal with sexual victimisation.

"[I was] *taken to the* [psychiatric] *hospital because I couldn't live with it all anymore. The doctor asked me why I did it* [attempted suicide] *and I felt I could talk to him, he seemed pretty nice, so I started to tell him about the abuse, I just really wanted to get it all out finally, but I could tell quickly that he didn't want me to talk about it ...he looked really uncomfortable and then gave me some medication and said I'd probably be ok to leave the next day if I felt ok." (#062)*

The other option, private counselling, was described as too expensive by most participants. Rates were generally well over $100 per session, and this option was not regarded as feasible by the majority of participants, particularly by many participants who acknowledged that it would not be a short-term activity. There was also a sense of resentment among many participants, because they had been sexually victimised as innocent people, but yet were forced to pay for their own counselling.

"[When I called for counselling], *I was told there was a 3 months waitlist or something like that. I was horrified...when you call for an appointment, you need it then ... you probably needed it yesterday." (#012)*

"Counselling should be free for as long as people need it because I did nothing to cause the abuse so I shouldn't have to pay for it. I can't afford private counselling and I don't think many other people can either." (#025)

Some statements by male victims of sexual offences indicated that they feel they have to carry some additional burdens. Some extra burdens include friends and family questionning their sexuality if the perpetrator was male, difficulty with their own sexuality, not feeling comfortable accessing support services that are predominantly set up for female clients, and societal expectations of men to handle things easily on their own.

"Men are not taught to express themselves. This leads to more shame and guilt. They are taught that they must be the support of the society, they cannot be weak." (#034)

Feeling left out was another persistent theme in the accounts of male participants. They reported that women are encouraged to express their feelings and get counselling, but that men are expected not to be affected as much by sexual victimisation. Men also described feeling frustrated and sometimes angry that fewer support services are available to men. They noted that the myth in society that only women can be sexually assaulted is extremely damaging, making them feel that their feelings and experiences will not be believed, and that they will never be able to receive the validation they require to deal with the sexual offences more successfully. Societal myths and expectations of men appear to add additional difficulties to an already difficult coping process.

"Not much real support from friends, it's difficult to understand ... they sometimes make fun about it, suggest that I'm a paedophile or that I'm gay or something, it's very insensitive stuff... when people make fun of me about it, I get very angry and violent ... it's very hard to trust people." (#032)

The Meaning of *Justice*

While some participants discussed issues relating to their personal meanings of justice without being prompted by the researcher, the topic was specifically raised by the researcher in the majority of cases. Some participants found it difficult to verbalise what justice meant to them and took considerable time thinking about it before answering. The majority of responses from participants fell into three categories: acknowledgment, punishment/revenge, and restoring balance.

The first category, acknowledgement, was the most common type of response from participants. This concept of justice included having the truth made known and recognition and acknowledgement of the offence by the perpetrator and/or the authorities. (Some other findings that allude to victims' meanings of justice are discussed in a later section entitled "Reasons for reporting to the police.")

"Justice comes from society saying, 'that's wrong, that shouldn't have happened to you.' Justice is repairing, it is a statement, 'this is unacceptable behaviour, this should not happen.'" (#005)

"Face to face, let the public know what happened, and dealt with appropriately. Face what they did was wrong, otherwise they believe what they did was ok." (#007)

"The Judge saying 'guilty' to my father (perpetrator). *I want him* (father) *to explain why he did it. I want him to be punished, not necessarily a jail term, but at least community work." (#009)*

"Justice isn't necessarily prison, (it's) *rehabilitation, owning up to it, acknowledgement." (#017)*

"Justice is the truth." (#025)

"Accountability, just own it, not revenge, I wanted it to be quiet, disappear, not lose face, but he wouldn't agree to it." (#039) [so she reported it to the police]

"Justice is an acknowledgement about what happened and about the effects of it. Especially how it ruined my school days. Justice isn't about punishment, it's about acknowledgement." (#040)

"People who have had wrong done to them feel that there has been a recognition that that wrong has been done and some effort has been made to repair the wrong ... it doesn't have to be financial. It's not about revenge I don't think ... actually I'm sure it's not." (#063)

The second most common meaning of justice focussed on issues relating to punishment of the perpetrator and/or revenge. Participants generally expressed these concepts with intense emotion attached, explicit anger, and hostility for the wrongs done to them.

"Revenge ... death penalty is not enough ... they get a special last meal, injected to be numbed so it doesn't hurt. Victims didn't get that, why should the perpetrator?" (#008)

"Castrate them, their penis is their weapon, if someone used a gun to hurt someone, they would take their gun away from them, this is the same. And punishment--pay for it some major way." (#016)

"An eye for an eye...I know he (perpetrator) *has been raped in prison so I feel that God has given me some justice." (#062)*

"Suffer, cut his balls off, I want to make him suffer like he made me suffer." (#077)

The third main category of the meaning participants attached to justice was the idea of having some kind of balance or equality in the way that the offenders and victims are treated.

"If the rules are broken then the services and procedures are equally applied. If the perpetrator gets (free) rehabilitation, then so should the victim. Same with legal representation." (#002)

"Justice is making people equal, paying for the things you have done so that you are equal." (#072)

"Both sides present their sides equally and fairly and at the end of the day 12 people pass judgment." (#064)

Throughout the exploration of participants' personal definitions of justice, it became clear through two examples that achieving justice is possible outside or beyond the traditional retributive justice system. These two situations are strikingly similar, but both will be described here because of some unique aspects. The first example was a female participant (#121) who had been sexually abused as a child by her brother. She has had no contact with the police regarding her victimisation, and expressed no intention to do so at any time in the future, because she feels she is able to achieve more justice without

the justice system. She stated, "*It's about getting better rather than waging a war.*" She indicated that she has been able to achieve therapeutic gains by confronting her brother and discussing the abuse with him. Once she assured him that she was not intending to report the abuse to the police, he became willing to discuss the abuse with her and has given her financial compensation for some of her counselling expenses. He has also paid for some of her educational expenses at university on the basis that she had to repeat several courses due to lack of concentration she attributed to the effects of the abuse. She reported feeling that she has got much more from discussing things with her brother than she ever would have got out of going to the justice system.

The second example was also a female participant (#127) who was sexually abused as a child by her brother. As an adult, she confronted her family about the abuse. She stated that her brother was extremely remorseful and has always tried to "make it up" to her. For example, he moved to another State because he knew that she would never feel completely comfortable knowing he was close to her. Since her brother lost his wife and children as a result of the abuse coming to light, and since she feels that he continues to punish himself over it everyday, she feels that he has been punished enough, that prison would only make things worse. He has attended counselling which also seemed to satisfy her. She also stated that she feels very empowered in the position she has been in since confronting her family, because she knows that her brother is aware that she can go to the police to report him if he stops taking it seriously. She stated, "I feel that I got justice without the justice system, but I wish other people would understand and accept that."

Reasons For Not Reporting To The Police

Participants who were sexually abused as children mostly described not knowing the abuse was wrong until they were in their teenage years or even later, so reporting to the police was not a consideration for them until they realised it was wrong. By this time, many participants described feeling that it was too late to do anything about it. Another common reason described by many participants, regardless of when the sexual offence occurred, is their fear that nobody would believe them, either the police, or family and

friends. Shame and embarrassment also led many victims to decide not to report their victimisation to the police.

"I had consensual sex with him [perpetrator] *previously, I didn't report it to the police because I didn't want anyone to ask me if I had sex with him before." (#007)*

"People would know about it, especially my family, they would think it was my fault, I thought it was my fault too." (#023)

"I was afraid of being called a liar...they would bring my character down, bring up my criminal record, things I had to do to sustain my heroin habit [participant referred to sex work later in the interview], *they'd look me up in the computer and see my armed robbery conviction and call me a liar or treat me like shit." (#062)*

Lastly, the other common reason given by participants involved their beliefs about the justice system. For instance, some participants felt the justice system process would be too difficult emotionally and that it would be better for them just to try to "forget about it". Others described feeling that reporting would not solve anything anyway since they believed the conviction rates for sexual offences to be extremely low. There was a sense of hopelessness, of risking their emotional well-being and their relationships with friends and family, for little or no eventual gain.

While some participants appeared to have never really considered reporting the offence to the police, others appeared to have thoroughly weighed up the pros and cons of reporting and after a long process decided not to report. One victim in particular who appeared to have thought about the decision very thoroughly gave the following reasons for eventually deciding not to report the child sexual abuse by her father (#020):

- *she still feels intimidated by her father*
- *it was a long time ago, she feels it may be too late*
- *she doesn't know what would happen...fear of the unknown*
- *she doesn't know if her husband would support her about it*
- *it would have a huge effect on her kids, she doesn't want to put them through it*
- *her father would deny the abuse and somehow put it back on her*

Some participants who did not to report the sexual offences to the police described feeling guilty for "not protecting others". One victim said, "*In a way I wish I had* [reported it], *I wish I had enough courage...it would stop him from doing it to other people.*" (#023)

Reasons For Reporting To The Police

Although the reasons for reporting sexual offences to the police varied largely, they appeared mostly to do with acknowledgment of wrong-doing and the effects of the offence, and keeping others safe from the perpetrator. Some participants mentioned issues that appeared to be along the same lines as revenge, but many others actually spontaneously said that it has nothing to do with revenge. There appeared to be three main themes or patterns that emerged from the interview data.

First, participants wanted acknowledgment from the perpetrator and/or from the justice system that the offence occurred and that the offence resulted in substantial damage to the life of the victim.

"My main goal in reporting it was an acknowledgement that he had done it, I felt I had to prove it happened." (#025)

Second, participants appeared to want to restore justice to the situation in some way. For some participants, this meant punishment for the perpetrator - a prison term in some instances. But for other participants, justice meant compensation in some way, for example, counselling for the victim, or participants' offence-related medical bills being paid by the perpetrator.

Third, participants overwhelmingly reported the sexual offences to prevent perpetrators from sexually victimising other people. This focus on trying to help others was particularly evident in cases where participants endured substantial damage to their own emotional, social, and financial well-being in order to have the perpetrator prosecuted.

"My reason for reporting it is more process-driven than outcome-driven...I wanted to make his family aware of his behaviour...he has grandchildren now." (#064)

"I [reported it because I] *didn't want it to happen to anyone else...it was the only thing that kept me from giving in." (#130)*

Experience Of Reporting To The Police

Participants reported spending a lot of time, energy and emotion preparing to go to the police to report a sexual offence. Unfortunately, upon making the decision to report a sexual offence to the police and taking initial steps by going to the police station, many were told to "come back on Monday", or come back in the morning to see someone.

"I went to the police in [suburb name] *on a Friday and was told to come back on Monday since there were no female police officers on duty over the weekend. This made me feel worthless and that what I had been through was insignificant." (#018)*

[After going to the police on Friday and being told to come back on Monday]... *"It was very difficult to wait the 2 days to speak to the police about it...2 nights of hell, I just couldn't hold it in." (#056)*

These messages to come back later were interpreted as rejection by some participants; it reinforced their beliefs that their situation is not worth anyone's time, and that they are worthless. This type of response from the police made it much less likely that they were satisfied with their justice system experiences, and it also made it less likely that they even went back to the station to report their sexual assault at all.

Participant #016 wrote the following passage on her questionnaire:
"Told police about the first time at 15 [years old]. *They didn't believe me and nothing was done. No support from family or welfare system. After this time and being called a liar, I didn't let anyone know of the other rapes. Due to my first experience I had no trust in the justice system what so ever."*

And in the interview, participant #016 stated the following:
*"The attitudes of police made me feel like a slut, my family felt the same way about me, I lost trust in my parents, the justice system, and the welfare system [*child protection*] .... I felt as if I was the perpetrator."*

The following passages are from a male victim of child sexual abuse (#030). The police took his statement but then nothing ever happened with it because they told him not to bother about it. His pain and dissatisfaction with the treatment he received by police were expressed very emphatically.

"The police weren't interested in my case. I went to make a complaint and because I was 16 they said I was too old to do anything and I should have come forward earlier. I was told to forget about what had happened and to try to get on with my life. They said they had too much work to do to try and prosecute a case that they wouldn't win." (#030)

"*I was very angry, it just wasn't right...to go through crap for years* [the abuse] *and then to be told 'there's the door'* [by police]... *The officer who took my statement asked me stupid questions like 'did you enjoy it'?...It felt like getting raped all over again, it felt like I was on trial, he didn't seem interested in finding out the facts ... A woman would never be expected to give a statement with a male officer if she was raped by a man, yet I had to ...They* [police] *should realise that guys cop it* [sic] *just as much as chicks...there's a huge flaw in the system there." (#030)*

In taking the steps to report a sexual offence to the police, many participants reported feeling that they lost control in this process. It could be that not allowing participants to make choices may reinforce any feelings of powerlessness they already feel (see the reference to "again" in the statement below). Having choices about the following matters with respect to giving a statement appeared to make victims more satisfied with the reporting experience: taking breaks, being in control of the pace of statement (all at once or over a few days), bringing a support person with them, and gender of the officer taking the statement.

"It's your decision to report the crime to the police or not, you have the control there, but then as soon as you do report it, all your control is taken again and you are reminded of it [loss of control] *over and over again." (#021)*

"The police acted as if my boyfriend was in the way...they could have used our good relationship well but they didn't...when they were taking me to the station I said I wanted my boyfriend to come for support, and they strongly discouraged it, said things that implied I was being inconsiderate by asking him to come with me, things like 'it's going to be a few hours, are you sure you want to ask him to come and stay all that time? He'd probably prefer to stay home, it's going to be a long time.' I was adamant that I wanted him to be there with me, so he came, but he was put in a dark room in the police station and told to wait there, pictures of murderers all over the walls and things." (#086)

"They [victims] *should have somebody present at the interview who understands their background, as a support person while the victim gives the statement." (#032)*

"[Advice for someone who is planning to report]...*don't do it alone, get someone to go with you, even if they aren't in the actual room while you give the statement, at least get them to drive to the station with you and pick you up." (#019)*

While the majority of participants reported that the manner of the police officers who took their statements were very positive, there were several participants whose statements reflected they believed they had been treated in a horrible manner. Male participants were more likely to report insensitive police treatment than female participants. Participants noted that police often demonstrated a lack of understanding of the issues surrounding sexual offences, and portrayed insensitivity. Several questions asked by police, such as why victims did certain things before or during the offence, implied to victims that the police were blaming them for the offence. Other kinds of statements that participants felt were insensitive are as follows:

Did you enjoy it? [to a male victim] (#030)
You could have got out of there if you wanted to. (#043)

You should have reported it when it started [regarding child sexual abuse] (#030)
Don't take your personal problems to the police to solve. (#001)
You don't want to do that [report it], *that's vindictive* [regarding spousal abuse]. *(#027)*
Why did it take you so long to come and say what happened? (#011)

It seems that by police making such statements, cases are stopped even before there is an official report because victims are too afraid to continue with the reporting process or they are discouraged from reporting. For instance, one victim with schizophrenia in the current study was told by police that there was no point in her reporting the sexual assault because she would not be a credible witness in court (as a result of her mental illness), and therefore it would be a waste of time to take her statement (#066). Other participants have been called liars, or have been told (when the perpetrator is known to the victim) that it is a personal manner, not a criminal one. All these factors would appear to reduce the already extremely low reporting rate for these crimes and make these victims feel worthless, unimportant, and deserving of the violence they have experienced.

"Police need to be compassionate, gentle, they need to be trained how to interview victims differently than how they interrogate perpetrators. Interviewing techniques and perspectives need to be different." (#015)

Experience Of The Interim Period Between Reporting And Trial

Overwhelmingly, the factor that seemed to influence participants' satisfaction with this interim period to the greatest degree was the extent to which police officers kept the participants informed about their cases. Lack of continuity with police officers handling their cases meant participants had to explain their experiences over and over again to new police officers. This was described as one of the most frustrating and upsetting experiences. Part of the problem is that cases generally take years to get to court and officers are transferred to different departments by that time. Even when the police officers remained the same, participants often described having to call the officers several times over several weeks before they were able to make contact. Officers not returning participants' phone calls within a reasonable period of time (a day or two) was

one of the major complaints, and this appeared to lead to immense distress and a cost to participants' self-esteem and self-confidence by not feeling heard.

A remark made by almost all participants who reported their victimisation was that the period between giving their statement to police and going to trial was too long. Most cases took in excess of two years to finalise, putting the victims' lives and healing processes on hold, straining relationships and performance at work, and delaying any sense of safety.

"One of the main problems I had was that it took so long for things to happen...taking so long seemed to make me lose hope and feel depressed...It put my life on hold, my son missed 2 years with his mother, my partner missed out too ...I am angry all the time now, [I] *never used to be like this" (#001)*

"I ended up stopping the proceedings when he pleaded not-guilty. I felt it would be more traumatic for me to continue, especially since it was taking so long." (#001)

"The justice system doesn't ever let you forget what happened. Sometimes you wish there was a happy medium where what you feel is acknowledged but yet not too much focus on you." (#005)

During this interim period, there is always the legal possibility that a decision will be made not to continue with prosecuting the case. This decision is made by the Office of the DPP when it is perceived that there is not enough evidence to proceed. However, many participants reported not knowing that this was a possibility until months or even years after giving their statement to the police, when they received a letter in the mail from the Office of the DPP, stating that the decision had been made to cease prosecution. There are four main reasons participants gave for becoming very upset upon hearing this news.

First, they had not been given any warning that this could happen and therefore fully expected their cases to go to trial. After three years, the following participant was told

that the case was going to be dismissed. He had the following to say about this experience:

"The justice system should have prepared me better for the possible outcomes. I had no idea that after all that time the case could still be dismissed. I was shocked and angry ... when I found out I lost it...I felt like I sort of failed. I thought 100% it would go to court...I never knew to expect anything else." (#032)

Second, they were informed by mail, as opposed to over the phone or in person. Victims described feeling that it was a very impersonal way to be informed about such a personal issue, and there was also the sense that the DPP did not have the "courage" to face his decision.

"I was especially angry to hear of the dismissal through a letter, a very impersonal one too. Important news like that should be given face-to-face. They should make an appointment for the victim to go in to meet the prosecutor. They don't realise how important that decision is, it's your whole life." (#032)

Third, the decision had been made so long after their statement, and they had put their lives on hold with the belief that they case would go to trial. They described feeling that the DPP should make those kinds of decisions much sooner after reporting, that many months or years after reporting was too late.

"I reported it 5 years ago, I just learned a few months ago that it wasn't going to go ahead...very angry that it took this long to decide that it wasn't going to go ahead." (#007)

Fourth, there was a sense of a having endured emotional upheaval for nothing, and also a sense of worthlessness, that their case must not mean anything very important if it is dropped by the DPP.

"After all that, after 3 years, it was so draining, and then nothing." (#032)

Experience Of The Trial Period

In the period leading up to the trial, participants reported problems of continuity of staff from the Office of the DPP, similar to those described regarding police. They also described not meeting the prosecutor for their case until the day or two before the trial. This made many participants feel that their case was not prepared as well as it could be, and this is turn made some participants feel that this was just another sign that their case was worthless and not worth the effort to do a good job.

"I had contact with the DPP lawyer once for about 10 minutes, a day or two before the trial. This was insufficient and really made my case feel like nothing." (#029)

Another commonly reported problem was insufficient information and preparation about the court process. The trial proceedings usually ended up being very different from what participants' expected. For example, most participants described being shocked when they arrived to court to find members of the public sitting in there watching and listening to all their very personal experiences. Additionally, many participants were shocked when they ran into the perpetrators and/or the perpetrators' families in the courthouse before the trial. They reported feeling extremely intimidated. One victim proposed that separate waiting rooms and entrances for victims in cases of personal violence would help immensely (#064).

"The police were great, very helpful, [but] *court was another matter, altogether very stressful and traumatic. One of the worst parts was that he* [perpetrator] *stared us* [victim and her family] *down as we passed each other on the street in front of the courthouse, and in the court he stared us all down, then I had to give evidence in court... These things were all worse than the actual sexual assault. (#012)*

*"At the plea hearing, he [*perpetrator*] walked into the courtroom with his lawyer and sat in the row in front of me in the public gallery for half an hour until his case was called. I was shocked to find out that he could do that. I thought he would have been accompanied by security guards or something, by a separate entrance." (#025)*

"It's not good that I have to walk past his family when I walk into the court house. There should be a separate area for them or for me to wait." (#064)

Testifying in court was often described as "*worse than the actual sexual assault*" because it was done in front of many people, including the public, and it was done by people in authority who should care about victims (e.g., lawyers, Judges). This gave victims the impression that they were being blamed for the rape, and that they were being treated like criminals, rather than innocent victims. Another distressing feature of giving testimony that participants reported was being forced to answer only "yes" or "no" to the lawyers' questions rather than being allowed to tell their stories in their own words.

"I was really upset in court because they wouldn't allow me to fully answer the questions as I wanted to, I was only allowed to answer yes or no." (#043)

"In court, I remember not being able to give the whole story, they would ask a question and I could only answer yes or no, I wasn't allowed to give the context of the answer. This was distressing." (#046)

"Giving evidence in court was very traumatic, he [perpetrator] *sat there and laughed at me. I felt like everyone thought it was all a joke except for me.... He* [perpetrator] *was very intimidating, I felt like giving up in trial, felt very small, worthless, insignificant, like nobody cared." (#021)*

A major theme here is that nobody cares or appreciates the depth of emotion they feel and the significance of the issues they face. This theme started out with many victims' family and friends, and when the victims took the risk in reporting it to the police, in hope of some acknowledgement, their needs were often neglected there too.

One of the most common sentiments portrayed throughout this research is indicated in the following statements:

"I felt like the perpetrator in court." (#029)

"I felt like I was the one on trial." (#045)
"I came out feeling I had done something wrong." (#049)
"I felt like I was the criminal...very degrading." (#018)

In the reports of participants, some Judges showed a lack of understanding about sexual offence issues and insensitivity towards victims. Comments suggested that some Judges have very little understanding and sometimes very little compassion. In line with the therapeutic jurisprudence perspective, court staff, including Judges, can play a very therapeutic role in the process, even if there is an acquittal (Holmstrom & Burgess, 1983). For instance, one victim recalled something the Judge in her case said before the trial was officially over. The Judge said that on behalf of the community, he would like to thank the victim for reporting the crime to the police, at the expense of her own emotional well-being, and that many negative insinuations had been made by the defence team about the victim's character during the trial, hut that her reputation remained intact. The victim stated that this statement made by the Judge gave her all the acknowledgment, validation, and justice she had been searching for and took away some of the shame surrounding the situation (#130).

"People say it's a horrible crime, but when you go to the justice system, it doesn't seem that way." (#007)

The response of participants to the outcome of the trials was interesting. It was evident that their satisfaction was rarely based only on whether a conviction was obtained. While obtaining a conviction appeared to be very important as a way of vindicating the victims, other more process-oriented factors were also emphasised as important. For some victims, a conviction was not necessary to satisfy their search for justice. Positive meaning was sometimes found in the situation by acknowledging that the perpetrator was brought out into the public and accused of the crime, and that people took them (the victims) seriously because they had reported the crime to the police. Other victims felt positively about the ending because they had given it their best effort, and could then move on from the incident with a sense of closure.

However, for other victims, a conviction was not enough to satisfy them. They often reported feeling relieved when they heard the news that the perpetrator had been convicted, but then feelings of being let down took over weeks later when the sentencing took place. There appeared to be a consistent expectation that the perpetrators would receive more prison time. For instance, when one female victim's child sexual abuse case against her father was met with a conviction, he received 33.5 years for the many offences, but to be served concurrently, meaning that with parole he only served 3 years in prison (#021). A member of staff in the justice system remarked to her, "You would be happy to know that if he was younger he would have got longer in prison." This comment outraged the victim, as she said to the researcher, "*Why on earth would I be happy to hear this? He didn't take my age into account when he first started abusing me, why should they consider his age when punishing him for it?*" After he was released from parole, this same father came back and raped the victim again (at age 40), telling her it was her punishment for taking him to court in the first place. This victim feels that if the perpetrator had not been allowed to serve the 33.5-year sentence *concurrently*, he would not have been able to sexually assault her again. As a result, she reported feeling let down by the justice system and holds it partially to blame for her more recent victimisation.

During the interim period, but also after the finalisation of the case, many participants were angry that they were not offered free counselling for them to heal from the offences. They noted that offenders in prison get all the counselling they want, but victims really get nothing. Counselling may be especially important for victims at the end of the justice system process. Counselling might be beneficial to victims when their court cases are dropped, when defendants receive a not-guilty verdict, and even when the case has led to a guilty verdict. Discussing the end result of the case with a counsellor, to achieve some sense of closure and a plan for the future, was described by some participants as a therapeutic way to end the justice system experience.

"Prisoners get skills training to rehabilitate them and reintegrate them back into society, but victims get no such training. Victims need anger management too, they need self-esteem training.... " (#005)

"Perpetrators get rehabilitation after conviction, but the victim gets nothing, no rehabilitation, must pay for it themselves or go to a government place with a long waitlist and only maximum 6 sessions. The perpetrator gets all the info about all the programs available, can get free uni education etc., but the victim gets nothing, has to find out about everything by themselves." (#021)

Participants Most Satisfied With The Justice System

While the majority of participants in this study described harmful and terrifying experiences throughout the justice system process, there were some participants who described a fairly positive experience. The experiences of participants who were satisfied with their justice system experiences (or a portion of their experiences) are described below.

With respect to giving a report to the police, satisfied participants were offered a choice of a male or female police officer to take their statement, they were encouraged to give their statement at their own pace, they were not pressured to give their statement all at one time, and they were regularly asked if they wanted to take breaks to go to the washroom or get a drink. Further, they dealt with police officers who showed compassion and told them they believed the victims, and that it was not the victims' fault. Even when procedures were inherently distressing to victims (i.e., having to answer embarrassing or humiliating questions), explanations and apologies by police and prosecutors were received positively by victims and appeared to increase their tolerance of the procedures.

"Aside from [being told to come back on Monday to report the offence], *I found the personal manner of the police caring and supportive... on my side... I felt they believed me, which was the first time I ever felt that someone was on my side, it meant everything to me." (#021)*

With respect to the interim period between reporting and the trial, participants satisfied with the justice system experience said they dealt with the same one or two police

officers throughout the entire process, they dealt with police officers who returned their phone calls within a reasonable period of time (within a day or two), even if they did not have any new information, and they dealt with police officers who kept them informed of the progress of their case. The police officers called them to check to see how they were feeling every once in awhile (every 2 months or so) and offered them telephone numbers of counselling agencies. One victim of a recent sexual assault emphasised the compassion of the police officers well when she stated, *"The police were so good to me, really cared, told me 'since you live alone if you get scared at night or something, just call us and we'll come around and have a coffee with you', and this made me feel so supported, so safe."* (#029)

With respect to the trial period, they did not see the perpetrator in the courthouse before the trial, they felt informed and prepared for the trial, they were not told that the outcome would be 100% this way or the other (i.e., they had realistic expectations that it could go either way), and their cases were finalised within a reasonable period of time (within a year). Further, they did not mention feeling that they were treated as criminals in court and to blame for the offence. Additionally, they had more timely personal contact with the same DPP staff throughout the process, and were told by police and DPP staff that even if a conviction is not obtained, it does not mean that nobody believes them; it just means there was not enough evidence. Lastly, irrespective of a conviction, Judges who made comments showing compassion with respect to the victims' situations gave these victims the acknowledgment they had been longing for. These comments helped victims feel positively about their decision to report the offence to the justice system.

CHAPTER 8

Results

Quantifying Qualitative Data

Aspects of the qualitative data that appeared to the researcher to be related to psychological functioning were coded to allow quantitative analysis. Coding the data was conducted in two phases. The first phase resulted in frequency counts that were too low to conduct inferential analyses for some of the variables, and therefore a second phase of coding took place. The criteria in the second phase were broadened, which resulted in increasing the frequency counts.

Both phases of coding consisted of the same general steps and so these will be described here first before each variable is discussed in turn. Initially, variables were established that the researcher hypothesised would predict outcomes. This process was made easier since the researcher conducted all the interviews herself. The themes in the data developed over time as each successive interview was completed, based on the interview notes. A coding system for each variable was then established. Some variables were coded as a presence or absence of the variable (dichotomous yes/no). In these cases, *presence* referred to situations where the factor was noted as reported or inferred by the participant, whereas *absence* referred to situations where the factor was not noted as reported or inferred by the participant. It is important to note that in classifying a participant's situation as *absence* for a particular factor, it cannot be assumed that the factor did not exist in the participant's situation, only that it was not salient for the participant at the time of the interview or that the participant did not wish to relate such information to the researcher. Therefore, the presence/absence dichotomy might also be considered as *having evidence* for the factor versus *not having any evidence* for the factor. While some variables were dichotomous, others were coded along a continuum (e.g., 4-point rating scale). The next step involved reading through each set of interview

notes and assigning labels and values to the sections of the notes that were relevant to each variable. The final step involved going back through the notes and entering the coding labels and values into SPSS. Frequency counts were established for each variable using SPSS Frequencies. As a result of some rating scales yielding low frequency counts, some categories were collapsed (e.g., from a 5-point scale to a 3-point scale). The coding process in terms of the criteria of each variable and the resulting frequencies will now be described.

The Coding Process Of Variables

Personal Support For The Sexual Offence

This variable was initially divided into four categories: a) no sense of social support in life in general, b) no sense of support for the sexual offence but sense of support in other areas, c) counselling support only for the sexual offence, or d) support for the sexual offence in personal life (e.g., friend/family). The second category (b) yielded only 2 participants so it was combined with the first category to represent no social support for the sexual offence or in life in general. The categories were then collapsed once again to yield two final groups: no support for sexual offence in personal life (Group 1, n = 73) and support for sexual offence in personal life (Group 2, n = 59).

Prototypical remarks in Group 1 are "my family just doesn't understand, I have to pay someone [a counsellor] to get someone to really listen to me and understand me" (#041) and "it's an awful feeling having to deal with this all on my own...nobody understands." (#088) Prototypical remarks in Group 2 are "my husband is very supportive, I would not have been able to come so far without him" (#081) and "I can tell my best friend anything and she never makes me feel that I bring it up [the sexual offence] too much." (#067)

Disclosure Of Sexual Offence

Participants' disclosures of the sexual offences to family, friends, or other people, were rated, initially using three categories: a) no disclosure, b) disclosure experience more negative than positive, and c) disclosure experience more positive than negative. Only one participant indicated no disclosure to anyone, and therefore this datum was removed

from the categories, leaving only the two categories: disclosure experience more negative (Group 1, n = 27) and disclosure experience more positive (Group 2, n = 20), with the remaining cases (n = 84) referred to as missing data since there was not enough information to assign the case to either category. Two separate variables were then created: Evidence of positive disclosure (yes = 21, no = 111) and evidence of negative disclosure (yes = 27, no = 105).

A prototypical remark for negative disclosure is, "When I told my mum [about the abuse] she told me not to lie and blamed me for trying to break up the family." (#114) A prototypical remark for positive disclosure is, "I told my dad and he was very good, even better than I had expected...he told me it was my decision about reporting it to the police and whether we told [stepmother] about it." (#117)

Police Contact

Police contact was initially categorised into four groups: a) no police contact, b) police contact experience more negative than positive, c) police contact more positive than negative, and d) police contact equally positive and negative. Since only 9 participants fell into the last category, these were removed from the categories. Two variables were then created: Evidence of positive police contact (yes = 33, no = 99) and evidence of negative police contact (yes = 31, no = 101).

A prototypical remark for negative contact is, "the police made me feel like I was the criminal...I was appalled at the way they treated me." (#033) A prototypical remark for positive contact is, "they made sure I had access to a female police officer which was a relief...she was fantastic, she really connected with me on a human level." (#111)

Chaotic Childhood Environment

Participants were categorised as having a chaotic childhood environment if their interviews indicated abuse of any kind (including neglect) in the family home as a child (whether directed at the participant or other family members), or if there was mention of parental substance use problems. There were 90 cases where this was present and 42 cases where there was no evidence of a chaotic childhood.

A prototypical statement that exemplifies a chaotic childhood environment is, "I didn't get much education, my father often took me out of school to go to home to abuse me.... I told my mother a couple times but she didn't believe me, then she walked into my room once and saw him on top of me, she just closed the door and walked out and didn't mention anything." (#008)

Hopelessness

The presence of this variable was noted if participants stated that they felt they lacked control over what happens in their lives, if they mentioned that they did not have any hope for the future, or if they did not see any way of improving their situations. A prototypical statement for this variable is a case where the participant spoke about the perpetrator being released from prison and his refusal to obey parole conditions to stay away from her: "This reinforced the message that I have no control in my life as far as my own safety is concerned, and it reinforced the message that he still controls my life." (#021)

Phase 1 of data coding yielded 9 cases where this was present and 122 cases where this was absent. Phase 2 of data coding broadened the criteria for this variable by not requiring the participant to actually *state* a deficiency of control or hope; the *sense* that this was the case (by reading through the interview notes) was enough to satisfy the criteria. A prototypical statement that led to this sense of hopelessness is "things in childhood set life" (implying little room for change) (#007). The results of phase 2 of data coding yielded 82 cases of hopelessness and 50 cases where this was not apparent.

Substance Use As Coping

The presence of this variable was noted if participants mentioned having used alcohol or other drugs to help them cope with the sexual offence. There were 34 cases where participants mentioned this, and 34 cases where participants specifically mentioned that they had not used substances to deal with problems (usually in response to a question from the researcher).

Using Sex To Cope

The presence of this variable was noted if participants mentioned having used sex to deal with the sexual offence, or if they noted being promiscuous in a way that they felt was related to the sexual offence. A prototypical statement for this variable is, " I used to be promiscuous...to get men to do what I wanted." (#077) There were 13 cases were this was mentioned, and 119 cases where it was not mentioned.

Self-harming Behaviour

The presence of this variable was noted if participants stated they had engaged in self-harming behaviours. Included in this category were cutting, burning, taking excess amounts of drugs with the intention of overdosing, and eating disorder behaviours such as starving patterns typical of anorexia nervosa, or engaging in binge-purge patterns typical of bulimia nervosa. An example is a case where the participant mentioned she used to cut and bum herself (she had scars covering her arms) and had been admitted involuntarily into a psychiatric hospital earlier this year for risk of self-harm. There were 12 cases where this was mentioned.

Substantial Withdrawal From Social Activities

The presence of this variable was noted if participants mentioned that they had cut themselves off from social activities to what the researcher considered to be a substantial degree. A substantial degree of withdrawal involved little or no ongoing day-to-day contact with anyone, or participants stating that they have stopped calling or meeting with most friends and family members. This categorisation yielded 17 cases of substantial withdrawal, and 115 cases of no evidence of such withdrawal.

An example case is a woman who participated in the research at her house. She lived on her own, did not work, did not have a partner or children, said she rarely goes outside, said she rarely sees people, had the curtains of her house drawn to prevent light entering or people being able to see inside, and had a sign outside her door that stated, "Please do not ring doorbell or knock on the door: I am a shift worker and need my sleep." (#042)

Obstructive Coping

As a result of the low frequencies counts for the previous four categories (substance use, using sex to cope, self-harm, and substantial withdrawal) and the common link among them (coping behaviours that are thought to obstruct the therapeutic process), they were combined to form one variable. If participants reported engaging in any of these behaviours, they were coded as having engaged in obstructive coping behaviours. This new coding process yielded 62 cases where obstructive coping was present, and 70 cases where there was no evidence of such coping behaviours.

Task-oriented Coping

The presence of this variable was noted if participants described behaviours that signified task-oriented (problem-focussed) coping. Examples of task-oriented coping behaviours include: reading books on problem issues or otherwise attempting to learn about the causes and solutions to problem issues, taking self-defence classes to feel empowered, installing a security system at home to increase sense of safety, setting small goals to raise self-confidence, and exercising to reduce feelings of anxiety. This categorisation yielded 41 cases of task-oriented coping, and 91 cases where no evidence of such behaviour existed.

Quantifying The Qualitative Variables

The qualitative variables evolved from being imprecise themes in the interview notes to being quantified in terms of frequency counts. The result of this process is shown in Table 2 below. The variables in the table will be included in quantitative analyses in the next chapter. These variables will be clearly distinguished from the other quantitative variables in the following chapters by using a superscript "Q" to denote the variables that were established through qualitative data analysis (e.g., task-oriented^{Q}).

Table 2

Frequency counts of qualitative variables

Qualitative Variable	**Yes (n)**	**No (n)**
Evidence of personal support for the sexual offence	59	73
Evidence that disclosure of sexual offence was positive	21	111
Evidence that disclosure of sexual offence was negative	27	105
Evidence that experience of contact with police was positive	33	99
Evidence that experience of contact with police was negative	31	101
Evidence of a chaotic childhood environment	90	42
Sense of hopelessness	82	50
Evidence of obstructive coping behaviours	62	70
Evidence of task-oriented coping behaviour	41	91

CHAPTER 9

Results

Quantitative Data

Data Screening

Prior to analysis, the variables were examined through various SPSS programs for accuracy of data entry, missing values, and fit between their distributions and the assumptions of univariate and multivariate analysis. There were eight missing values: one missing value for each of the four coping strategy variables, two missing values for the frequency of rumination variable, and two missing values each for guilt-proneness and shame-proneness. All of these eight missing values were replaced by their respective means.

Several univariate outliers were revealed with examination of boxplots. These were dealt with using the method described by Tabachnick and Fiddel (2001), of replacing outliers with a score one unit higher/lower than the most extreme score. This way, the disproportionate influence of the outliers on the distribution is reduced, but their position in the distribution as highest/lowest scores is retained. The Mahalanobis distances method of detecting multivariate outliers was used and revealed no multivariate outliers.

Variables were normally distributed except for state anger, frequency of rumination, and the two self-blame attributions (self-character and self-behaviour blame). The state anger variable was so severely positively skewed (the majority of participants endorsed the lowest possible score) that transformation was unhelpful. It was deemed futile to include this variable in any inferential statistics. However, the descriptive statistics and comments from participants about the use of this state anger scale are reported later in this chapter in section A, and the implications of the use of this scale are discussed in the

Discussion chapter. The frequency of rumination variable had severe negative kurtosis, which was dealt with by collapsing the original 7-number rating scale down to a 4-number rating scale. This recategorisation was successful at normalising the variable. The last two variables, attributions of self-blame (character and behaviour), were severely positively skewed and were also successfully dealt with by collapsing the rating scales from 7-point scales to 3-point scales.

It should be noted that since multiple t-tests were conducted, the likelihood of Type I errors may be inflated.

Outline Of The Remaining Sections Of This Chapter

The remaining sections of this chapter will describe the quantitative results. The first section (A) will provide descriptive information about the standardised test scores and comparisons between the current sample's scores and normative data. This information will provide an indication of the current level of symptomatology in the sample. The second section (B) will report inferential patterns found amongst the predictor variables themselves. The third section (C) will report inferential patterns found between the predictor variables and the outcome variables. These sections will provide a basis for the fourth (and final) section (D), where the results of regression analyses shed interesting light on the search for predictors of psychological functioning.

A: Descriptive Statistics and Comparisons with Normative Data

Comparisons with normative data were conducted using one-sample t-tests with significance levels reported throughout the relevant passages. Normative data were obtained in test manuals, where possible, and journal publications.

Dynamic Psychological Factors

Perceived Control

The two scales used in the Spheres of Control Scale (SOCS) measure perceived *personal* control and perceived *interpersonal* control. The mean perceived *personal* control score in the present sample was 48.52 (SD = 10.47, range 20-67) and the perceived *interpersonal* control mean score was 40.61 (SD= 11.83, range 13-70).

Three normative samples were used to compare the scores of the current sample: a) a group of 108 men and women ranging in age from 18 to 65 (mean age of 36) seeking help at a traumatic stress clinic in the UK (Charlton & Thompson, 1996), b) a non-treatment sample of 382 male and female undergraduate college students (mean age of 20) in New Zealand (Spittal et al., 2002), and c) a non-treatment non-student sample of 576 male driving examiners in the UK (mean age of 48) (Paulhus & Van Selst, 1990). The present sample displayed lower levels of perceived interpersonal control compared with the latter two normative samples, but did not differ from these samples in terms of perceived personal control. Figure 6 displays the levels of perceived personal and interpersonal control between the present sample and the three normative samples.

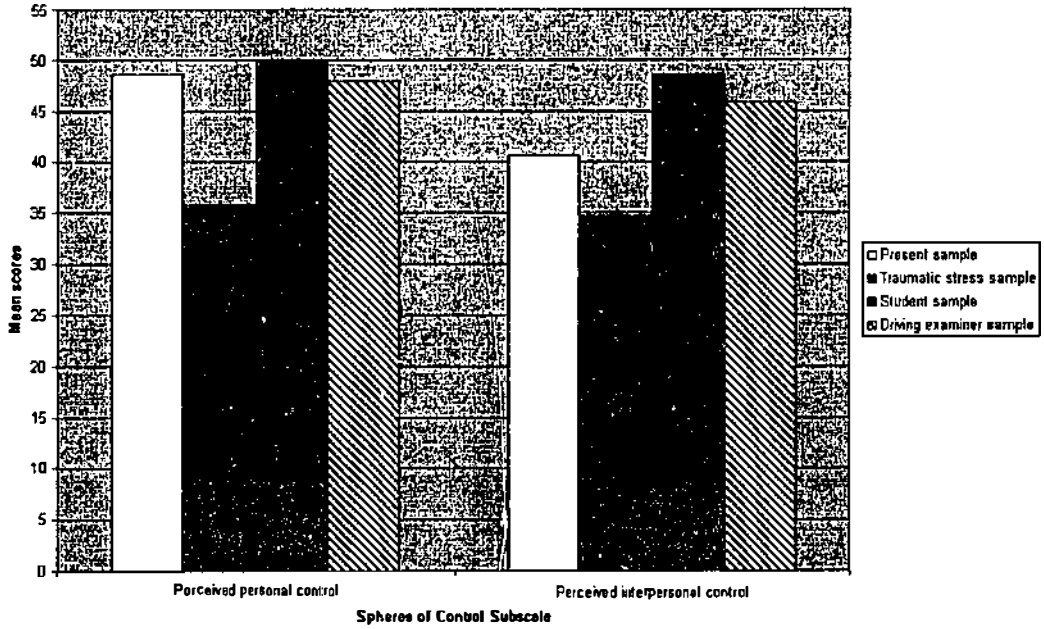

Figure 6: Mean scores of the personal and interpersonal scales of the Spheres of Control Scale in the present sample and three normative samples.

Compared to the first normative sample, the group of adults seeking help at a traumatic stress clinic, the current sample had significantly higher perceived control on both scales (personal and interpersonal) ($p < .001$). The normative sample indicated a mean perceived personal control score of 35.76 (SD = 6.79) and a mean perceived interpersonal control score of 34.68 (SD = 9.66) (Charlton & Thompson, 1996).

The current sample did not differ from the second normative sample, the sample of college students, in terms of perceived personal control ($p > .05$). However, the current sample displayed significantly lower levels of perceived interpersonal control than the college sample, $t(131) = 7.699$, $p < .001$. The college sample revealed a mean perceived personal control score of 49.96 (SD = 7.55) and a mean perceived interpersonal control score of 48.54 (SD = 8.85) (Spittal et al., 2002).

A similar pattern was found with the third normative sample, the driving examiners, as with the college sample. The current sample had significantly lower perceived interpersonal control scores ($t(131) = 5.038$, $p < .001$), but similar perceived personal control scores ($p > .05$), compared to the normative sample of driving examiners. The

driving examiner sample reported a mean perceived personal control score of 47.9 (SD = 6.8) and a mean perceived interpersonal score of 45.8 (SD = 8.2) (Paulhus & Van Selst, 1990).

Shame-proneness and Guilt-proneness

The Tests of Self-Conscious Affect (TOSCA) was used to measure shame-proneness and guilt-proneness. The shame-proneness scores ranged from 22 to 75, with a mean score of 48.61 (SD = 10.66). The guilt-proneness mean score was 61.15 (SD= 6.24), with scores ranging from 46 to 75. Guilt-proneness scores were significantly higher than the shame-proneness scores, $t(131) = 16.725, p < .001$.

The mean shame and guilt scores in the current study were compared with those reported in two normative samples in Tangney's research (Tangney et al., 1989). The two normative samples were a) male and female adults travelling through a large urban airport on a weekend, and b) mothers and fathers of 5th grade children in a culturally and socioeconomically diverse public school. The current sample appears to make significantly more shame-type attributions than people in the general population, but they are just as likely as people in the general population to make guilt-type attributions. The mean shame-proneness score in the current study is significantly higher (reflecting more shame) than the mean shame scores reported in both normative samples ($p < .001$). However, the guilt-proneness mean score in the current study is similar to both normative samples' mean guilt scores ($p > .05$). The adults in the airport reported a mean shame-proneness score of 42.79 (SD = 9.51), and a mean guilt-proneness score of 60.61 (SD = 5.06). The sample of parents reported a mean shame-proneness score of 39.43 (SD = 9.98), and a mean guilt-proneness score of 61.09 (SD = 6.30). Thus it is shame-proneness that seems to characterise sexual offence victims.

Coping Strategies

The Coping Scale for Adults was used to assess the degree to which participants use each of the four main types of coping strategies: a) dealing directly with problems, b) nonproductive coping, c) optimism, and d) sharing with others. Participants most commonly reported using nonproductive types of coping strategies (M = 68.31, SD =

15.15), followed by dealing directly with problems (M = 2.56, SD = 14.26). Optimism (M = 59.15, SD = 14.96) and sharing with others (M = 53.61, SD = 30.07) were used less often by participants in this sample.

The normative sample reported by Frydenberg and Lewis (1997) consisted of 409 male and female adults in the general community in Melbourne, Australia. This sample consisted of parents of university students (n=30), school teachers (n=20), middle level managers in a large retail corporation (n=134), shoppers at a range of Melbourne malls (n=187), and people waiting in doctors' waiting rooms (n=38). The majority of participants (72%) were between 20 and 39 years of age. Compared to this normative sample, the current sample reported using significantly higher levels of nonproductive ($p < .001$) and optimism coping strategies ($p < .05$), and significantly lower levels of dealing with the problem ($p < .01$) and sharing ($p < .001$).

Attributions For The Sexual Offence

Participants were asked to indicate the level of blame for the sexual offence they attributed to various sources. Since the questions that elicited participants' attributions for the sexual offence were created by the researcher, norms are not available, however, descriptive data based on the current sample are provided here to gauge the attributional patterns in the sample. Respondents indicated the strength of their attributions on a scale of 1 (not at all) to 7 (strongly). Attributing the sexual offence to the perpetrator was the strongest response (M = 6.13), followed by (in descending order) society (M = 4.77), the victims' behaviour (M = 3.45), the victims' character (M = 3.37), bad luck (M = 2.80), and someone else (M = 2.66). Figure 7 displays the strength with which participants endorsed each specific attribution.

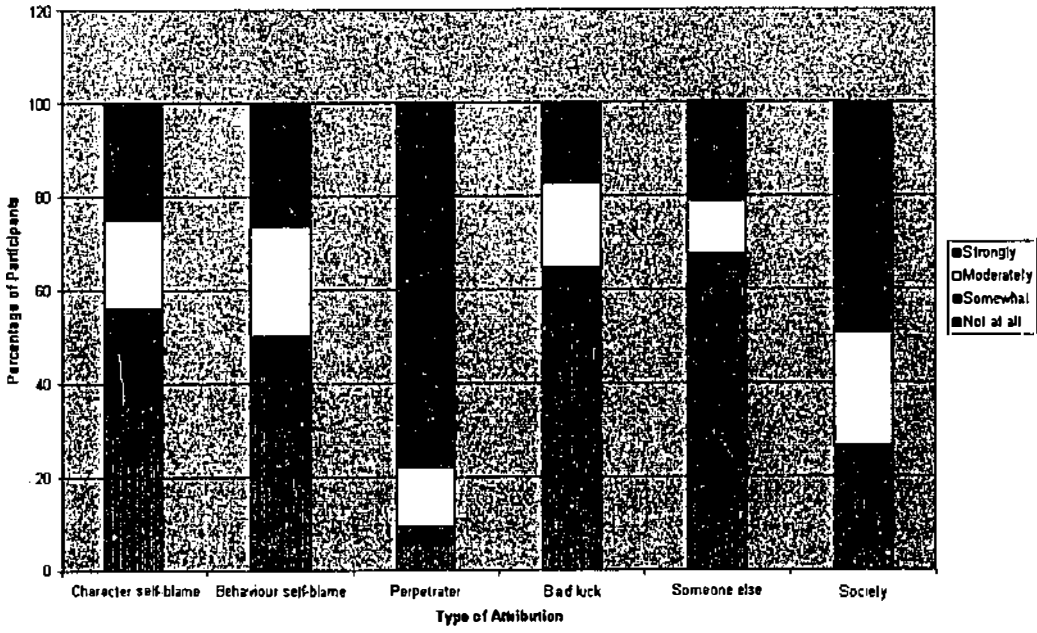

Figure 7: Strength of attributions for the sexual offence.

Additionally, an interesting finding occurred with the attribution scale throughout the course of data collection. Several participants noted that it was frustrating completing these questions because what they *think* differed from what they *feel*, and therefore it was difficult to choose only one response per attribution. As a result of these comments, the researcher modified the questions to elicit participants' thoughts *and* feelings about the items. Thirty-six participants completed both sets of responses. Analysis of the data revealed that participants indicated significantly less behavioural self-blame when they responded about their thoughts (M = 2.58, SD = 2.31) compared to when they responded about their feelings (M = 4.03, SD = 2.44), t (35) = 4.38, $p < .001$. Similarly, participants indicated significantly less characterological self-blame when they responded about their thoughts (M = 2.69, SD = 2.12) compared to when they responded about their feelings (M = 4.11, SD = 2.44), t (35) = 4.26, $p < .001$.

Outcome Variables: Symptomatology of the Sample

Depression and Anxiety

The Hospital Anxiety and Depression scale (HAD) scores revealed a mean depression score of 6.49 (SD = 4.31), with scores ranging from 0 to 16. The anxiety scores ranged from 2 to 21, with a mean score of 11.55 (SD = 4.29). Comparison with norms shows the sample to have higher levels of depression and anxiety than a healthy control sample.

Clark, Cook, and Snow (1998) reported HAD scores of a group consisting of 25 male and female adult non-depressed healthy controls recruited from clerical and support staff at an eastern Canadian university. The group's mean age was 40.7 years, and 44% had a highschool education while 52% had some postsecondary education. The current sample of participants displayed significantly higher levels of both depression and anxiety compared to the group of healthy controls (see Figure 8). This control group reported a mean depression score of 1.68 (SD = 2.36) and a mean anxiety score of 3.84 (SD = 3.69). Both of these scores for the healthy control group are significantly lower than the mean scores of the current study sample (depression: $t(131) = 12.828, p < .001$; anxiety: $t(131)\ 20.637, p < .001$).

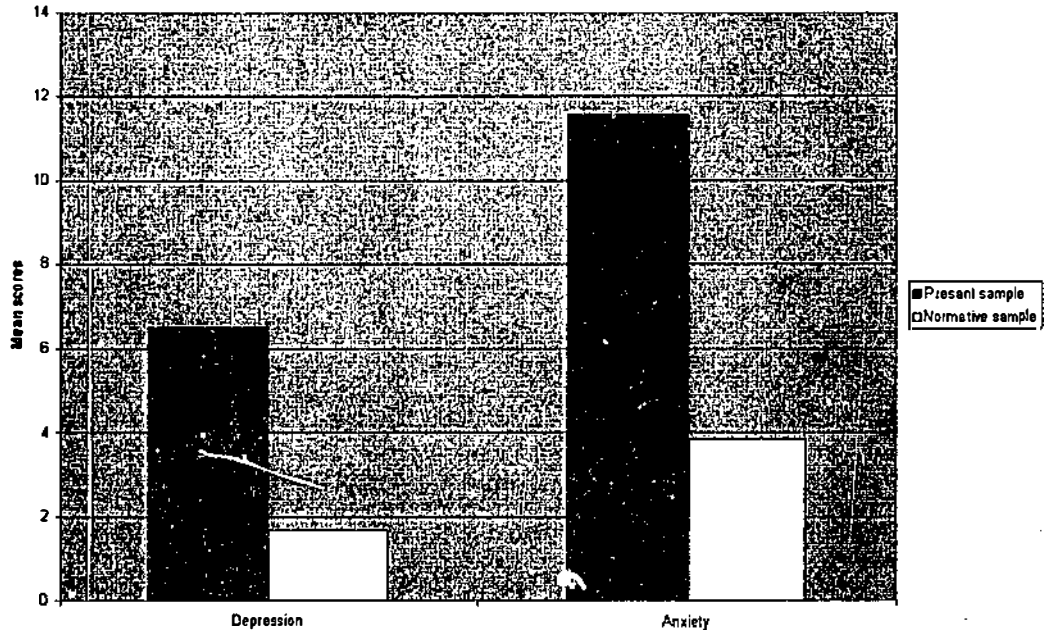

Figure 8: Mean depression and anxiety scores on the Hospital Anxiety and Depression Scale (HAD) of the present sample and the normative sample.

Posttraumatic Stress Symptomatology

There was a high degree of posttraumatic stress symptomatology in the current sample, as measured by the Trauma Symptom Inventory (TSI). Specifically, 42.4% of the sample had clinically significant symptomatology on the Anxious Arousal scale. Percentages of the sample with clinically significant levels on the other scales are Depression (37.1%), Anger/Irritability (31.8%), Intrusive Experiences (51.5%), Defensive Avoidance (49.2%), Dissociation (53%), Sexual Concerns (47.7%), Dysfunctional Sexual Behaviour (22.7%), Impaired Self Reference (37.1%), and Tension Reduction Behaviour (34.8%).

Posttraumatic stress symptomatology (mean raw scores) of the current sample was compared to Briere's (1995) normative sample of 261 women with a self-reported history of trauma (but not necessarily PTSD diagnoses). Overall, the present sample and the normative sample indicated similar levels of posttraumatic stress symptomatology. Specifically, the current sample (including the women only, for comparison purposes) displayed similar levels of symptomatology to this normative sample on the following

scales: Anger/Irritability, Defensive Avoidance, Dissociation, Sexual Concerns, Dysfunctional Sexual Behaviour, and Tension Reduction Behaviour ($p > .05$). Further, the current sample displayed significantly higher levels of Intrusive Experiences than this normative sample ($p < .05$), but significantly lower levels of Anxious Arousal, Depression, and Impaired Self Reference ($p < .05$).

Another normative sample consisted of 423 women from the general population known not to have a PTSD diagnosis (Briere, 1995). Analyses revealed that the current sample (including the women only) had significantly higher symptomatology on all TSI 10 scales than this normative sample ($p < .001$) (see Figure 9).

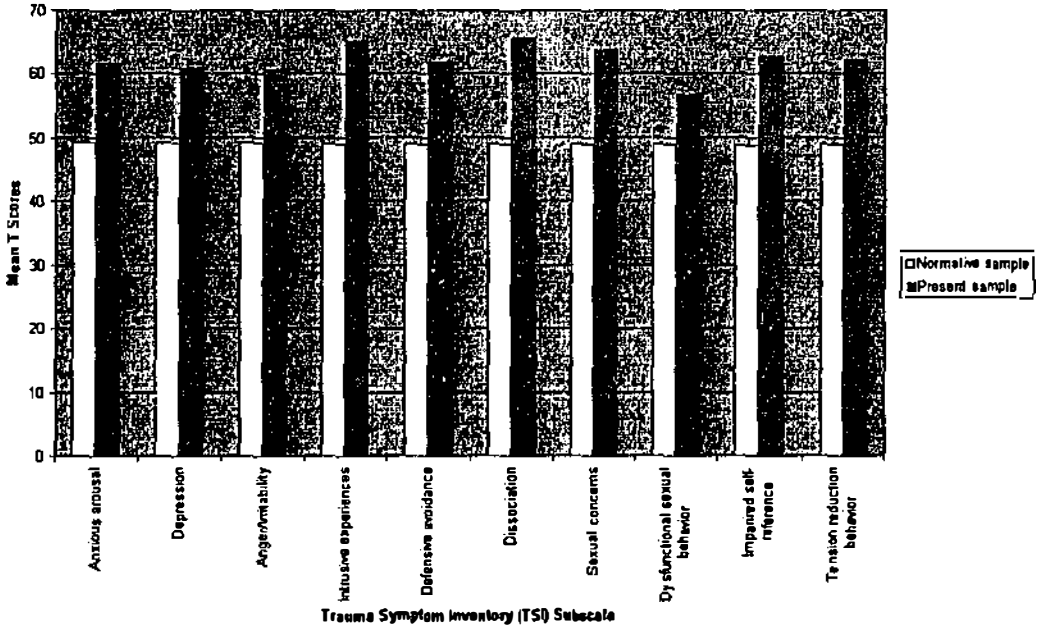

Figure 9: Levels of posttraumatic stress symptomatology (using the TSI) in female participants in the present sample (n = 116) and a normative sample of women from the general community (N = 423).

Self-esteem

The mean self-esteem score on Rosenberg's Self-esteem Scale was 26.25 (SD = 7.14), with scores ranging from 10 to 40. A sample of 112 university students enrolled in

educational psychology courses at the University of Iowa in the US served as the comparison sample (Vispoel et al., 2001). The comparison sample was mostly made up of female students (74%) who were at the second year (25%), third year (31%), fourth year (22%), or graduate (20%) level of university. Compared with the self-esteem scores of the comparison sample (M = 32.76, SD = 4.78), the current sample of participants had significantly lower self-esteem scores, $t(131) = 10.481, p < .001$.

A similar situation arose with the self-esteem measure as with the specific attributions item. The researcher noticed that many participants expressed frustration while completing this questionnaire. Participants commented that the way they *feel* about the statements about themselves differed from the way they *think* about the statements about themselves, and that they were unsure which one (the thought or the feeling) they should respond with. As a result of this apparent differentiation, the researcher decided to assess whether this difference was significant. A subsample of 31 participants differentiated between their *thoughts* and *feelings* when responding to the self-esteem statements. As participants had suggested, their *thoughts* about themselves revealed higher self-esteem (M = 28.5, SD = 5.1) than their *feelings* about themselves (M = 26.3, SD = 7.1). A repeated-measures t-test with the subsample of 31 participants revealed that this difference is significant, $t(30) = 3.489, p < .01$. This has implications for future use of these scales, as discussed in the final chapter.

State Anger

State anger was measured by the state anger scale of the State-Trait Personality Inventory. The mean state anger score was 15.7 (SD = 7.6) with scores ranging from 10 to 40. While completing this measure, several participants stated that they thought it was amusing that they were asked such questions. When probed for more information by the researcher, one participant summed up the responses of many others when she said, "Why would I be angry *right now*? I was probably angry yesterday, and probably even this morning, but *right now*, I couldn't possibly be angry...here is someone [the researcher] who is doing something to help people like me, someone really listening to me for the first time...what have I got to be angry about *right now*?" Since the scores on this scale were severely positively skewed, this variable is not included in the inferential analyses. Implications of this using this scale are discussed in the Discussion chapter.

B: Relationships Among Predictor Variables Themselves

Relationships between two continuous variables were analysed by correlational analysis, and relationships between continuous and categorical variables were analysed by t-tests. The pertinent patterns are reported with respect to the static predictor variables and then the dynamic predictor variables. Dynamic predictor variables are reported separately for the variables that originated from quantitative measures and those that originated from the qualitative data coding process.

Static Factors

There were no differences on any of the predictor variables between victims who are currently married, de facto or in serious relationships, and victims who are not currently in any such relationship ($p > .05$). Further, there were no significant associations or patterns involving gender or whether participants reported their victimisation to the police. However, interesting patterns emerged from the t-test analyses with regard to offence characteristics. Victims who reported experiencing penetration during offences were not distinguishable from victims who reported not experiencing penetration during offences, on any of the predictor variables. In contrast, child sexual abuse history, multiple offence incidents, multiple perpetrators, and offences within the family were related to less perceived control, more behavioural self-blame attributions, and more frequent rumination. See Table 3 on the next page for these significant findings.

Table 3

Pertinent t-test results involving offence characteristics and other predictors

Variables	Multiple Perpetrators		Multiple Offences		Offence in family		CSA history	
	Yes (n= 61)	No (n= 71)	Yes (n= 121)	No (n= 20)	Yes (n= 87)	No (n=45)	Yes (n= 108)	No (n=24)
Personal control[8]	47.4 (10.2)	49.5 (10.7) (df=130, t=1.125)	47.6 (10.6)	53.4 (8.6) (df=130, t=2.302)*	47.0 (10.9)	51.4 (9.0) (df=130, t=2.333)*	47.3 (10.6)	54.2 (8.0) (df=130, t=3.036)**
Interpersonal control	39.5 (11.5)	41.6 (12.1) (df=130, t=0.995)	39.7 (11.8)	45.6 (11.3) (df=130, t=2.051)*	39.2 (12.2)	43.3 (10.7) (df=130, t=1.887)	39.5 (11.7)	45.3 (11.6) (df=130, t=2.536)*
Rumination	2.9 (.9)	2.6 (1.0) (df=130, t=2.186)*	2.8 (1.0)	2.5 (.9) (df=130, t=1.312)	2.9 (.9)	2.5 (1.0) (df=130, t=1.956)	2.8 (.9)	2.4 (.8) (df=130, t=2.465)*
Behaviour self-blame	2.0 (.8)	1.7 (.8) (df=130, t=2.014)*	1.9 (.8)	1.6 (.7) (df=130, t=1.794)	1.9 (.8)	1.8 (.8) (df=130, t=0.265)	1.9 (.8)	1.7 (.7) (df=130, t=1.211)
Guilt-proneness	62.1 (6.1)	60.3 (6.3) (df=130, t=1.628)	61.5 (6.2)	59.2 (6.1) (df=130, t=1.527)	62.1 (6.3)	59.4 (5.8) (df=130, t=2.359)*	61.5 (6.4)	59.5 (5.4) (df=130, t=1.183)

Notes: Figures represent mean scores (standard deviations) *p <.05 **p <.01

[8] In tables such as this one, *personal control* and *interpersonal control* refer to perceived personal control and perceived interpersonal control, respectively, however due to space restrictions it is not possible to refer to the whole phrase.

Dynamic Factors

From Quantitative Measures

Several notable patterns emerged from the correlational analyses. Perceived personal and interpersonal control were moderately correlated with each other ($r = .64$, $p < .001$), but perceived interpersonal control was consistently more strongly associated with the other dynamic variables than perceived personal control. This is not surprising as it is perceived interpersonal control, rather than perceived personal control, that characterises the symptoms of the victims in this sample (See Section A). Similarly, shame-proneness and guilt-proneness were moderately correlated with each other ($r = .59$, $p < .001$), but shame was consistently more strongly correlated with the other dynamic predictor variables than guilt. Character and behavioural self-blame attributions for the sexual offence were also moderately correlated with each other ($r = .65$, $p < .001$), but characterological self-blame attributions were consistently more strongly correlated with the other dynamic predictor variables than behavioural self-blame attributions. Fourth, among the coping strategies, nonproductive coping and dealing directly with problems appear more consistently strongly related to the other predictor variables than the other two coping strategies. In fact, sharing is not significantly correlated with any of the other variables. Table 4 on the next page displays the pertinent findings.

Table 4

Correlation coefficients (r) among predictor variables

	Predictor variables	1	2	3	4	5	6	7	8	9	10	11
1	Shame-proneness	----	.59***	.44***	.26**	-.49***	-.57***	.25**	-.40***	.42***	-.36***	-.22*
2	Guilt-proneness	.59***	----	.27**	.17	-.26**	-.26**	.12	-.15	.21*	-.21*	-.06
3	Character self-blame	.44***	.27**	----	.65***	-.31***	-.46***	.38***	-.26**	.51***	-.27**	-.20*
4	Behaviour self-blame	.26**	.17	.65***	----	-.16	-.38***	.29**	-.17*	.32***	-.22*	-.05
5	Personal control	-.49***	-.26**	-.31***	-.16	----	.64***	-.26**	.41***	-.33***	.25**	.12
6	Interpersonal control	-.57***	-.26**	-.46***	-.38***	.64***	----	-.25**	.53***	-.45***	.49***	.31***
7	Rumination	.25**	.12	.38***	.29**	-.26**	-.25**	----	-.06	.39***	-.01	.05
8	Dealing with problems	-.40***	-.15	-.26**	-.17*	.41***	.53***	-.06	----	-.23**	.50***	.29**
9	Nonproductive coping	.42***	.21*	.51***	.32***	-.33***	-.45***	.39***	-.23**	----	-.11	-.22*
10	Optimism	-.36***	-.21*	-.27**	-.22*	.25**	.49***	-.01	.50***	-.11	----	.38***
11	Sharing	-.22*	-.06	-.20*	-.05	.12	.31***	.05	.29**	-.22*	.38***	----

*p <.05 **p <.01 ***p <.001

From Qualitative Data

Sense of hopelessness[Q].

Victims who conveyed the impression that they feel they have little or no control in their lives, or a sense of hopelessness, had higher levels of characterological self-blame attributions, shame-proneness, and nonproductive coping, and lower levels of perceived personal and interpersonal control, and dealing independently with their problems ($p < .05$). Table 5 displays the means, standard deviations, degrees of freedom, t-test statistics, and significance levels for the pertinent t-test analyses.

Table 5

T-test results that examine a sense of hopelessness[Q]

Variables	M	SD	df	t-statistic	*p*
Personal Control			130	4.06	< .001
Hopelessness	45.78	10.75			
No hopelessness	53.00	8.32			
Interpersonal Control			130	4.93	< .001
Hopelessness	36.96	10.88			
No hopelessness	46.60	10.93			
Character Self-blame			130	2.78	< .01
Hopelessness	2.04	.78			
No hopelessness	1.66	.72			
Shame-proneness			130	3.03	< .01
Hopelessness	50.74	9.79			
No hopelessness	45.11	11.18			
Deal directly with problems			130	3.25	< .01
Hopelessness	59.52	14.56			
No hopelessness	67.55	12.35			
Nonproductive coping			130	3.97	< .001
Hopelessness	72.18	13.51			
No hopelessness	61.96	15.66			

Task-oriented^{Q} coping behaviours.

Victims who conveyed using task-oriented coping behaviours showed significantly lower levels of characterological self-blame attributions, shame-proneness, rumination, and nonproductive coping, and higher levels of perceived personal and interpersonal control, and dealing independently with their problems ($p < .05$). The finding that task-oriented coping^{Q} is associated with dealing independently with problems (from the Coping Scale) supports the validity of the qualitative coding. The means, standard deviations, degrees of freedom, t-test statistics, and significance levels are displayed in Table 6 for the pertinent analyses.

Table 6

T-test results that examine the differences of task-oriented^{Q} coping behaviours

Variables	M	SD	df	t-statistic	*p*
Personal Control			130	3.64	< .001
Not task-oriented	46.38	10.68			
Task-oriented	53.24	8.31			
Interpersonal Control			130	5.23	< .001
Not task-oriented	37.32	11.17			
Task-oriented	47.93	9.89			
Character Self-blame			130	2.65	< .01
Not task-oriented	2.01	.80			
Task-oriented	1.63	.66			
Shame-proneness			130	3.00	< .01
Not task-oriented	50.42	10.65			
Task-oriented	44.59	9.63			
Deal directly with problems			130	2.97	< .01
Not task-oriented	60.16	14.78			
Task-oriented	67.90	11.50			
Nonproductive coping			130	3.56	< .01
Not task-oriented	71.33	14.78			
Task-oriented	61.61	14.48			
Rumination			130	2.42	< .05
Not task-oriented	2.88	.96			
Task-oriented	2.46	.84			

***Obstructive coping behaviours*[Q].**

The only difference in other dynamic predictors with respect to obstructive coping behaviours was that participants who indicated they used such coping behaviours reflected higher nonproductive coping in the Coping Scale for Adults quantitative measure ($M = 71.11$, $SD = 15.50$) than those who showed no evidence of using such behaviours ($M = 65.83$, $SD = 14.48$), $t(130) = 2.025$, $p < .05$. The congruence displayed with respect to the qualitative and quantitative measures supports the validity of the qualitative coding process.

Personal support*[Q] *for the sexual offence.

While it was previously reported in Section B of this chapter that there were no differences on any of the measures based on the static factor of relationship status, examination of the personal support[Q] for the sexual offence variable led to valuable results. Specifically, those who reported having support for the sexual offence in their personal lives reported significantly less shame, and significantly higher levels of both types of perceived control (personal and interpersonal). When counsellors were initially included as support-people, these differences did not appear, so it is having someone in their *personal life* that appears to make a significant impact on the above measures. Table 7 displays the means, standard deviations, degrees of freedom, t-test statistics, and significance levels for the significant findings.

Table 7

T-test results that examine personal support[Q] for the sexual offence

Variables	M	SD	df	t-statistic	*p*
Shame-proneness			130	2.03	< .05
Evidence of personal support	46.53	9.67			
No evidence of personal support	50.28	11.17			
Personal Control			130	2.45	< .05
Evidence of personal support	50.95	9.44			
No evidence of personal support	46.55	10.90			
Interpersonal Control			130	2.58	< .05
Evidence of personal support	43.51	10.85			
No evidence of personal support	38.27	12.14			

Disclosure experience[Q].

There are two variables that emerged from the qualitative coding process with respect to disclosure experiences. The first variable, labelled positive disclosure experience, refers to the presence or absence of evidence suggesting that the participant's disclosure experience was positive. Similarly, the second variable, labelled negative disclosure experience, refers to the presence or absence of evidence suggesting that the participant's disclosure was negative. While there were no differences among the dynamic predictor variables with respect to negative disclosure experiences, a significant finding arose with respect to positive disclosure experiences. Specifically, participants who reported evidence of a positive disclosure experience indicated significantly lower levels of shame-proneness and guilt-proneness, compared to those who reported no evidence of positive disclosure experiences. Table 8 displays the means, standard deviations, degrees of freedom, t-test statistics, and significance levels for the significant findings.

Table 8

T-test results that examine positive disclosure experiences

Variables	M	SD	df	t-statistic	*p*
Shame-proneness			130	2.72	< .01
Evidence of positive disclosure	42.95	10.06			
No evidence of positive disclosure	49.68	10.47			
Guilt-proneness			130	3.12	< .01
Evidence of positive disclosure	57.38	4.66			
No evidence of positive disclosure	61.87	6.26			

***Chaotic childhood*[Q].**

Participants who reported evidence of a chaotic childhood environment indicated significantly lower levels of perceived personal and interpersonal control, and significantly higher levels of shame-proneness, guilt-proneness, and rumination about why the offence occurred. Table 9 displays the means, standard deviations, degrees of freedom, t-test statistics, and significance levels for the significant findings.

Table 9

T-test results that examine chaotic childhood[Q]

Variables	M	SD	df	t-statistic	*p*
Personal Control			130	2.61	< .05
Evidence of chaotic childhood	46.92	10.74			
No evidence of chaotic childhood	51.93	9.08			
Interpersonal Control			130	2.47	< .05
Evidence of chaotic childhood	38.91	11.96			
No evidence of chaotic childhood	44.26	10.80			
Shame-proneness			130	2.18	< .05
Evidence of chaotic childhood	49.97	10.57			
No evidence of chaotic childhood	45.69	10.36			
Guilt-proneness			130	2.20	< .05
Evidence of chaotic childhood	61.96	6.28			
No evidence of chaotic childhood	59.43	5.86			
Rumination			130	2.57	< .05
Evidence of chaotic childhood	2.89	0.89			
No evidence of chaotic childhood	2.45	0.99			

Police contact experience.

There were no differences in any of the dynamic predictor variables with respect to whether there was evidence of positive or negative police contact experiences. The connection between aspects of psychological functioning seems to be more complex and pervasive than evidence of positive or negative police contact experiences. However, there might be issues of reliability in coding this qualitatively as it might not be the main focus of talk, yet present nevertheless, and thus not coded in some cases.

C: Relationships Between Predictors And Outcomes

There are several significant relationships between the predictor variables and the four outcome variables (depression, anxiety, posttraumatic stress, and self-esteem). Tables 10 to 14 display the results of correlation and t-test analyses. Only the pertinent findings are presented in text in the following paragraphs. Due to the number of t-test analyses performed, a more conservative alpha level of .02 was applied for t-test analyses in this section. The results are reported separately for dynamic and static predictor variables, to allow easy comparison.

Static Predictor Variables

The age of participants at the time of their first sexual offence was slightly positively related to self-esteem, meaning that the older participants were at the time of this offence, the higher their current self-esteem ($r = .20$, $p < .05$). There were no relationships between age at first offence and the other outcomes ($p > .05$). Neither the age of participants at their most recent sexual offence nor their current age was related to any of the outcomes ($p > .05$).

Gender made a difference only in levels of posttraumatic stress: Men displayed significantly higher levels than women ($p > .02$) (see Table 13). None of the other three outcomes (depression, anxiety, self-esteem) were significantly different between male and female participants ($p > .02$). Further, having participated in the justice system appeared not to play a role in victims' outcomes, as none of the four outcomes was different between victims who reported to the police and those who did not ($p > .02$). That is, there were no differences in psychological functioning between victims who had reported their victimisation to the police and victims who had not reported to the police.

Perhaps surprisingly, the correlational analyses revealed that the length of time since the most recent sexual offence incident was not significantly associated with any of the four outcome variables (depression, anxiety, posttraumatic stress, and self-esteem) ($p > .05$). Therefore, participants who had been sexually victimised many years before did not display any differences in psychological functioning compared to participants who had been victimised relatively recently. Indeed, few of the other offence characteristics were

strongly related to outcomes. Whether the offence occurred within the context of the victims' family or not, there were no significant relationships with any of the outcomes ($p > .02$). Likewise, whether penetration occurred or whether victims experienced sexual offences by multiple perpetrators throughout their lifetime, there were no differences in any of the outcomes ($p > .02$). The only two offence characteristics that were significantly associated with at least some of the outcomes were child sexual abuse history and further revictimisation. Specifically, victims who were sexually abused as children displayed significantly higher levels of depression (Table 11) and lower levels of self-esteem (Table 14), than victims who experienced sexual offences for the first time as adults ($p < .02$). However, the levels of anxiety and posttraumatic stress were not different between the two groups ($p > .02$). Further, victims who experienced sexual offences in childhood and were revictimised in adulthood, displayed significantly higher levels of depression (Table 11) and anxiety (Table 12), than those who experienced sexual offences in childhood only ($p < .02$). However, the levels of posttraumatic stress and self-esteem between the two groups were not statistically different ($p > .02$).

Dynamic Predictor Variables

It appears that the cognitive, behavioural, and social aspects of victims' *current* situations are more strongly related to outcomes, than the static factors of how long ago the incident occurred and other characteristics of the offence. Indeed, shame-proneness, characterological self-blame, rumination, perceived personal control, perceived interpersonal control, nonproductive coping behaviours, dealing directly with problems, optimism, task-oriented coping behaviours^{Q}, hopelessness^{Q}, and having personal support for the sexual offence^{Q}, were all consistently strongly related to outcomes. Table 10 displays the pertinent correlational patterns with the continuous dynamic predictor variables and the outcomes. Tables 11 to 14 display the pertinent patterns from t-test analyses with respect to dichotomous dynamic predictor variables and outcomes.

Table 10

Correlations (r) between predictor variables and outcomes

	Depression	Anxiety	Posttraumatic stress	Self-esteem
Shame-proneness	.53***	.50***	.45***	-.67***
Guilt-proneness	.28**	.29**	.26**	-.40***
Character self-blame	.43***	.36***	.48***	-.57***
Behaviour self-blame	.27**	.29**	.26**	-.40***
Personal control	-.55***	-.47***	-.44***	.64***
Interpersonal control	-.56***	-.53***	-.52***	.72***
Rumination	.43***	.44***	.54***	-.28**
Dealing with problems	-.45***	-.36***	-.30**	.49***
Nonproductive coping	.43***	.54***	.55***	-.58***
Optimism	-.40***	-.31***	-.18*	.45***
Depression	-------	.67***	.57***	-.66***
Anxiety	.67***	-------	.69***	-.60***
Posttraumatic stress	.57***	.69***	-------	-.55***
Self-esteem	-.66***	-.60***	-.55***	-------

*$p < .05$ **$p < .01$ ***$p < .001$

Table 11

T-test results between dichotomous predictor variables and depression

Variables	n	M	SD	df	t-statistic	p
CSA history				130	2.72	< .01
Yes	108	6.96	4.45			
No	24	4.38	2.79			
Revictimisation				106	2.62	< .05
Yes	31	8.68	4.04			
No	77	6.26	4.44			
Hopelessness[Q]				130	4.38	< .001
Yes	82	7.69	4.23			
No	50	4.52	3.69			
Task-oriented coping[Q]				130	5.33	< .001
Yes	41	3.78	4.27			
No	91	7.71	2.99			
Personal support[Q]				130	3.15	< .01
Yes	59	5.22	4.66			
No	73	7.52	3.47			

Table 12

T-test results between dichotomous predictor variables and anxiety

Variables	n	M	SD	df	t-statistic	*p*
Revictimisation				106	2.58	< .05
Yes	31	13.52	4.01			
No	77	11.25	4.20			
Hopelessness[Q]				130	4.34	< .001
Yes	82	12.73	4.02			
No	50	9.6	4.04			
Task-oriented coping[Q]				130	4.53	< .001
Yes	41	9.20	3.88			
No	91	12.60	4.05			

Table 13

T-test results between dichotomous predictor variables and posttraumatic stress

Variables	n	M	SD	df	t-statistic	*p*
Hopelessness[Q]				84	4.09	< .001
Yes	82	66.20	7.98			
No	50	59.23	10.33			
Task-oriented coping[Q]				130	4.60	< .001
Yes	41	58.26	8.90			
No	91	65.94	8.86			
Gender				130	2.37	< .02
Female	116	62.84	9.40			
Male	16	68.77	9.13			

Table 14

T-test results between dichotomous predictor variables and self-esteem

Variables	n	M	SD	df	t-statistic	*p*
CSA history				130	2.90	< .01
Yes	107	25.4	7.2			
No	25	29.9	5.7			
Multiple offences				130	2.64	< .01
Yes	112	25.57	7.18			
No	20	30.05	5.66			
Hopelessness[Q]				130	4.24	< .001
Yes	82	24.32	6.93			
No	50	29.42	6.35			
Task-oriented coping[Q]				130	3.94	< .001
Yes	41	29.71	5.61			
No	91	24.69	7.23			
Personal support[Q]				130	2.75	< .01
Yes	59	28.10	6.10			
No	73	24.75	7.59			

A noteworthy pattern regarding social support evolved from the data. Victims who identified themselves as being married, de facto, or in a serious relationship, did not report any better on any of the four outcomes (depression, anxiety, posttraumatic stress, and self-esteem), than those not currently in such a relationship ($p > .02$). However, those who were identified as having someone in their *personal* lives who provides them with support *for the sexual offence*[Q], reported significantly lower levels of depression and higher self-esteem, than victims who did not appear to have such a person in their lives ($p < .01$).

Distinguishing between participants' thoughts and feelings with respect to their attributions for the sexual offence provided remarkable findings. Participants' feelings of self-blame were consistently more strongly related to outcomes than participants' thoughts of self-blame. See Table 15 below for the correlations.

Table 15

Correlations (r) between self-blame attributions and outcomes, distinguishing between feelings and thoughts

	Depression	Anxiety	PTS	Self-esteem
Characterological self-blame				
Thoughts	.32	.34*	.54**	-.47**
Feelings	.43***	.36***	.48***	-.57**
Behavioural self-blame				
Thoughts	.41*	.44**	.31	-.21
Feelings	.27**	.31***	.34***	-.34***

*$p < .05$ **$p < .01$ ***$p < .001$

Findings relating to specific attributions for the sexual offence were noteworthy. Although characterological self-blame and behavioural self-blame were highly correlated (r = .65), partial correlations indicated that characterological self-blame was more strongly related to outcomes (depression, anxiety, posttraumatic stress, and self-esteem) than behavioural self-blame. The correlations between characterological self-blame and outcomes range from 36 to .57 in magnitude, and the correlations between behavioural self-blame and outcomes range from .27 to .34 in magnitude. When behavioural self-blame is controlled for, the correlations between characterological self-blame and outcomes are still moderate, ranging from .21 to .49 in magnitude. However, when characterological self-blame is controlled for, the relationships between behavioural self-blame and outcomes disappear, with correlations ranging from .01 to .11 in magnitude. In terms of the other attributions for the sexual offence, blaming the perpetrator appeared to be somewhat therapeutic, since it was related to lower levels of depression (r = -.19), posttraumatic stress (r = -.18), and higher levels of self-esteem (r = .32). None of the other attributions (bad luck, someone else, or society) were consistently related to outcomes. Further, perceived controllability of future offences

was not consistently related to outcomes. Only depression and anxiety were related to controllability and these relationships were weak (r = -.19 and r = -.18, respectively).

Three other interesting patterns arose (see Table 16 below). First, although shame-proneness and guilt-proneness were moderately correlated (r = .59), partial correlations indicate that shame-proneness is more strongly related to outcomes (depression, anxiety, posttraumatic stress, and self-esteem) than guilt-proneness. The correlations between shame-proneness and outcomes range from .45 to .67 in magnitude, and the correlations between guilt-proneness and outcomes range from .26 to .40 in magnitude. When guilt-proneness is controlled for, the correlations between shame-proneness and outcomes remain high, ranging from .38 to .58 in magnitude. However, when shame-proneness is controlled for, the relationships between guilt-proneness and outcomes disappear, with correlations ranging from .004 to .05 in magnitude.

Second, although perceived interpersonal control and personal control were highly correlated (r = .64), partial correlations indicate that perceived interpersonal control is more strongly related to outcomes than perceived personal control. The correlations between perceived interpersonal control and outcomes range from .52 to .72 in magnitude, and the correlations between perceived personal control and outcomes range from .44 to .64 in magnitude. When perceived personal control is controlled for, the correlations between perceived interpersonal control and outcomes remain high, ranging from .32 to .53 in magnitude. However, when perceived interpersonal control is controlled for, the relationships between perceived personal control and outcomes are drastically reduced, with correlations ranging from .17 to .33 in magnitude.

Third, shame-proneness and characterological self-blame were moderately correlated (r = .44), but partial correlations indicate that shame-proneness is somewhat more related to outcomes than characterological self-blame. The correlations between shame-proneness and outcomes range from .45 to .67 in magnitude, and the correlations between characterological self-blame and outcomes range from .36 to .57 in magnitude. When characterological self-blame is controlled for, the correlations betweens shame-proneness and outcomes remain high, ranging from .30 to .56 in magnitude. However, when shame-proneness is controlled for, the relationships between characterological

self-blame and outcomes are somewhat lower, with correlations ranging from .18 to .41 in magnitude. However, since the correlations between characterological self-blame and outcomes are still significant, this points to the possibility that although some of the relationship between characterological self-blame and outcomes can be accounted for by underlying feelings of shame (measured by shame-proneness), there still remains some unique aspect of characterological self-blame attributions for the offence that are related to outcomes.

Table 16

Zero-order and partial correlations between general attributional tendencies, self-blame, perceived control, and outcomes

	Depression	Anxiety	PTS	Self-esteem
Shame-proneness	.53***	.50***	.45***	-.67***
Controlling for guilt-proneness	.47***	.43***	.38***	-.58***
Guilt-proneness	.28**	.29**	.26**	-.40***
Controlling for shame-proneness	-.05	-.01	-.004	-.01
Characterological self-blame	.43***	.36***	.48***	-.57***
Controlling for B_SB	.35***	.21*	.36	-.49***
Behavioural self-blame	.27***	.31***	.34***	-.34***
Controlling for C_SB	-.01	.11	.05	.06
Interpersonal control	-.56***	-.53***	-.52***	.64***
Controlling for personal control	-.32***	-.34***	-.34***	.53***
Personal control	-.55***	-.47***	-.44***	.64***
Controlling for IP control	-.30**	-.20*	-.17	.33***

* $p < .05$ ** $p < .01$ *** $p < .001$

The patterns just described, with respect to general attributions, specific attributions, and perceived control, are consistent with the comparisons between the current sample and normative samples reported in Section A of this chapter. Namely, shame-proneness

rather than guilt-proneness, characterological self-blame rather than behavioural self-blame, and perceived interpersonal control rather than perceived personal control, distinguished the sexual offence victims in the current sample from healthy control samples in the normative data.

D: Regression Analyses

A series of exploratory multiple regression analyses were performed for the four outcome variables: depression, anxiety, posttraumatic stress, and self-esteem, in order to determine the optimal predictive model. In each case, the predictor variables were chosen initially on the basis of correlations with the outcome variables and the other predictors, and from variables on which victim scores departed from norms. Initial models were then modified until it appeared that the best predictive model had been established with the available predictors. Collinearity diagnostics indicated that there was no cause for concern with respect to multicollinearity for any of the four regression models. Further, cross validation estimates are high, since the level of reduction from R^2 to Adjusted R^2 is low, ranging from 1% for predicting self-esteem to 6% for predicting depression. Table 17 displays the standardised regression coefficients (β), and the significance of contribution for each predictor variable pertaining to each regression model. Table 18 displays the results of the ANOVA (degrees of freedom and F), R, R^2, and Adjusted R^2 values for each regression model.

Predicting Depression

The best model for predicting depression was found to include the following predictor variables: rumination, personal perceived control, optimism, shame-proneness, sharing, personal support[Q], vaginal-penile penetration in offence incident, and oral sex in offence incident. The regression model was significant, $F(8, 120) = 22.47, p < .001$, and predicted 57% (Adj$R^2$) of the variance in depression. Sharing was the only nonsignificant contributor.

Table 17

Standardised beta coefficients (β) and Significance of contribution (Sig.)

Variables	β	Sig.
Depression (Adj R^2 = .57)		
Personal perceived control	-.325	***
Rumination	.245	***
Optimism	-.235	**
Shame-proneness	.188	**
Vaginal-penile penetration	.168	**
Personal support[Q]	-.161	**
Oral sex	.143	*
Sharing	.106	ns
Anxiety (Adj R^2 = .48)		
Nonproductive coping	.293	***
Rumination	.244	**
Perceived control	-.195	*
Shame-proneness	.173	*
Optimism	-.148	*
Task-oriented coping[Q]	-.118	ns
Character self-blame	-.109	ns
Posttraumatic stress (Adj R^2 = .51)		
Rumination	.336	***
Nonproductive coping	.245	**
Perceived personal control	-.234	**
Oral sex	.150	*
Self-blame attributions	.137	ns
Obstructive coping[Q]	.097	ns
Vaginal-object/digit penetration	-.085	ns
Self-esteem (Adj R^2 = .73)		
Perceived control	.391	***
Shame-proneness	-.225	***
Nonproductive coping	-.210	***
Character self-blame	-.199	**
Optimism	.153	**
Child sexual abuse	.123	*
Behaviour self-blame	.078	ns
Offence within family	.073	ns

*$p < .05$ **$p < .01$ ***$p < .001$ ns ($p > .05$)

Predicting Anxiety

The best model for predicting anxiety was found to include the following predictor variables: rumination, optimism, shame-proneness, nonproductive coping, characterological self-blame, problem-focussed coping, and perceived control. The regression model was significant, $F(7, 124) = 18.47, p < .001$, and predicted 48% ($AdjR^2$) of the variance in anxiety. Character self-blame and problem-focussed coping were not significant contributors.

Predicting Posttraumatic Stress

The best model for predicting posttraumatic stress was found to include the following predictor variables: rumination, nonproductive coping, perceived control, obstructive coping^Q, self-blame attribution, vaginal penetration with digit or object during offence incident, and oral sex during offence incident. The regression model was significant, $F(7, 121) = 19.83, p < .001$, predicting 51% ($AdjR^2$) of the variance in posttraumatic stress. Obstructive coping^Q, self-blame attributions, and vaginal penetration with object or digit in offence incident were not significant contributors.

Predicting Self-esteem

The best model for predicting self-esteem was found to include the following predictor variables: nonproductive coping, perceived control, optimism, shame-proneness, characterological self-blame, behavioural self-blame, and experience of child sexual abuse. The regression model was significant, $F(8, 123) = 44.56, p < .001$, and predicted 73% ($AdjR^2$) of the variance in self-esteem. Behaviour self-blame and offence incident by family member were not significant contributors.

Table 18

Regression models for predicting depression, anxiety, posttraumatic stress, and self-esteem

Criterion Variables	df	F	R	R^2	AdjR^2
Depression	8, 120	22.47***	.77	.60	.57
Anxiety	7, 124	18.47***	.71	.51	.48
Posttraumatic stress	7, 121	19.83***	.73	.53	.51
Self-esteem	8, 123	44.56***	.86	.74	.73

Note: ***$p < .001$

CHAPTER 10

Discussion

In this research, which was conducted from March 2001 to July 2002, 132 participants (116 female, 16 male) who were at least 16 years of age at the time of participation completed a battery of psychological tests and questionnaires, and were interviewed. The majority of participants (69%) responded to advertisements in the community. The findings of this research project will be discussed in this chapter, using the aims of the research (stated in Chapter 5) as the structure for the most part[9]. Throughout the course of addressing the aims, comparisons will be made with the findings of past research, and implications will be discussed for the management of victims on clinical and justice system levels. The implications for research in the sexual victimisation field will be then discussed, followed by the strengths and limitations of the project. Finally, directions for future research will be suggested in light of the present findings, followed by brief conclusions.

Throughout the literature review, seven main limitations became apparent. A concise review of these seven limitations, and the manner in which the present study addressed them, are as follows.

1) Outcomes in the prediction studies were often only measured with one indicator of psychological functioning such as depression (e.g. Regehr et al., 1998). This is problematic because the research into the effects of sexual victimisation has shown great variation in the symptomatology victims experience (Frazier, 1991; Weaver & Clum, 1995), and that some types of symptomatology (i.e., depression) may improve faster than others (i.e., anxiety) (Steketee & Foa, 1987). There are also potential correlations

[9] The only aim that is not discussed separately under its own heading is Aim 5 (identifying factors influential in the coping process through qualitative methods). It appeared more appropriate to discuss the findings from Aim 5 throughout the course of addressing the other aims.

among indicators of psychological functioning that are unexplored if only one indicator is examined. Further, indicators of psychological functioning may have unique predictors. Clearly, the measurement of outcomes should canvass a range of indicators of psychological functioning. The current study design addressed this concern by measuring outcomes in terms of five indicators of psychological functioning that have been found to be common problem areas after sexual victimisation: depression (MacMillan et al., 2001), anxiety (MacMillan et al., 2001), posttraumatic stress (Rothbaum et al., 1992), self-esteem (Mezey & Taylor, 1988), and anger (Becker et al., 1982).

2) Samples are most often recruited from either clinical sources (particularly sexual assault crisis centres) (e.g. Becker et al., 1982; Mezey & Taylor, 1988) or universities (Frazier & Schauben, 1994) and therefore may be unrepresentative of the wider community of victims.[10] Australian Bureau of Statistics research (1996) suggests that only 18% of victims have accessed professional support services regarding the sexual offence. Therefore, accessing clinical/counselling samples for research purposes may not be indicative of the experiences of the majority of the victim population. For this reason, the current research aimed to access victims of sexual offences from the larger community, who may or may not have accessed support services, the justice system, or medical services, regarding the sexual offence. To this end, the current study accessed 132 community members who had been sexually victimised, of which only 15% of these were recruited through professional agencies (i.e., counselling or justice system). As a result, the current study avoids the bias inherent in clinical and student samples, and aims to make conclusions that represent the community of victims more generally, including those who have not accessed any of the various systems (e.g., support services, the justice system). Although the current research improves on some sampling concerns in previous research, sampling limitations remain (see the Limitations section later in the discussion).

[10] Some research utilised navy recruits (Merrill et al., 2001) and community samples (Ullman, 1997), however they form a much smaller portion of the research compared to those that utilised clinical and student samples.

3) Another sample-related issue is that of the length of time between the sexual offence and study participation. While it is acknowledged that it is important to examine the period immediately after a sexual offence in order to guide interventions with recent victims, the majority of victims are not thought to access support services until much later (Lindberg & Distad, 1985). Indeed, many of the cases that are now coming to light are cases that are several decades old; victims who are in middle age and beyond, who are seeking professional support assistance for the first time. It is important to examine the long-term effects in order to provide professionals working clinically with victims of sexual offences with accurate knowledge about the long-term therapeutic process so that they can work most effectively with their clients. Unfortunately the majority of research to date has focussed on the immediate to short-term coping period (e.g. Mezey & Taylor, 1988). The current study aimed to access victims with varying periods of time since the offence, to allow an examination of the influence of time on psychological functioning. The average length of time since the most recent offence in the present study was 21 years, with a range of 3 weeks to 62 years.

4) Most research that examines the therapeutic process after sexual victimisation utilises only quantitative methods (e.g. Frazier & Schauben, 1994). Given the known complexity of psychological functioning and potential predictors (Merrill et al., 2001), the present study combined quantitative and qualitative research methods to produce a thorough analysis of the impact of sexual offences on victims' lives. A combination of qualitative and quantitative methods allowed a richer complimentary exploration of research material than either method would have allowed on its own. While quantitative methods allow inferential statistics to describe powerful relationships among variables that can more easily be generalised to a larger proportion of the population, qualitative methods are able to give the data depth in a different way. For instance, qualitative methods allow a deeper understanding of participants' experiences as they view them and allow participants to express their experiences in their own words. This is beneficial because it can identify issues that are salient to victims but are not easily assessed by scales, and this can help build valid scales for the future. Further, issues that are not known to be important during the research design phase might clearly become relevant later on in the data collection phase through interviewing participants. In this way, another benefit of qualitative research is that it can serve to identify new avenues for research.

5) There are two vital issues in the research literature that have led to inconsistent findings and therefore need more attention. The first issue relates to the specific attributions victims make regarding the sexual offence, particularly the relationship between characterological self-blame (akin to shame), behavioural self-blame (akin to guilt), and psychological functioning. Janoff-Bulman's (1979) hypothesis that characterological self-blame would be damaging while behavioural self-blame would be adaptive, has sparked great interest in the field. While some research suggests that both types of self-blame are associated with worse outcomes for victims (e.g. Frazier, 1990; Meyer & Taylor, 1986), there is other evidence that suggests that only characterological self-blame is damaging (e.g. Regehr et al., 1998). The present study was designed, in part, to test this hypothesis. From a clinical management perspective, it is important to know where to place most of the focus when it comes to addressing the self-blame issue. If both types of self-blame are equally associated with poor psychological functioning, then it would appear that both are equally in need of being addressed in counselling. However, if one type of self-blame is more strongly associated with poor psychological functioning than the other type, then focussing on addressing the more strongly associated type should lead to more effective counselling. The findings regarding whether one or both types of self-blame are associated with poor psychological functioning will also have justice management implications. If some justice system procedures appear to lead victims to feel more self-blame of the harmful type(s), then a need will arise to identify practices that invoke less self-blame in victims. This research addressed these issues by measuring the association between characterological self-blame, behavioural self-blame, and psychological functioning.

The other issue with inconsistent findings is the role of dynamic versus static factors in the psychological functioning of victims of sexual offences. Some research suggests that static factors (e.g., offence severity) play a large role in outcomes (e.g. Cohen & Roth, 1987; Ellis et al., 1981), whereas other research suggests that dynamic factors (e.g., victims' cognitions) play a far more important role (e.g. Weaver & Clum, 1995). This is an important distinction to make because it has enormous implications for the viability of clinical practice. The present study contributed to this area of knowledge by examining both types of factors in the one design, to test for the relative importance of each type of factor, as well as the relative importance of specific variables within the

two categories of factors. In this way, the need for a *best model* of predictors in explaining psychological functioning in victims of sexual offences was addressed.
6) There are two areas of research that have surprisingly not yet reached the sexual victimisation research field. The first issue is the dissection of the perceived control variable. Research to date in this field has thus far only examined perceived control in terms of internal/external locus of control (essentially one continuum) (Porter & Long, 1999) or levels of perceived personal control (also along one continuum) (Regehr et al., 1998). It is proposed here that the distinction between perceived *personal* control and perceived *interpersonal* control (two separate continua) may prove to be valuable due to the interpersonal nature of sexual offences. This study measured perceived control on both levels and measured the relationship between these two forms of perceived control and psychological functioning.

The second issue is the expansion of the shame-proneness and guilt-proneness field into the field of sexual victimisation. While there has been plenty of interesting and fruitful research with shame-proneness and guilt-proneness in student samples, general population samples, or general clinical samples (Alexander et al., 1999; Tangney, 1990; Tangney et al., 1992), there is a need to expand the study of these concepts specifically to victims of sexual offences. This need exists because guilt and shame are common responses to sexual victimisation (Doyle & Thornton, 2002) and therefore they appear to be likely targets for intervention. The present study addressed these needs by examining the relationship between shame-proneness, guilt-proneness, and psychological functioning.

7) While it is important to know why people *do not* report, so that we can find ways of reducing the barriers to reporting, it is equally important to know why other people *do* report. There is ample information about the reasons victims do not report sexual offences to police (Australian Bureau of Statistics, 1996; Dussich, 2001), however there is a dearth of information about the smaller group of victims who do report to the police. There is also a lack of knowledge about what *justice* means to victims of sexual offences. A further aim of this study was to address this limitation by examining the reasons why victims report sexual offences to the police and victims' personal definitions of justice. These factors are important to examine because it appears they

would provide an indication as to victims' expectations of the justice system process and victims' needs regarding the justice system. By focussing only on reasons for *not* reporting, we may be successful in getting more victims to report sexual offences to the police, but if we do not attempt to meet the expectations or needs of victims once they are in the justice system, it may be rather unjust to have encouraged them to report in the first place. Considering the basic tenet of therapeutic jurisprudence, we need to be making efforts to create a more therapeutic justice system process for the participants in the system, in this case, the victims of sexual offences. Identifying victims' reasons for reporting and their personal definitions of justice will provide an indication of their needs and expectations, which can be used in policy development regarding justice system procedures, and in preparing victims for the justice system process (e.g., in counselling). In this way, victims would be in a better position to maximise the therapeutic potential of the justice system process, and through various processes of communication, other victims may be encouraged to report.

The Symptomatology of the Sample of Participants

The findings of this project are consistent with numerous past studies that demonstrate the harmful consequences of sexual victimisation (e.g. Cohen & Roth, 1987; Higgins & McCabe, 2000; Resick, 1993). The participants in the current project displayed significantly poorer psychological functioning than norms with control samples and similar levels of psychological functioning as clinical samples (Briere, 1995; Clark et al., 1998; Vispoel et al., 2001). Specifically, participants displayed significantly higher levels of depression, anxiety, and posttraumatic stress, and lower levels of self-esteem than healthy control samples. These findings also point to a lengthy adjustment process after sexual offences, since the average length of time between the most recent offence and study participation was 21 years. That is, participants in the current project displayed significant psychological symptomatology compared with control samples, even several years after sexual victimisation.

The degree of symptomatology in this sample suggests that the sexual offences participants experienced continue to be destructive in numerous aspects of their lives.

This suggestion, gained from the qualitative interviews with victims, was also overwhelmingly supported in the quantitative data from the questionnaires. Victims described lives filled with relationship difficulties, family breakdowns, mental illness, suicide attempts, and stigma from having experienced a sexual offence. This stigma reached so far into the lives of many victims, that they found themselves unable to access assistance from professionals as a result of intense feelings of shame. However, the recurring theme of insufficient service availability is also important to acknowledge.

It was clear from the qualitative data that participants' subjective experiences of their victimisation and the problems that each participant faced in dealing with their experiences differed from one another. These findings support the general suggestion in the literature that victims experience sexual offences differently from one another and that one set of effects does not exist for all victims (Frazier, 1991; Weaver & Clum, 1995). Also gained from these findings is support for the use of qualitative data collection methods in conjunction with quantitative methods, as the latter utilised on their own may simplify victims' experiences by averaging them out. Using qualitative methods in this project retained the uniqueness in participants' experiences.

Given that the quantitative and qualitative findings both strongly indicate that the impact of sexual victimisation was immensely damaging to the lives of many victims, the next step in this investigation process was to determine which factors were associated with better or worse psychological functioning. The end goal was to find ways of improving the psychological functioning of victims. The two types of factors that were examined were static and dynamic factors. The relationship between static factors and psychological functioning will be discussed first.

Relationships Between Static Factors And Psychological Functioning

Victim Characteristics

Similar to the findings of Briere and colleagues (1988) and Oddone Paolucci and colleagues (2001), the current research found that victims' demographic variables were not consistently related to psychological functioning. The current age of victims and

their relationship status were not related to any of the outcome measures (depression, anxiety, posttraumatic stress, and self-esteem). Additionally, of all four outcome measures, the only gender difference in the present research was that men displayed significantly higher levels of posttraumatic stress, even with the male and female norms for the Trauma Symptom Inventory taken into account (Briere, 1995). This particular difference between male and female participants is in contrast to Ketring and Feinauer (1999) who found no gender differences in posttraumatic stress on the Trauma Symptom Checklist (Briere & Runtz, 1989) in victims of sexual offences. This gender difference is also in contrast to other findings that found similarity in psychological functioning in male and female victims of sexual offences (Briere et al., 1988; Oddone Paolucci et al., 2001).

One potential reason to account for the difference in posttraumatic stress symptomatology between male and female participants in the current research may be the small number of men in the sample (n = 16). It is possible that with more men in the sample, a greater degree of variation and subsequent lower posttraumatic stress scores might have ensued. It could be that the men who volunteered for this research represented the more severe cases of men who have been sexually victimised. However, it is also possible that a higher degree of posttraumatic stress might be an accurate reflection of the effects of sexual victimisation in male victims. In the qualitative data, male participants indicated that they were less likely to attend support services or talk to friends or family about their victimisation, compared to the female participants. It is not known whether this is the case with most male victims in general, or whether this was a unique feature of the sample of male participants in this study, but reduced support-seeking behaviours in this sample may have served to prolong and/or exacerbate posttraumatic stress symptomatology by preventing the process of working through the trauma.

Given that a gender difference arose only with respect to posttraumatic stress and none of the other three outcomes, it should be said that there is still no *consistent* quantitative evidence to date that warrants distinguishing intervention strategies for male and female victims of sexual offences. While Bennice and Resick (2002) suggested using the same intervention strategies with male and female victims in clinical practice, future research

with larger samples of male victims may indicate otherwise, since the qualitative data in the current study suggested that the male victims may form a separate group. The male victims revealed feeling that they are faced with more barriers in dealing with sexual victimisation. For example, they reported that they are expected to be emotionally stronger than women and they indicated that fewer appropriate support services are available to them than to women.

Overall, these findings suggest that victim characteristics such as age, gender, and relationship status, do not appear to be strongly related to psychological functioning. This tentative conclusion means that people who work with victims in the justice system, in clinical practice, and in research settings, are advised against assuming that a victim who is younger or older, male or female, married or single, will respond similarly to other victims in the same demographic group that they may have dealt with previously. As one example in clinical settings, counsellors need to be aware that clients' objective characteristics, such as their age or gender, will likely not be very indicative of their psychological functioning. Kennerley (2002) gave this same advice in her clinical literature so it would appear that this suggestion is the norm in clinical practice. Likewise in the justice system, police officers dealing with reports of sexual victimisation should not assume that sexual victimisation is less traumatic for male victims (as was seen to be the case in the qualitative data when one male victim was asked by a police officer if he "enjoyed" the sexual assault experience [#030]). The evidence is clear that each victim has a unique situation and a unique way of perceiving and dealing with sexual victimisation, and efforts must be made to educate justice system staff in this regard.

History of Reporting Sexual Victimisation to the Police

There were no differences in psychological functioning between participants who reported their sexual victimisation to the police and those who did not. This is similar to the finding in the truth and reconciliation commission (TRC) in South Africa, where no significant differences in depression, PTSD, or other anxiety disorders were found among participants who gave public testimony, closed testimony, or no testimony (Kaminer, Stein, Mbanga, & Zungu-Dirwayi, 2001).

At first glance the finding of the present study may appear to indicate that participation in the justice system did not affect participants' psychological functioning, but the relationship is likely far more complex. Since there are no data on participants' psychological functioning prior to reporting their victimisation to the police, it is not possible to draw conclusions about the real impact of participating in the process. In order to examine the impact of the justice system quantitatively, a pre-test/post-test controlled design would be necessary. This design would entail random allocation of victims to "justice system" or "no justice system" groups, and assessment of victims' psychological functioning before and after participation in the justice system process. The obvious difficulties in conducting such research continue to leave many unanswered questions about the impact of the justice system on victims' psychological functioning. While clinicians and researchers have observed that the justice system process is often a distressing and harmful process (Holmstrom & Burgess, 1983), it is still possible that some aspects of the justice system may be distressing in the short-term but potentially therapeutic in the long-term.

There was a hint of this "distressing at first but eventually therapeutic" relationship in the qualitative data with respect to coping in general, and it is possible that a similar relationship can exist with justice system experiences. A prime example of this relationship in the coping process is the participant who became distressed when she first started completing the questionnaire and had to cease participation.[11] She explained that agreeing to participate in the study brought up some difficult issues that she had not yet dealt with. Later contact with her revealed that through counselling subsequent to participation, she was able to work through those issues, leaving her feeling more satisfied with her emotional well-being. She stated that although the process of dealing with those issues was difficult at the time, she was nonetheless glad she had dealt with the issues because she was able to gain some closure. Whether the justice system serves as a similar type of short-term distress leading to long-term benefit in the form of closure is currently unknown. Research needs to advance to the stage of being able to more accurately assess the impact of the justice system on a quantitative level. Due to methodological issues discussed above, such research will be a challenge.

[11]There is no participant identification number for this woman because participation officially ceased soon after it began.

Sexual Offence Characteristics

Similarly, the relationship between psychological functioning and sexual offence characteristics, such as whether penetration occurred during the offence, was also minimal. Perhaps counter intuitively, not even the length of time since the sexual offence was related to outcomes. These findings are consistent with previous research that found little or no evidence for a link between characteristics surrounding the sexual offence and psychological functioning (e.g. Dunmore et al., 1999). Therefore, it appears that police would be more successful in their interactions with victims if they have an understanding that victims' responses to the sexual offence will generally not be based on what the offence constituted objectively, and similarly, that even though victims may be reporting a sexual offence that happened 30 years ago, they will likely be equally vulnerable to insensitive comments as victims who were victimised only a year ago.

The only significant pattern of offence characteristics was that a history of childhood sexual abuse and revictimisation (child and adult sexual victimisation) were both related to poorer outcomes on some measures. Indeed, it is quite a consistent finding in the research literature that these two factors are related to poorer outcomes in a number of ways (e.g. Arata, 2002; Gidycz et al., 1993; Murphy et al., 1988). For instance, Arata (2002) reported that victims of child sexual abuse and later adult sexual revictimisation had significantly higher levels of PTSD and dissociation than victims with a history of child sexual abuse alone.

Despite the relationship between child sexual abuse, revictimisation, and poorer outcomes on some measures in the current research, when entered into multiple regression analyses with the dynamic predictive factors, revictimisation was not associated with outcomes, and child sexual abuse was only significantly associated with self-esteem. Even then, the dynamic factors predicted substantially more variance in self-esteem than the child sexual abuse variable, as discussed in more detail in the next sections.

Particular importance was placed on a) behavioural self-blame and characterological self-blame, due to the inconsistency in the research literature regarding these factors to date (Hill & Zautra, 1989; Koss et al., 2002; O'Neill & Kerig, 2000), and b) shame-proneness, guilt-proneness, personal perceived control, and interpersonal perceived control, due to the absence of research on these variables in the sexual victimisation literature.

General And Specific Attributions

Shame-proneness had a stronger relationship with all four outcomes (i.e., depression, anxiety, posttraumatic stress, self-esteem) compared to guilt-proneness, though the latter still had significant relationships with outcomes. It appears, however, that it is guilt fused with shame that is related to outcomes, rather than guilt in its pure form, because the relationships between guilt-proneness and outcomes are drastically reduced and no longer significant when shame-proneness is controlled for. In contrast, the relationships between shame-proneness and the outcomes remain strong when guilt-proneness is controlled for. Guilt-proneness and shame-proneness are moderately correlated, meaning that they are likely to occur together, but the evidence indicates that it is only shame-proneness that is likely to be a factor in psychological functioning. This pattern is consistent with past research with college samples that demonstrated that shame-proneness is more strongly related to psychopathology than guilt-proneness (e.g. Gilbert, Pehl, & Allan, 1994; Tangney et al., 1992), and therefore contradicts other research evidence that suggests that both shame-proneness and guilt-proneness are related to poorer outcomes (e.g. Harder et al., 1992). In this way, a new step has been taken in the sexual victimisation field, since the knowledge of the impact of shame-proneness and guilt-proneness on psychological functioning previously found in college samples has been broadened to the area of sexual victimisation.

Since shame and guilt are common responses to sexual victimisation (e.g., Cruz & Essen, 1994), the expansion of shame-proneness and guilt-proneness into the sexual victimisation field is important because in practice, clinicians and justice system personnel are likely to come in contact with these factors if they encounter victims of

sexual offences. The evidence suggests that clinicians should consider shame-proneness as a priority area of intervention, and that justice system personnel should try to avoid treating victims in a manner that may encourage feelings of shame. The qualitative data identified one such practice for front-line police personnel to avoid, and that is being faced with a victim who wants to report a sexual offence and telling the victim to come back at another time. Victims described this experience as making them feel worthless and inferior. Although the police officers who told the participants in this study to come back later probably did so in order to have a more appropriate officer take the victim's statement (for instance an officer with specialised training who is considered to be sensitive to the needs of victims reporting sexual offences), victims are not in a position to know this without being told explicitly. Had the victims been adequately informed of *why* they were being asked to come back later, for instance because the police officer was hoping to make the reporting experience as positive as possible for the victim, then perhaps the victims would not have felt so worthless and ashamed.

Since the need for control (and the fear of losing control) was such a major theme in both the quantitative and qualitative data, it would appear that police officers in the above instance could offer victims the choice of coming back later to give their statement with an experienced police officer of the gender of the victims' choice, or to go ahead with the statement at that time with an officer who is available but may not be the most appropriate officer. When police officers make decisions for victims, they appear to do so for the benefit of the victims, but they may be inadvertently harmful by taking control away from the victims.

A similar situation arose with the offence-specific attributions. Janoff-Bulman (1979) proposed that characterological self-blame is associated with poorer psychological functioning whereas behavioural self-blame is actually adaptive in victims of sexual offences. The present research supports the first half of Janoff-Bulman's hypothesis, as characterological self-blame was strongly associated with poorer psychological functioning. Indeed, there is now strong consistent evidence across many studies that characterological self-blame is related to poorer outcomes (e.g. Frazier & Schauben, 1994; Frazier, 1990; Meyer & Taylor, 1986; O'Neill & Kerig, 2000).

As described in the literature review, while the existence of a strong link between characterological self-blame and poorer outcomes is not usually disputed (Frazier & Schauben, 1994; O'Neill & Kerig, 2000), controversy lies in relation to the association between behavioural self-blame and psychological functioning (e.g. Frazier, 1990; Regehr et al., 1998). Janoff-Bulman's (1979) hypothesis that behavioural self-blame is actually adaptive was not supported in the present research, as behavioural self-blame was not associated with better outcomes. However, the findings of the present research also contradict other proposals and research evidence that suggest that behavioural self-blame is associated with poorer outcomes in a similar way as characterological self-blame (e.g. Arata, 1999; Frazier & Schauben, 1994; Frazier, 1990; Meyer & Taylor, 1986; O'Neill & Kerig, 2000). The present research found that behavioural self-blame (in its pure form) was not related to psychological functioning in any way. The reason for the discrepancy may lie in the fact that while the present study measured behavioural self-blame in its pure form (controlling for characterological self-blame), many other studies gave no indication that they did this (e.g. Arata, 1999; Frazier & Schauben, 1994; Meyer & Taylor, 1986; O'Neill & Kerig, 2000). Therefore, the relationship that past researchers found between behavioural self-blame and poorer psychological functioning might actually have been a result of the behavioural self-blame being fused with characterological self-blame. The present research suggests that there may be no link between behavioural self-blame and poorer outcomes. Rather, only characterological self-blame was related to poorer psychological functioning in sexual offence victims in this research. What this research was also clear about is that guilt and shame are related to psychological functioning in very different ways, suggesting that they are two distinct concepts. Unfortunately, there is no distinction made between guilt and shame in the clinical literature reviewed for the purposes of this thesis (Cruz & Essen, 1994; Koss & Harvey, 1991; Paludi, 1999; Petrak & Hedge, 2002), which suggests that clinicians may not be distinguishing between shame and guilt in clinical practice with victims of sexual offences.

Since shame-proneness and characterological self-blame are moderately correlated with each other, it appears that the underlying issue of character defect and unworthiness that these two concepts share should be considered a large barrier to the therapeutic process. Further, the findings suggest that working clinically with a victim's feelings of

characterological self-blame with respect to the sexual offence may not be effective if there is an underlying feeling of shame that is not also addressed. Correlations between characterological self-blame and outcomes (depression, anxiety, posttraumatic stress, and self-esteem) were high, but were reduced when shame-proneness were controlled for. Therefore, dealing with shame-proneness may be more effective than dealing with offence-specific characterological self-blame. This makes intuitive sense, since shame-proneness covers a broader underlying feeling and thought process than one's attribution for only one type of event.

Research so far has been limited in its ability to guide clinical practice with respect to specific attributions. While past research has provided strong evidence for reassigning attributions away from the victim's character (Arata, 1999; Frazier, 1990; Meyer & Taylor, 1986; O'Neill & Kerig, 2000), there is a lack of evidence to identify a more therapeutic target for the reassignment process. Since there is a strong suggestion that people need to be able to explain adverse events (Kübler-Ross, 1969; Pennebaker, 1997; Ullman, 1997), it appears important that victims be able to place blame *somewhere*. Researchers have looked to blaming society as a more therapeutic target, however, blaming society was unrelated to psychological functioning in this research and in past research (e.g. Meyer & Taylor, 1986). Therefore, blaming society for the sexual offence is neither helpful nor harmful, which makes it a more therapeutic attribution than characterological self-blame, but still not ideal.

The place where the present research differs from past research is in its finding with respect to attributing blame to the perpetrator. While previous research found no association between blaming the perpetrator and psychological functioning (Meyer & Taylor, 1986), the present study provides more optimism for clinical practice. Specifically, blaming the perpetrator for the sexual offence in the current study was significantly related to lower levels of depression and posttraumatic stress, and higher levels of self-esteem. Therefore, not only do the findings of the present research strongly indicate that characterological self-blame is anti-therapeutic, but it also indicates that blaming the perpetrator can actually be therapeutic. With the apparent benefits of blaming the perpetrator, it might seem that blaming the perpetrator formally (i.e., in court) should be therapeutic, yet as stated earlier, the current study found no relationship

between reporting sexual victimisation to the police and psychological functioning. However, there is probably more complexity to the relationship between reporting sexual victimisation to the police and psychological functioning than attributions of blame alone.

Nonetheless, these findings suggest that clinicians should encourage the reassignment of attributions from the victims' character, to the perpetrator. According to the clinical literature by Koss and Harvey (1991) and Cruz and Essen (1994), it would appear as if this reassignment process is already happening in clinical practice, which is encouraging. However, clinicians must be careful not to encourage too much anger toward the perpetrator, since it appears that it can become destructive to victims' psychological functioning if the anger is too intense and if victims do not move on (Freedman & Enright, 1996). There are also strong social implications that may be addressed on a clinical level. For example, people's efforts to support friends or relatives who have been sexually victimised would be more effective if they place blame elsewhere than on the victim. Clinical interventions involving this sort of support education with friends or relatives of victims may provide a more therapeutic environment for the victims.

From a therapeutic jurisprudence perspective, the findings advise justice personnel to avoid placing blame on victims. The qualitative data revealed that blaming the victim may take place inadvertently by justice system staff. Closer attention to wording of questions when taking a victim's statement, for example, may lead to more therapeutic experiences for victims. For example, victims indicated that questions such as "Why did you invite him to your place?" are sometimes inferred by victims as blame for the sexual offence. Victims in this research appeared more amenable to difficult procedures (e.g., intense questionning) if they were given adequate explanations. Therefore, if police have a legitimate reason to ask such questions (i.e., it would advance the investigation), explaining these reasons to the victims may alleviate the sense of blame that the questions imply to the victims. For instance, it might be explained to victims that the offence was not their fault, but they (the police) need to ask the questions because if the case goes to court the defence might ask the victim questions of that sort.

Perceived Control

The present findings are consistent with other research findings that perceived control is a major factor in psychological functioning in many areas (e.g. Grace & Schill, 1986; Solomon et al., 1988; Strickland, 1978), including sexual victimisation (Regehr et al., 1998). From a therapeutic jurisprudence point of view, these findings suggest that during the justice system process, procedures that lead victims to perceive that they have some measure of control should be encouraged. The qualitative data emphasised the importance of control throughout the justice system process. The procedural justice literature theorises that having a sense of control should increase satisfaction with the justice system (Tyler, 1988; Lind & Tyler, 1988), and the qualitative data in this research supported this line of theorising. One striking example was the female victim whose incarcerated perpetrator had started the parole process. A victim advocate was able to drastically reduce the victim's distress by helping her gain some sense of control in the process by placing her on the victim register, effectively meaning that the victim would be informed and consulted at every stage of the perpetrator's parole process. Other situations that victims encouraged are as follows: control over the pace of the statement, a choice of gender of police officer taking the statement, the option to bring a support person with them for the statement, the option to request a closed court for their trial, and the option to request CCTV for their testimony.

An important part of the therapeutic jurisprudence perspective is that in attempting to create a more therapeutic justice system, the basic values of the court system, including defendants' rights, should not be compromised (Wexler & Winnick, 1996). Therefore it is important to assess how any suggestions to improve the justice system for victims would affect these values. Of the suggestions stated above, it appears that the most questionable suggestion is the option for victims to request CCTV for their testimony. Some may argue that the defendant's right to face his/her accuser may be compromised if CCTV for victim testimony were to occur. However, since defendants in CCTV testimony scenarios are still able to view the victim by way of video link, their right to face their accuser would not be compromised. Others may argue that victim testimony by CCTV prevents the jury from being able to fully assess victims as they give testimony. One suggestion that would address both concerns (defendant facing accuser and jury being able to fully assess victim) would be to have the victim give testimony in

court while the defendant watches the testimony via CCTV in another room. Other suggestions, such as giving victims a choice of gender of the police officer who takes their statement, would not appear to affect defendants' right in any way.

Participants in the current sample indicated similar levels of perceived personal control as participants in studies of the general population, but their levels of perceived interpersonal control were significantly lower. This may be because sexual victimisation is an interpersonal issue, leaving perceived personal control relatively intact. Further, perceived interpersonal control was more strongly related to outcomes than perceived personal control. The clinical implication here is that interventions with people who have been sexually victimised might be more effective if perceived interpersonal control is targeted specifically, rather than dealing with control issues on a general level. However, there is no indication in the treatment literature (e.g. Bagley & Thomlison, 1991; Halpern, Hicks, & Crenshaw, 1978; Koss & Harvey, 1991; Mitchell & Morse, 1998; Paludi, 1999) that this is currently a distinction made in clinical practice.

The implications with regards to perceived interpersonal control and justice system practices are abundant. For example, victims identified the court corridor as a situation where they felt the perpetrator and the perpetrator's family and friends had more control than the victims. As a result of this perceived power discrepancy in favour of the perpetrator, the victims felt intimidated and afraid. One measure that could be taken to help victims feel less afraid and more in control of this situation, without compromising the legal rights of defendants, would be to provide separate entrances and waiting rooms for victims of crime, or at least victims of interpersonal violence such as sexual offences. This specific recommendation has been made not only by several participants in this research, but also by researchers and clinicians in the sexual victimisation field (e.g., Holmstrom & Burgess, 1983). However, separate waiting facilities for victims are not provided in Western Australia, and the Dublin Report suggests that it is not common practice in European jurisdictions either (Dublin Rape Crisis Centre and School of Law Trinity College, 1998).

Coping Strategies and Social Support

Nonproductive coping (i.e., drinking/taking drugs to cope, self-harm, high levels of self-blame, hiding feelings from others) was the coping strategy that was most strongly related to outcomes (depression, anxiety, posttraumatic stress, and self-esteem). The relationship between nonproductive coping and outcomes was a negative one as expected, that is, the more victims utilised these coping strategies, the poorer their psychological functioning. The relationship between these types of coping strategies and poorer psychological functioning has also been found elsewhere in the research literature (Merrill et al., 2001). With respect to the clinical implications of these findings, coping strategies such as trying to block out painful memories, keeping feelings from others, excessive self-blame, worry and substance use, should be discouraged due to their strong association with poorer psychological functioning. However, clinicians would need to build up more positive coping strategies with clients first, otherwise merely taking away the nonproductive coping strategies may leave clients in more distress. This suggestion comes from the qualitative data, as victims appeared to need some way of trying to deal with the trauma, some form of coping strategy. Those that did not adopt positive coping strategies (seeking counselling, taking a positive attitude about themselves, setting small achievable goals to build self-confidence) appeared to adopt obstructive ways of dealing with the trauma, such as drinking alcohol, smoking marijuana, or self-harming, in order to temporarily ease the emotional pain. Specific guidance on how to develop more constructive strategies was not referred to in any of the clinical resources (Cruz & Essen, 1994; Koss & Harvey, 1991; Paludi, 1999; Petrak & Hedge, 2002).

The finding that coping strategies such as blocking out painful memories are harmful to the psychological functioning of victims also has implications for the justice system. When victims are engaged in the justice system process after reporting sexual offences, the qualitative data suggest that they are continually reminded of the offences because of ongoing issues in the justice system that they need to deal with. In essence, the justice system process does not allow victims to block out the offence for long periods of time. While the quantitative data suggest that not being able to block out the offences should be therapeutic, the qualitative data suggest that ideally there would be a middle ground. Victims reported that blocking out the offences altogether for long periods of time (i.e., years) was damaging in the long run, because it meant that they did not deal with the

issues and problems related to the offences properly. But victims also suggested that too much focus on the sexual offence for long periods of time (which the justice system demanded) was also anti-therapeutic. This idea appears related to Herman's (1997) notion of dealing with trauma and the need to achieve resolution or closure. On one hand, the justice system appears to force victims to deal with their victimisation, but on the other hand it seems to prevent (or delay) closure. Holmstrom and Burgess (1983) also observed that drawn-out justice system procedures prevented victims from getting on with their lives.

Victims who described feeling that they coped with the sexual offence well described a process of acknowledging their victimisation and dealing with problems that arose as a result of their victimisation, but also having other things in life that needed their focus and attention (e.g., children to take care of), so that they were not preoccupied with their victimisation. Therefore, it would appear that while the justice system may be therapeutic in the way that it does not permit victims to block out their painful memories, the justice system may also be anti-therapeutic in the way that it may demand too much attention from victims, for too long a period, preventing closure.

From a therapeutic jurisprudence perspective, it would seem that one way to make the justice system more therapeutic for victims would be to shorten the length of the justice system process so that victims are not forced to attend solely to their victimisation for excessive periods of time. This way, the justice system should benefit victims by encouraging them to think about and process their sexual victimisation, but it would not consume their thoughts more than what is necessary. This view is supported by the qualitative data, as participants consistently noted that the justice system process is too long and as a result, wears them down. Since reducing the length of the justice system process is not a new recommendation (e.g., Holmstrom & Burgess, 1983), it appears that substantial reductions in the length of the processes may be unrealistic in the current form of the system. However, if there were alternatives to the current system, perhaps victims would be able to achieve closure from their victimisation in a more therapeutic timeframe. Restorative justice programs may provide some relief to the retributive justice system and may also provide victims with a shorter time period in which to wait for resolution of their cases since, for example, defendants and their lawyers would not

have to spend time preparing a defence. Discussion of restorative justice programs will be continued later in this chapter once all the pertinent issues have been raised.

Another coping strategy that was examined in this research was sharing. Sharing with others appears to have important implications. The findings of the present research indicate that sharing should not be viewed on a continuum of "shares very little" to "shares a lot" (with the focus on *quantity*). Instead, sharing should be viewed on a spectrum of *quality*, whereby various forms of sharing are either helpful or unhelpful. In this way, the present study has shown that simply being in a relationship (married, de facto, or other serious relationship) did not contribute to psychological functioning. However, when victims feel they have a trusted person in their personal lives with whom they can share their sexual victimisation experiences (personal support^{Q}), they tend to indicate better psychological functioning. Therefore, traditional coping scales that measure sharing or use of social support on a quantitative scale may not tell the whole story. For instance, the sharing variable from the Coping Scale for Adults (Frydenberg & Lewis, 1997) used in the present study does not correlate very strongly with much of anything, outcomes or otherwise. It appears that the difference between this variable and the personal support^{Q} variable is that the Coping Scale measures *how much* respondents share their problems with *people in general*, whereas the qualitative personal support^{Q} variable was concerned with having someone in their personal life (one person is enough) with whom they can share their thoughts and feelings specifically about the sexual offence. There are two differences noted in the two variables. First, sharing experiences about the *sexual offences* versus *problems in general*. Second, having someone in their personal lives, as opposed to sharing with anyone in general (i.e., counsellor or doctor).

There is an additional issue with respect to measuring support. It seems that the last item in the sharing subscale of the Coping Scale may cause some problems, where it asks respondents how often they "hide things from others". This item is reverse-scored and is subtracted from the other sharing scale items. It is possible that a victim might have one very close friend with whom she/he is able to talk about the sexual offence and gain immense benefit from, but he/she may, at the same time, hide problems from many other people (i.e., work colleagues, family members, and so on). This person would

consequently end up with a low sharing score on the Coping Scale, but a high score on the personal support^{Q} qualitative variable. Since the personal support^{Q} variable was positively related to better psychological functioning whereas the sharing variable on the Coping Scale was not related to psychological functioning at all, it is suggested that developers of coping scales be cautious in their use of "hiding feelings" types of items, which may overshadow other positive sharing efforts.

Nonetheless, the implications here for clinical practice and the justice system are clear. Victims in counselling should be encouraged to develop their social situation to the point where they can confide in a trusted friend or relative about their thoughts and feelings with respect to the sexual offence. Further, friends and relatives of sexual offence victims may be misguided if they assume that victims attending counselling are receiving a sufficient amount of support. Indeed, positive personal support may be even more valuable than attending counselling in some instances. The qualitative data clearly support the therapeutic value of personal support. The interviews with victims suggest that victims who attend counselling but do not have personal support often feel isolated and misunderstood by their friends and relatives. Clinicians working with sexual offence victims may find it valuable to the therapeutic process to encourage friends and family members of victims to be more involved in the counselling and justice system processes (if the victim is agreeable) in order to educate them about how best to support their loved one. It must be recognised, though, that friends and loved ones of victims also must deal with their own emotions surrounding the sexual offence, and they may not have the resources to support the victim. The clinical resources that deal with sexual victimisation that were reviewed for this research did not identify the need for victims to have a person in their personal lives with whom to discuss their sexual victimisation (Cruz & Essen, 1994; Koss & Harvey, 1991; Paludi, 1999; Petrak & Hedge, 2002). However, generic counselling resources routinely describe the development of social support networks as a goal of counselling (e.g. Egan, 2002). Therefore it appears that the foundation is already strong for fine-tuning support networks in clinical practice.

From the therapeutic jurisprudence perspective, victims may benefit from having a personal support person (of their choice) available to them when engaging in justice system processes. This direction is supported by the qualitative data, where victims

strongly asserted that the experience of giving a statement to the police would be much easier if they had such a support person with them. Victims who did have such support people with them for their police statements stated that this was very positive, and victims who did not have such support people with them stated that this would have valuable. Some participants stated that the support person need not necessarily be in the room when the statement is being taken, but that merely having a support person accompany them to the police station and stay there while their statement is being taken, would be valuable to the statement process. It appeared from some instances in the qualitative data that police officers were discouraging supportive others from accompanying victims to the police station to make their statements. The reasons for this are unknown but the evidence suggests that this practice should be discouraged. The justice system necessarily requires the cooperation of victims and it appears that the easier the police make procedures for victims, the more cooperative victims are likely to be. Further, from a therapeutic jurisprudence approach, justice personnel should include in their duties, efforts to make the process therapeutic for individuals in the process (Wexler & Winnick, 1996). Aside from the situation of making statements to police, other areas of the justice system process where victims may benefit from bringing a support person with them are identification procedures at the police station, meetings with the prosecutor, and court attendances.

There are two other noteworthy trends in the findings regarding coping strategies. First, the correlations between shame-proneness and coping strategies are moderate, while none of the correlations between guilt-proneness and coping strategies are significant. Specifically, shame-proneness is positively correlated with nonproductive coping, and negatively correlated with dealing directly with problems, sharing, and optimism. In turn, nonproductive coping is related to poorer outcomes, whereas dealing directly with problems is related to better outcomes. Although it is recognised that correlations cannot lead to conclusions about direction or causality, it appears that underlying feelings of shame (indicated by shame-proneness) may lead victims to adopt certain coping strategies over others. For example, having strong feelings of shame may discourage victims from sharing their negative experiences with other people, as a result of feeling that the negative experiences are inherently their own fault due to their character defect. Similarly, strong underlying feelings of shame appear to lead to few attempts to deal

directly with problems, perhaps because problems are seen as being caused by the self, which is inherently bad and unchangeable. On the other hand, people with low levels of underlying shame may feel that the *situation* is the problem, rather than their character, and they may consequently make more efforts to change the problem situation. Further research may be able to shed light on the likelihood of this hypothesis.

Second, the research findings suggest that having a sense or perception of control in one's life appeared to lead victims to utilise different coping strategies than victims who had a weaker sense of control. It appears that victims who had high levels of perceived control are the ones who engaged in the direct task-oriented types of coping, seen from the positive correlation between these two variables. Since they feel that they can influence the course of their lives, they may feel better able to take direct action to improve their situation. On the other hand, victims appeared to resort to using nonproductive types of coping when they did not feel they had much control in their lives, since there was a negative correlation between these two variables. The victims appeared to cope with stress by trying to escape the negative emotions with behaviours such as increased use of alcohol and other drugs, and self-harm. In this way, nonproductive coping strategies may be a reaction to low levels of control, indicating some degree of helplessness about their situation. Evidence for these quantitative trends was also found in the qualitative data in this research, and in past research with various samples (Strickland, 1978).

These hypothesised pathways reinforce the clinical importance of dealing with control issues and underlying shame feelings in the therapeutic process of victims. In addressing control and shame issues, it appears that clients would tend to adopt more therapeutic coping strategies, such as more problem-oriented strategies and fewer nonproductive strategies, which in turn should lead to better psychological functioning.

Rumination

The search for meaning for negative events was considered a basic human need by Kübler-Ross (1969) and the present research supports this line of theorising since the search for meaning for the sexual offence (rumination) was strongly related to all four indicators of psychological functioning (depression, anxiety, posttraumatic stress, and

self-esteem). Correlations between rumination and other predictor variables were low, suggesting that rumination may tap into a different sphere than the other predictors, which were more strongly correlated with each other. Rumination has been seldom researched in the sexual victimisation field, but so far it has been associated with poorer psychological functioning in victims of sexual offences (Silver et al., 1983; Ullman, 1997). Therefore the findings of this study provide a stronger basis for studying this concept more closely, in the hope of finding the specific components that make searching for meaning so important in the therapeutic process. The qualitative data revealed that victims were either concerned with finding a reason for their victimisation or had in fact already come to some sort of conclusion as to why they were victimised. There was no indication from any victims that finding a reason for their victimisation was not important to them.

The findings with respect to the search for meaning have strong implications for clinical interventions with victims of sexual offences. Addressing clients' need to answer the question, "*Why* did it happen?" would appear to be a valuable target area in counselling, because it appears that if victims are able to place blame for the offence somewhere (i.e., find an explanation for the offence), they should ruminate less, which in turn should lead to better psychological functioning. Of the four treatment resources for counsellors and therapists that were reviewed for the purposes of this research (Paludi, 1999; Koss & Harvey, 1991; Petrak & Hedge, 2002; Cruz & Essen, 1994), only one of them (Koss & Harvey, 1991) touched on the issue of finding meaning for the clients' victimisation. However, exactly *how* one is helped to find meaning for their victimisation was not discussed. Therefore, it appears that the importance of finding meaning for clients' victimisation is not an entirely new focus for clinical intervention in the sexual victimisation field, but it is not a widespread target and there are few, if any, guidelines for clinicians to follow in addressing this seemingly important factor. It is acknowledged, however, that more *generic* clinical literature (e.g., Herman, 1997) appears to address the issue of finding meaning in traumatic events to a fuller extent and may be useful in guiding this practice in the particular field of sexual victimisation.

While it may seem that the justice system should provide answers to victims and therefore victims should need to ruminate less, the qualitative data suggested that this

was not the case. Victims stated that during their testimony it was frustrating that they were limited to answering only "yes" or "no" to the lawyers' questions and therefore were not permitted to convey the whole story in their own words. Similar observations were described by Lees (1996). As a result, victims are prevented from having a *voice*, which according to Lind and Tyler (1988) results in a decrease in satisfaction with processes and minimises one's sense of procedural justice. Further, victims in the current research stated that the defence lawyers often misconstrued their testimony during cross-examination. As a result, victims described feeling that the truth of the offence was concealed and that the results of the trials (conviction/acquittal) were not based on the truth. It was clear from victims' accounts of their court experiences that they did not feel they obtained any real sense of truth about the offence incident. Therefore, it did not appear as if victims were given any real answers about the offence incident that would serve to reduce their rumination and search for meaning behind the offence.

Indeed, it is possible that justice system practices may even promote rumination in victims. For instance, police interviewing styles were portrayed in the qualitative data as similar to cross examination styles in court. Although a victim who initially decides to report a sexual offence may feel that the perpetrator is to blame for the sexual offence, victims indicated that police interviewing and cross examination experiences often led them to question their own behaviour and their worth as a person, making them feel as if they were to blame for the offence. It is possible that these experiences raised more questions than they answered in terms of why the offence occurred, and therefore the experiences may lead to more rumination rather than less. Further, the frequent court delays and postponements recorded in the qualitative data of this research and in past research (Holmstrom & Burgess, 1983; Madigan & Gamble, 1989) may increase and prolong rumination to the point where closure cannot be obtained and psychological functioning is adversely affected. More research on this matter would be encouraged, particularly since rumination was so strongly related to psychological functioning in the current research.

An Optimal Explanatory Model Of Participants' Current Psychological Functioning, Utilising A Combination Of Static And Dynamic Variables

The bivariate correlations between predictor variables and psychological functioning variables (depression, anxiety, posttraumatic stress, and self-esteem) strongly suggested what the multiple regression analyses later confirmed, that the dynamic predictors consistently accounted for substantially more variance in outcome scores than static predictors. This pattern indicates that rather than the objective characteristics of the victim or the offence being vital in victims' adjustment to the offence, it is the appraisals and interpretations that victims make following the offence that play a large role in their long-term psychological functioning. These results are consistent with Weaver and Clum's (1995) research that found that subjective factors were substantially more influential in psychological functioning than objective factors. Therefore, the present research provides stronger evidence to conclude that across different samples and different sorts of methodology, dynamic variables tend to predict psychological functioning in victims of sexual offences to a greater degree than static variables.

This conclusion provides optimism for the sexual victimisation field, for if dynamic factors had not been influential, counselling efforts would be of little therapeutic value. Since victims' dynamic (modifiable) characteristics are more influential in their psychological functioning than their unmodifiable circumstances (e.g., how long ago the victimisation occurred or their current age), professionals who deal with victims of sexual offences in the justice system and in clinical practice are (theoretically) able to create a more therapeutic environment for the victims they deal with.

Comparative evaluation of the predictors by way of regression analyses identified particular issues that can be considered priority areas for introducing therapeutic environments for victims. Four explanatory models were produced from the multiple regression analyses, one for each of the indicators of psychological functioning. Depression was best explained by perceived personal control, rumination, optimism, shame-proneness, vaginal-penile penetration in the offence, having personal support[Q] for the sexual offence, and oral sex in the offence. Anxiety was best explained by nonproductive coping strategies, rumination, perceived control, shame-proneness, and

optimism. The best model explaining posttraumatic stress included rumination, nonproductive coping, perceived personal control, and oral sex in the offence. Lastly, self-esteem was best explained by perceived control, shame-proneness, nonproductive coping, character self-blame, optimism, and a history of child sexual abuse. The factors that were most consistently influential in psychological functioning on a general level (based on being significant contributors on at least three of the four indicators of psychological functioning) were therefore perceived control, rumination, optimism, shame-proneness, and nonproductive coping strategies. The specific implications regarding these crucial factors have already been discussed in the previous section of this chapter, so they will not be reiterated here.

The Needs Of Sexual Offence Victims In The Justice System, Reasons For Reporting And Not Reporting To The Police, And Meanings Of *Justice*

For participants who did not report their victimisation to the police, the reasons they gave were mostly that it was too late, nobody would believe them, they felt too much shame and embarrassment about their victimisation, and they felt that the justice system would be too damaging for little or no expected gain. Some of these reasons are similar to reasons reported in other research (e.g., Australian Bureau of Statistics, 1996). The themes of shame, embarrassment, and the fear of not being believed, appear to be common reasons for not reporting sexual victimisation, over time and across countries. However, unlike the Australian Bureau of Statistics research, there were no participants in the present research that stated that they did not regard their victimisation as a serious offence (14% of the Australian Bureau of Statistics research sample stated this as a reason for not reporting the sexual offence).

For participants who reported their victimisation to the police, the reasons they gave focussed on preventing the offender from re-offending, acknowledgement of the offence against themselves, and bringing the offender to justice. These reasons are similar to the reasons stated in the Women's Safety Survey (Australian Bureau of Statistics, 1996), however, acknowledgement was emphasised in the current research whereas it was not in the Women's Safety Survey. It is possible that the victims who chose to participate in

the current research were the ones still looking for acknowledgement, and perhaps participating in the research was one way they were able to achieve this.

The results of canvassing these issues with participants by way of interview led to several themes that are useful in hypothesising about the needs of victims in sexual offence cases. It is interesting that there is considerable overlap among the reasons for reporting, the reasons for *not* reporting, and victims' personal definitions of justice. For instance, the most common personal definition of *justice* involved the need for acknowledgement and recognition that the sexual offence actually occurred. This need led some victims to report their victimisation to the police, on the belief that the justice system process would give them the acknowledgement and recognition they needed. Many of these participants ended up disappointed with the justice system because they did not get the acknowledgement they were looking for. Many cases were stopped before they reached the court stage, on the basis that there was not enough evidence to proceed. To many participants, the cessation of their case meant that nobody believed them. Therefore, they ultimately received the exact opposite from what they expected and needed from the justice system.

Although many of the participants who did *not* report their victimisation to the police reported the same need for acknowledgement and recognition, many of them did not believe that the justice system could fulfill their needs and consequently they did not report to the police. It appears that perhaps these victims were more realistic in terms of their expectations of the justice system process. Two examples of participants (#121 and #127) described in Chapter 7 exemplify the idea that justice can be achieved outside or beyond the traditional retributive justice system, and indeed, it appeared as if these two participants achieved more of a sense of justice (and therapeutic benefit) without the justice system than they would have been able to accomplish with it. It is therefore suggested that for victims who primarily want acknowledgement and recognition of the impact of the offence, the current justice system process appears inadequate. Processes that encompass elements of restorative justice (e.g., victims have a *voice*, offenders confess to the crime and take responsibility for the consequences), may provide these victims with more of a sense of justice than they are able to obtain through current justice system processes.

Similarly, victims whose personal definitions of justice focus on restoration of balance between them and the offenders may also be able to gain satisfaction and a sense of justice through restorative justice activities. For example, victims may be offered an apology by the offenders, and/or they may be offered to have their counselling paid for by the offender. Victims' focus on restoration in the current research is similar to the findings in Feldthusen and colleagues' (2000) study of victims' experiences in civil and criminal compensation processes.

The third main theme in the participants' personal definitions of justice encompassed a sense of revenge and a need to have the offender punished. Although the idea of revenge is far from the idea of restorative justice, victims who perceive justice as revenge may still be able to get a sense of justice from restorative justice activities if the punishment they desire does not involve a prison term. In such cases, victims may be able to gain a sense of justice and may also gain the other benefits of restorative processes. However, for victims who feel that justice can only be obtained by a prison term for the offender, restorative justice activities may not work because there would be little incentive for offenders to participate in the activities. For these victims, the traditional retributive justice system would appear to be the appropriate justice process.

It appears that the current retributive justice system in Australia does not fit all victims' ideas of justice, and that the justice system's sole focus on retribution might actually be preventing some victims from reporting sexual offences. The evidence suggests that programs with more restorative aims may meet the needs of some victims better. For some of the victims in the current sample, they wanted acknowledgement and they seemed to obtain a solid sense of justice without reporting the offence to legal authorities. The qualitative evidence suggests that for some victims, restorative types of processes within the official justice system may not be unwelcome, contrary to the suggestion that sexual offences may be too serious a crime to be dealt with by restorative programs (Crawford & Goodey, 2000). A positive result appeared to have eventuated for the victims just described in the current research, in that they seemed able to get answers they were looking for and were able to gain some closure. However, these restorative actions carried out privately to avoid the justice system eventually pose a problem for

society, because these offences are not recorded officially, and therefore the future behaviour of offenders cannot be checked (Gall & Allan, 2002). It appears that a justice system that is able to incorporate the restorative needs of victims (and offenders) may be more effective and therapeutic than viewing restorative programs as falling *outside* of the official justice system. Nonetheless, it was clear that victims did not share one particular personal meaning of justice; they had unique ways of constructing justice and therefore they had unique needs in the justice system. Paradine (2000) noted additional examples of justice in her research with victims of domestic violence. She noted that participants measured success in the justice system by the degree to which they were treated with respect in the justice system procedures and the degree to which the procedures made them feel safer. Further, Hankivsky (2002) noted that, "From the perspective of survivors, the need to participate, to be heard, and to be respected in all stages of the compensation or redress processes are seen as essential to empowerment and a therapeutic outcome. The unique meanings of justice across these studies suggest that victims need several options to consider. This conclusion mirrors Feldthusen and colleagues' (2000, p. 112) view that, "Society ought to provide a number of legal options to victims of sexual abuse, so that survivors themselves can elect the appropriate balance of confrontation, vindication, monetary and in-kind compensation, and other variables, that best matches their therapeutic needs." Since maintaining control seemed crucial to victims of sexual offences in the present research, providing them with options about how to deal with their victimisation would appear to be therapeutic.

The Therapeutic And Anti-Therapeutic Factors In The Justice System Experience

While several implications for the justice system have already been discussed in relation to the dynamic predictor variables, there are other noteworthy issues that have arisen from data other than the dynamic variables.

Participants in this research who reported their sexual victimisation to the police described similar experiences as those reported in past research such as Holmstrom and Burgess (1983). Participants complained that they were not kept informed, that the period between reporting and trial was too long with too frequent delays, that they were

only witnesses (without any input), and that the courthouse was a hostile environment for them since they had to wait with the perpetrator and/or the perpetrator's family and friends. Further, the experience of testifying has been described by many victims as humiliating and distressing, not unlike the original sexual offence (Holmstrom & Burgess; Lees, 1996; Madigan & Gamble, 1989).

Since the experiences of sexual offence victims in the justice system over the last couple decades (Holmstrom & Burgess, 1983; Madigan & Gamble, 1989) appear very similar, it is not surprising that the recommendations to improve these experiences are also similar. Therefore, suggestions to provide victims with a more important role in the justice system has been made several times, with limited apparent impact since recent victims in this research describe the same problems. However, there have been instances in some jurisdictions, as described in the literature review, where the satisfaction of victims of sexual offences has increased with efforts to give them more rights (e.g. legal representation for victims was described in the Dublin Rape Crisis Centre and School of Law Trinity College, 1998).

From a therapeutic jurisprudence perspective, the findings of the present study suggest that the current system in Western Australia can go a long way toward maximising its therapeutic potential for victims. As shown in the present research, the justice system process has the potential to be a very therapeutic process for victims, without compromising the rights of the accused. The qualitative data were very clear in conveying that some victims, treated with respect and given a sense of control in the situation, found the justice system to be very positive in their coping process. This was even true for some victims who did not get the end result that they wanted (conviction, or long incarceration sentence for the offender). This finding is consistent with Lind and Tyler's (1988) work on procedural justice and their observation that even in the face of negative outcomes, people will be more satisfied with a decision-making process if they are able to have a *voice* and some sense of process control. However, for the majority of participants who reported their sexual victimisation to the police, the justice system provided them with an outcome that was far from their idea of justice.

Accordingly, it is recommended that policy makers look to alternative models of the justice system process for victims of sexual offences, and likely interpersonal violence as a whole. The qualitative data support specialisation of justice system staff, such as in a sexual offence court, since many victims stated that some staff within the system do not seem to have a good understanding of the experiences of victims of sexual offences. If staff were specialised in the sexual offence field, then intense training of staff would work toward giving staff who work with victims of sexual offences within the justice system a better understanding of the pertinent issues victims face. Ultimately, a better understanding would lead to a more therapeutic justice system process for victims of sexual offences, since a main theme in the qualitative data was that many victims did not feel understood in the process, and this led them to experience the justice system as a negative process. An alternative option, and not one that is mutually exclusive, is providing more restorative justice options, as already discussed. Restorative justice would provide opportunities for acknowledgement, validation, and the opportunity for victims to tell their stories in the way that is therapeutic for them. In fact, it appears as if a problem-oriented sexual offence court, working in conjunction with restorative justice programs (for situations where offenders and victims are agreeable to such schemes) may provide victims with better opportunities to obtain a sense of justice in systems that are more therapeutic, without compromising the rights of defendants.

Whichever type of process victims undergo after they report a sexual offence to the police, it is clear from the qualitative data that they need to be better informed and prepared about the various legal processes. Victims in the present study whose expectations were too high were often disappointed and dissatisfied with their justice system experience. This finding is similar to that found by Feldthusen and colleagues (2000, p. 113) who observed that "high expectations are problematic because they can lead to disappointment and disillusionment." Dissatisfaction within victims in the present study also arose when they learned about distressing routine practices for the first time when they arrived at court (i.e., having to wait in the court corridor with the offender). Preparing victims for the justice system process is one area where the management of victims on clinical and justice system levels may require a coordinated effort. For example, police dealing with victims of sexual offences (and other offences too, for that matter) could refer victims to counsellors with specialised knowledge of

justice system procedures. Counselling could involve not only informing victims of the processes they are likely to encounter, but also preparing them psychologically for their journey through the justice system.

Justice system personnel must also be prepared for the victim's venture into the justice system if they are to interact therapeutically (or at least not anti-therapeutically) with them. The quantitative data in this research indicate that personnel should be aware that victims who enter the justice system may be especially prone to feelings of shame, they may feel little control in interpersonal interactions, they may have symptoms of depression, anxiety, posttraumatic stress, and they may have low self-esteem. The qualitative data suggest that personnel should be aware that victims may have had numerous experiences of not being believed about their sexual victimisation, that they may have had little or no support from friends or family, that they are taking significant risks in engaging the justice system and may be extremely reluctant to do so. Victims may therefore be put off very easily at any sign of insensitivity by justice system personnel. Further, victims may be extremely reluctant to trust anyone, their GP, their psychiatrist, their friends and family, let alone personnel in the justice system, for the very real fear of losing control. Justice system personnel may work most therapeutically with victims if they take these factors into account. This means that giving victims a sense of control in the process (giving them options), acknowledging their pain, their courage, and the risk they are taking by reporting their sexual victimisation. This is by no means an easy task for justice system personnel to perform, but it is necessary if victims are to be dealt with therapeutically, that is, in a way that promotes their psychological well-being.

Research Implications

It is clear that more research in this area is needed, but it is also clear that there are several issues that make this type of research difficult. The present research has identified three areas for discussion, in the hope of improving research in this field: participation, measuring anger, and measuring thoughts versus feelings.

Participation

Given the negative responses of receptionists at several health agencies about the researcher placing research advertisements on their premises (described in Chapter 7), it is not surprising that victims of sexual offences continue to report feeling different and alone, and stigmatised. These sorts of responses from societal members do not help victims reduce the shame they feel about their experiences, and it is not surprising that most victims do not report sexual offences to the police or to medical doctors. Co-ordinators of *counselling* agencies also often refused to place research advertisements in their waiting rooms, but for different reasons than the receptionists at the health agencies. The counselling co-ordinators' reasons were focussed on their fear that participating in research might be too difficult for their clients. The act of limiting such opportunities for clients reinforces the very messages that counsellors are undoubtedly trying to combat in the counselling process, namely that someone needs to make decisions (take control) for these victims, because they are not capable of taking control of their own lives. Since two strong themes that emerged from the qualitative data were victims' need for a sense of control and the need to share their stories, the practice of agency coordinators limiting research opportunities appears to be anti-therapeutic for the victims and therefore for the agencies themselves. This view is similar to Mezey and Taylor's (1988) suggestion that if victims are competent to consent to treatment, they would generally be competent to consent to research. Participants may directly benefit from the research participation experience by exercising control over their own decisions and telling their stories in a safe and anonymous atmosphere. Participants may also benefit from the advancement of the sexual victimisation treatment field. Further, by supporting local research, agency coordinators, their staff, and the agencies themselves, can benefit from links with researchers by keeping up to date with the latest research. Good communication between researchers and clinicians would provide valuable opportunities for research to inform clinical practice, and likewise, for clinical practice to inform research.

The qualitative data that outlined the reasons victims participated in this research and the benefits they stated they received from the research, suggest that research conducted sensitively is able to meet strong needs in the lives of some victims of sexual offences, and can also provide insight, encouragement, a sense of control and empowerment, and

a sense of direction in tenns of where to head next in the therapeutic process. Indeed, Pennebaker (1997) also provides strong evidence for the therapeutic value of sharing one's experiences with others. It is hoped that in the future, people will more accepting of advertising sexual victimisation research on their community noticeboards. More acceptance in the general community of sexual offence victims may not only lead to better research (increased sample sizes and more representativeness) with which to inform clinical practice, but also reduced stigma of victims of sexual offences (Mezey & Taylor, 1988), increased reporting rates, and ultimately, reduced prevalence of sexual offences.

Measuring Anger

A measure that warrants comment is the State-Trait Personality Inventory (STPI) which was used in the present research to measure state anger. Results from this scale were interesting in that about 90% of respondents endorsed the lowest possible score (no anger). As a result, little was possible in the way of analysing the data. It appears that *state* anger may not have been the best choice; trait anger might have provided a better outcome measure in terms of more variation in scores. When respondents in the current study were completing the state anger questionnaire, several of them expressed that they were the least angry at that exact point in time because the researcher was doing something to help victims of sexual offences and therefore they were grateful, and not angry. Perhaps trait anger, or a different response time-frame would be more effective, for example, asking respondents to answer the questions in terms of "the last week", rather than "right now". However, since predicting anger is rarely reported in the sexual victimisation research literature, it is difficult to propose whether this finding is unique to the present research, or a broadly experienced phenomenon.

Measuring Thoughts vs Feelings

This research found that minor differences in wording of questions led to marked differences in responses. The thoughts and feelings of victims were distinguished on two occasions: specific attributions and self-esteem. This distinction was made in response to participants' reported frustration at not being able to differentiate their responses based on their thoughts versus their feelings. The results indicated that when participants responded to questions with their *thoughts*, they were much more positive about

themselves than when they responded with their *feelings*. Specifically, they reported significantly less self-blame and significantly higher self-esteem with their thoughts, compared to their feelings. Also importantly, participants' self-blame attribution *feelings* were more strongly related to psychological functioning than their self-blame attribution *thoughts*. The idea that one's thoughts about oneself are more positive than one's feelings, is supported by the few participants who noted their frustration while responding to these questions on the questionnaire. They implied that their thoughts were what they were trying to convince themselves was true, whereas their feelings were more entrenched and therefore appeared to have more of an impact on their daily lives, such as how they interacted with other people.

These findings have direct implications for research. Specifically, the results suggest that researchers need to be very clear about the wording they use in their questions and must appreciate that a small change in wording can have enormous consequences, as it did in the present study. Although this matter will not be new to any experienced researcher, this specific distinction (between thoughts and feelings) may in fact be new to some researchers. Further, by initially not differentiating between thoughts and feelings in the present research, participants reported that they were frustrated. Therefore, researchers might want to consider this aspect in the course of questionnaire design for a variety of reasons, including maximising the clarity of the construct being studied, and participant satisfaction with the research.

Limitations Of The Research

The key limitation to the generalisability of the findings of the current research is the self-selected nature of the sample and the inherent bias that brings to the research. Participants in this research a) recognised that their experiences constituted sexual offences, b) had the courage and motivation to contact the researcher by telephone, c) were prepared to meet with the researcher for the purpose of relating those experiences, and d) were able to complete the questionnaire. Victims who do not have these characteristics, abilities, or motivations were not accessed through the research and are therefore unrepresented in the data. It is very likely that participants in the current

research have dealt with the sexual offence differently than victims who do not wish to participate in research of this nature. It is possible that the current self-selected sample of participants was more or less symptomatic than might be expected from a random sample of victims of sexual offences. In the case of Ullman's research (1997), the self-selected sample of victims of sexual offences was more symptomatic than a sample of participants generated from a random sample. Further, the research may have attracted respondents who wanted to discuss their experiences without the commitment of therapy, or those who were looking for acknowledgement. To the extent that the current sample differs in level of symptomatology from a randomly generated sample, the current sample would not be generalisable to the greater population of sexual offence victims. A random sample of community members using an anonymous mail-in data collection procedure was not deemed feasible for the present research, due to the ethical responsibilities regarding psychological test administration. However, many participants in the current research did not report their victimisation to the police or access support services regarding their victimisation and indicated a large variation in their psychological functioning. Therefore, the sample would appear to be more representative than a pure clinical or student sample.

Another common limitation in this area of research that is shared by the current research is the reliance on retrospective memory for key research data. However, since most of the key measures of the current research were dynamic in nature and assessed participants' *current* cognitions, feelings, and behaviours, retrospective memory was not heavily relied upon for details. Having said this, it is acknowledged that the details that *did* rely upon retrospective memory (i.e., offence characteristics) may not be entirely accurate. Indeed, some participants stated that they were not 100% sure of the exact actions that constituted the abuse, but provided their "best guess." This consequence of retrospective memory is inevitable, but is nonetheless important to acknowledge. Research in the area of retrospective memory is by nature difficult, but there is evidence to suggest that memory is largely accurate but can be distorted, and that wholly false memories are less likely than distortions of real memories (Kennerley, 2002).

Since the present research design is cross-sectional nature, the associations between variables are useful in describing which variables tend to occur together, however,

causality cannot be inferred from the data. Longitudinal research would address this limitation (Merrill et al., 2001), however high attrition rates characteristic of such designs (e.g., Frazier, 1990) often make them unfeasible or undesirable.

The participants in this study are a group of people, like any group, whose personalities and behaviours have been formed by the myriad of experiences that they have encountered in their lifetimes. As a result of this, it is impossible to distinguish which experiences led to the formation of certain aspects of their personalities and behaviours, and therefore the present-day symptomatology that some participants reported were likely generated from a background that was traumatic in more ways than just sexual offences. Although it was beyond the scope of this thesis to address such issues, it raises some interesting questions in terms of how much of the symptomatology of the present sample was due to a traumatic background in general versus sexual offences alone, and whether the trauma of sexual offences is inherently different from other types of trauma in terms of the effect on psychological functioning.

Limitations surrounding the qualitative data coding process are also noteworthy. Coding was carried out by only one coder; the same person who conducted all the interviews. It would have been a more valid process to have multiple coders to allow more objective and reliable conclusions to be made about the qualitative data.

Lastly, the sample in the current research predominantly consisted of female participants. Although effort was made to recruit male participants, it appeared more difficult to do so with the recruitment procedures used in this research than for female participants. As such, generalisations cannot be made from the data on the male portion of the sample since the group consists of so few men. However, the only difference in the scores between males and females was on the posttraumatic stress variable, so this provides some suggestion that effects on males and females may be similar. However, male victims suggested that they have additional barriers in the therapeutic process. Increased posttraumatic stress in men may be a result of fewer channels through which to work through posttraumatic stress, since there appear to be fewer appropriate services for male victims (Coxell & King, 2002). Nonetheless, valuable qualitative data were obtained from the male participants, particularly in terms of their experiences in the

justice system, and it is hoped that these data can provide a small but useful insight into the particular issues that some male victims of sexual offences experienced in dealing with sexual trauma, and it is hoped that the data will also point to useful and interesting avenues for future research.

Directions For Future Research

As stated in the limitations above, few men participated in this research. Since the proportion of men who have experienced sexual trauma at some time in their lives is considerable, and given the often damaging effects of sexual trauma, it is hoped that future research will endeavour to include and study male victims of sexual offences more extensively. It is acknowledged that it was more difficult to recruit male participants than female participants in the present research, and therefore some thought will need to go into identifying more successful methods of recruiting male victims of sexual offences for research. The men in this sample suggested that they were less eager to discuss their sexual victimisation with friends and family than the women in the sample, and as such it makes sense that men would be less likely than women to participate in research that focusses on sexual victimisation. The men also emphasised their feelings that society expects men to deal with difficult issues more easily than women, and that women have more outlets (including more counselling opportunities) than men.

It appears that the key to increasing male participation in research (and counselling too for that matter) would be to expand community education efforts with respect to sexual victimisation in men and providing men with better access to counselling. This would obviously be a long process rather than a quick fix, particularly with changing community attitudes. Working to provide men with better access to counselling appears to be a good place to start. Some sexual assault counselling agencies in the Perth area in Western Australia do not accept male clients. This in itself sends strong (false) messages to the community and to sexually victimised men in particular, that men have fewer needs than women or that it is less appropriate for men to address their problems with sexual victimisation. Male victims of sexual offences clearly need better community

support. Until this occurs, it would appear likely that men will continue to decline to participate in research on sexual victimisation at a higher rate than women. In the meantime, researchers hoping to recruit male victims of sexual offences might find support groups useful, depending on the geographic area. The present researcher attempted to make contact with male support groups but unfortunately was faced with few support opportunities for men in Perth. This is consistent with what the male victims in this research indicated.

Since the findings of the present research suggest a list of dynamic factors that appear to play a large role in adjustment to sexual offences, the next step from here is to try to identify ways of turning these factors into clinically useful intervention strategies. Future research that identifies effective intervention strategies in the areas mentioned would be very useful. For instance, intervention techniques that are shown to significantly reduce rumination about why the offence occurred are eagerly awaited.

Similarly, another step that follows on from the findings of the present study involves scale development with the factors identified as being priority areas. Research leading to development of such scales would be useful not only as a research tool, but also for clinical purposes. By constructing a scale that efficiently measures the important factors (i.e., shame-proneness, characterological self-blame, rumination, coping strategies, and perceived personal and interpersonal control), clinicians would be in a better position to measure the intervention needs of their clients. After identifying the areas in which clients are deficient, clinicians could then target their intervention efforts on these areas, with the aim of maximising the therapeutic potential of the intervention.

Given the findings of the present research with respect to the differences between perceived personal and interpersonal control, future research examining these distinct variables more closely might provide useful insight into the role of control in psychological functioning. For example, what is the cognition that underlies the perception of having little interpersonal control? How is this cognition different from the perception of having little personal control? The answers to these questions may prove to be valuable to the sexual victimisation field.

A persistent theme in the qualitative data was that the length of time victims normally had to wait from the time they reported the offence until they went to trial was anti-therapeutic. Victims described feeling that it was damaging because it disrupted work and family life, and delayed achieving any sort of closure about the offence. A valuable line of research would be to examine the quantitative relationship between the length of this interim period and psychological functioning. If there is strong quantitative evidence and/or more indepth qualitative data demonstrating that a longer waiting period between reporting and trial is related to worse psychological functioning, there would be a stronger case for policy makers to take steps to reduce this interim period.

The tentative finding that one's feelings are a better measure of their psychological functioning than one's thoughts, provides interesting research possibilities. For instance, the magnitude of the difference between victims' thoughts and feelings may provide a useful indication of their therapeutic progress. Research aiming to assess intervention strategies may find this type of indication useful.

Lastly, the present study canvassed the views of sexual offence victims, but there are several other perspectives that would be useful to understand and improve victims' experiences. These other perspectives may be canvassed from victims' friends and family members, Judges, police, and clinicians. Information about the feasibility and acceptance of various recommendations and efforts in legal reform would be useful. Further, information that would lead to the identification of barriers to dealing therapeutically with victims of sexually offences would also be useful.

Conclusions

The aim of the research was to identify ways of enhancing psychological functioning of victims of sexual offences from clinical and justice system management perspectives. This project examined clinical and justice system processes in one research design, aiming to contribute to both the clinical literature and the field of therapeutic jurisprudence. To contribute to the clinical literature in the sexual victimisation field, this research needed to provide a better understanding of clinical processes in terms of

the factors associated with better or worse psychological functioning. To this end, an optimal explanatory model of participants' current psychological functioning was developed. This information will be valuable in guiding clinical practice with victims of sexual offences. To contribute to the therapeutic jurisprudence field, this research needed to identify ways of making the justice system experience more therapeutic for victims of sexual offences. To this end, victims' experiences in the justice system and their personal definitions of justice, along with the quantitative findings about the relationships between various factors and psychological functioning, provided the basis for recommendations on how the justice system might better meet victims' needs.

The project administered significant psychological scales and identified critical areas for further research. One important new area examined in this project was the relationship between shame-proneness, guilt-proneness, and psychological functioning in victims of sexual offences. The project also discovered inconsistencies in past research which might be impacting on a full understanding of psychological functioning after sexual victimisation. In particular, the project explored the relationship between behavioural self-blame and psychological functioning. Some limitations of past research were identified and addressed, such as recruiting the majority of participants from the general community rather than from clinical or university sources, and recruiting both female *and male* victims. Further, by combining quantitative and qualitative methods, a complexity of the therapeutic processes that might not be easily or comprehensively captured by the psychological scales was identified.

Some of the main themes that arose throughout this research were the feelings of neglect and rejection that many victims of sexual offences feel. Simply being acknowledged appeared as a critical factor that should be identified as a serious cause for reflection within the clinical and justice systems. Overall denial of this can seriously hinder the fragile sense of control that victims are trying to restore. Clearly, some problems within the system are unchangeable (i.e., the presumption of innocence of accused people). However, the findings suggest that the majority of suggestions would not compromise defendants' rights and would not necessarily require legislation amendments (i.e., providing separate entrances and waiting rooms for victims attending court). Providing recommendations to improve the experience of victims in the current retributive justice

system is of great importance. However, victims' personal meanings of justice and their reasons for reporting or not reporting to the police also provide evidence for considering alternative processes that are more restorative in nature. Regardless of the process victims choose in their efforts to obtain a sense of justice, or whether they decide to access any official justice process at all, it is clear that clinical intervention has the potential to play an important role in the therapeutic process after sexual victimisation, given that dynamic factors played a substantially larger role in psychological functioning than static factors. The findings lead to suggestions that clinical efforts be made in the areas of perceived control (personal and interpersonal), rumination of why the offence occurred, optimism, shame-proneness, and nonproductive coping strategies for clients experiencing difficulties with depression, anxiety, posttraumatic stress, and self-esteem. However, the value of generic counselling goals including acknowledging and validating clients' feelings, and providing opportunities to empower clients, cannot be underestimated. It is very often these experiences that victims crave and describe as vital in their therapeutic journey.

This thesis has answered some old questions and taken some new steps. It also provides direction for further research. Critical areas to explore include developing effective clinical intervention strategies using the factors identified in this research as priority clinical areas, and developing scales that assess these priority clinical areas for use in clinical practice. Finally, few studies have examined male sexual victimisation, and since recruiting male victims of sexual offences has been challenging, developing effective strategies to recruit male victims is crucial.

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Appendix A

General study information sheet for potential participants

Sexual Assault / Sexual Abuse Research

I am a psychologist in the field of sexual assault/abuse and I am currently undertaking PhD research in Psychology at Edith Cowan University. My goal is to get a better understanding of the impact of sexual assault/abuse and subsequent adjustment in order to help those who are sexually assaulted/abused in the future. Part of this study focuses on looking for ways to improve the Justice System for those who choose to report sexual assault/abuse. To help me achieve these goals, I need participants, both male and female. If you are at least 16 years old now, and have experienced sexual assault/abuse as a child and/or as an adult, whether recently or many years ago, whether a single incident or ongoing abuse, you have much to contribute to this research.

Participating involves meeting with me and completing a set of questionnaires for about one hour. Participants may also decide to talk with me in a brief interview directly after completing the questionnaires if they would like. Participants may decline to answer certain questions and they may choose to withdraw from the study at any stage without any kind of penalty. This is a confidential survey. The information provided in this study will be used in my research project and may be used in a publication, though individual participants will *not* be identified. If you decide to participate in the study, we can arrange to meet at a time and location that is convenient for you.

Participating in this study means thinking about the assault/abuse and this may lead some people to feel distressed. Participants who are distressed about the assault/abuse are encouraged to contact the Sexual Assault Resource Centre (SARC) to speak with a counsellor. SARC has a 24hr crisis telephone line for people who have experienced sexual assault/abuse and are feeling distressed about these issues. The SARC crisis number is (08) 9340-1828 or country 1-800-199-888. Crisis Care is another 24hr crisis line, (08) 9325-1111, where people can speak to a counsellor about crisis matters of any kind.

This project has been approved by the Ethics Committee of Edith Cowan University. If you have any questions or concerns about this study or would like to participate, please contact me, Stacy Gall, at Edith Cowan University on (08) 9400-5529 or mobile 0419 933 637, anonymously if you wish. I hope to meet with as many people as possible before July 2002.
Thank-you for your time and I wish you well,

Stacy Gall
Psychologist
School of Psychology
Edith Cowan University
Joondalup WA 6027
[redacted]

Appendix B

Study information sheet sent by the DPP to victims of sexual offences on the researcher's behalf

(EDITH COWAN UNIVERSITY LETTERHEAD)

Research on Sexual Assault & The Justice System

My name is Stacy Gall, I am a counsellor in the field of sexual assault and sexual abuse. This letter has been sent to you by the Director of Public Prosecutions (DPP) Office on my behalf, I do not have your name or any other details. I am particularly interested in finding out how victims/survivors of sexual assault experience and deal with the legal process that may follow the incidents they were involved in, and how this process may influence their adjustment after the incident. This knowledge may be useful to advise the legislator and policy makers on changes in investigations and legal procedures. This knowledge may also be useful in advancing counselling in the sexual assault/abuse field. Unfortunately, our knowledge in this regard is limited because researchers in the field find it difficult to gain access to people who have experienced sexual assault.

I am currently doing PhD research at Edith Cowan University and my goal is to more fully explore this issue. In order to do this, I need participants for my study, people who have experienced sexual assault and who have been involved in the Justice System. The purpose of this letter is to ask you, as someone who has just had contact with the Justice System and whose knowledge and experiences are extremely valuable, to help me achieve this goal.

Participating in this study involves approximately 1 hour completing a set of questionnaires about your thoughts and feelings. Participants also have the option of participating in a brief discussion with me about their experiences in the Justice System. If you decide to participate in the study, we can arrange to meet at a location that is convenient for you. Please contact me if you are willing to participate in this research or if you would like to find out more about the project. If you call, you only need to tell me that you want to make inquiries regarding The Justice Study (you do not need to give your name).

Please be assured that your decision to participate or not, and any information provided in the study, will be confidential; I will not disclose any information to other people (unless I am obliged by law to do so). For those who agree to participate, they may decline to answer certain questions in the questionnaire or they may choose to withdraw from the study at any stage without any kind of penalty. I will not record the name of any participant and no member of the DPP staff will be informed about whether you contacted me or not. The information collected during the course of this study may be published in scientific journals, but no person will be identifiable.

This project has been approved by the Ethics Committee of Edith Cowan University. If you have any questions or concerns about this study, please contact me, Stacy Gall, at Edith Cowan University on (08) 9400-5529. Or if you would like to talk to a more independent person, you may contact my Supervisor, Associate Professor Alfred Allan, at Edith Cowan University on (08) 9400-5536.

Yours sincerely,

Stacy Gall
Registered Psychologist
School of Psychology, Edith Cowan University
Joondalup WA 6027 [redacted]

Appendix C

Recruitment advertisement

Sexual Assault/ Sexual Abuse Research

People who are over 16 years old now and who were sexually assaulted or sexually abused as children and/or as adults are urgently needed in a study at Edith Cowan University. The assault/abuse may have been recently or many years ago.

The experiences of people who have made a report to the Police are important in helping improve the Justice System. People who have *not* had any contact with the Police also have much to contribute in this research. Information from this research will contribute to helping others who are sexually assaulted/abused in the future.

Participants in this research spend about 1 hour completing a confidential questionnaire, and if they wish, a one-to-one discussion with the researcher. If you would like more information about participating in this study, please call psychologist Stacy Gall anonymously at the School of Psychology at Edith Cowan University on (08)9400-5529 or mobile [redacted] during or after office hours.

(pull tabs along the bottom with researcher's contact numbers)

Appendix D

Articles aimed at recruiting participants that appeared in local newspapers

Wanneroo Times Community Newspaper
"Assault Victims Sought"
January 1, 2001

Adult sexual assault victims are needed to take part in an anonymous research project that will investigate the psychological effects of dealing with the Justice System after their ordeal.

Stacy Gall, researcher at Edith Cowan University's School of Psychology at Joondalup, said the research would help guide victims of sexual assault through therapy or their own healing journeys.

"In my experience as a counsellor of sexual assault victims, I have found that some people find the justice system to be a therapeutic process while others seem to find the system extremely damaging," she said.

"My research aims to provide a clearer picture of the impact of the system on people who have experienced a sexual assault."

Ms Gall said past research suggested that a large proportion of sexual assault victims did not report the crime to the police.

She said it was surprising that little was known about the impact the system had on some people.

Sexual assault victims were encouraged to contact Ms Gall on 9400-5529 for more information.

Ms Gall said the anonymous questionnaire could be posted or participants could collect it.

West Australian Newspaper
"Justice 'can be costly'"
By Susan Hewitt
January 27, 2001

Victims of sexual assault need a clearer picture of how the legal system can affect their recovery, according to a counsellor doing research.

Stacy Gall, of Edith Cowan University, said reporting an assault to police was liberating for some people but horrendous for others.

When attackers went to trial, some victims felt being involved gave them control over the situation.

But others suffered from reliving the experience and said they felt pressured by family to follow the case through.

Ms Gall is researching what impact the justice system has on victims and how it can be turned into a positive.

She has been looking for volunteers to answer a questionnaire.

Wanneroo Times Community Newspaper
"Call draws positive response"
By Margaret Price
(photo included)

An appeal by researchers at Edith Cowan University, Joondalup, for sexual abuse victims to talk about their experiences has drawn a positive response.

PhD student and psychologist Stacy Gall has interviewed about 65 people, most of whom responded to an article in *Wanneroo Times Community* last year.

She said the research project had given them a chance to voice their opinions, beliefs, feelings and experiences in a safe and respectful atmosphere.

However to ensure the project fulfilled its full potential, she needed another 80 people aged 16 and over who had been sexually assault or abused at any time in their lives.

They would spend about an hour completing a questionnaire and, if they chose, sharing their stories.

Participants could refuse to answer specific questions and the interview could stop at any time.

Ms Gall said some participants had wanted to help other victims but did not know how.

"This research project has been one way people have fulfilled that wish to help others," she said.

"Participating in the research has also given several participants more insight into their own situations through answering the questionnaires."

Ms Gall said one participant had commented that although many people had suffered childhood sexual abuse, she had never met them.

"She described this as being somewhat lonely, going through everything as if she was the only persona who was dealing with it," Ms Gall said.

"Our society has been pushing the topic of sexual abuse under the carpet for so many years that is has silenced so many people about their experiences."

"This has prevented the natural development of supportive networks within communities."

Ms Gall said the woman suggested the research project was a good way of getting together people who felt the same way – several women now met for informal lunches every few months.

"This type of informal support group has worked well for some people but for others it is not something they wish to get involved in," Ms Gall said.

"It's about meeting the needs of individuals – not everything is going to work for everyone.

"People need to find what works best for them at various times in their lives."

Associate Professor Alfred Allan, who is overseeing the project, said it aimed to identify ways to make counselling and self-help more effective.

"This area has been under-researcher to date but is crucial in lessening the damaging impact that sexual assault and abuse often have on people's lives," he said.

Professor Allan, who is also a lawyer and forensic psychologist, said finding out about people's experiences of the justice system as victims and survivors was also important to identify what was working and what needed changing.

"The justice system has the potential to be a very therapeutic process despite the actual outcome of a conviction or acquittal," he said.

"Currently it seems the process is therapeutic for some people yet many others come away questioning whether they made the right decision in reporting the crime to the police."

To take part in the project, contact Stacy Gall anonymously on 9400-5529 or [redacted]

Wanneroo Times Community Newspaper
"Chance for sexually abuse to speak out"
By Margaret Price
(photo included)
June 26 2001

Researchers from Edith Cowan University's Joondalup campus want sexual abuse victims to talk about their experiences in the hope of improving the justice system.

Associate Professor Alfred Allan, a lawyer and forensic psychologist, and PhD student and psychologist Stacy Gall are gathering information of use to policy makers, therapists and victims.

They want to find out why victims do not report sexual assaults to police and how people who do report such incidents find their experience of the justice system.

Professor Allan said that for many years he had wanted to find ways to make the justice system help rather than hinder sexual assault victims adjust to their situation.

"Doing research in this area is very difficult because the only people who can provide the necessary information are those women and men who have been abused," he said.

"Many of them find it very difficult to share their experiences with researchers.

"This seems to be particularly true of those who did not report incidents. There is consequently still a lack of knowledge in this area, especially in WA.

"This makes it difficult to introduce some of the more subtle changes that are necessary to make the justice system more therapeutic for victims."

Professor Allan said that sexual abuse, despite all the attention it received, was relatively rare compared to some other forms of crime.

"However, for the victims of both genders it is real and an experience that can have grave consequences," he said.

"It also affects the victim's family and friends as well as society as a whole.

"All attempts should be made to prevent sexual abuse and to help victims adjust after being abused."

Professor Allan said medical and counselling support services had improved and most victims found police and lawyers dealing with their cases well trained, sympathetic, and caring.

The public had also been educated about myths surrounding sexual abuse.

Despite this, victims still found it difficult to report incidents to police and often those who did later chose not to proceed with a charge.

Professor Allan said reasons were complex and not yet well understood by researchers.

Despite many changes to investigative and court procedures and to the attitudes of those working in the justice system, laying a charge and proceeding in court made an already traumatic system even more difficult.

Past research indicated victims feared their claims would not be believed.

"However, some victims of sexual abuse who lay charges with police and proceed with the court case find the experience empowering and positive," Prof Allan said.

Volunteers for the research project will spend about an hour with Stacy Gall completing a confidential questionnaire and, if they choose, sharing their stories.

They can refuse to answer specific questions and the interview can stop at any time.

Call Stacy anonymously at ECU on 9400-5529.

Geraldton Guardian Newspaper
"Unreported sexual assaults subject of university study"
June 27 2001

Mid west residents who have been sexually assaulted but not reported the crime to police have been asked to take part in a new study.

Researchers at Edith Cowan University's School of Psychology are looking at why so few adults report sexual assaults to police in WA and continue with prosecution.

They are calling on 150 people who have been through such an ordeal to take part in the study.

The study follows the release of Australian Bureau of Statistics figures which show that one in three sexual assaults in WA are reported to police.

According to the WA Police Service figures, 3164 sexual assaults were reported to police from July 1, 1998 to June 30, 1999.

Taking into account ABS claims, more than 9500 sexual assaults could have occurred for the same period.

The researchers hope to gain an insight into peoples' reasons for not reporting sexual assault to the police and to develop an understanding of the way the justice system is experienced by people who do report sexual assault to police.

ECU psychologist Stacy Gall said the researchers already knew some reasons why sexual assaults were not reported to police and they had nothing to do with the justice system but were inherent to society.

"Some victims feel too ashamed to tell their family and friends that they have been sexually assaulted," she said.

"Some find it difficult to explain to themselves and others what prevents them from laying a charge and some victims' perceptions and experience of the justice system simply scare them away.

"Other sexual assault victims lay charges and start proceedings, but then decide to drop charges because they have bad experiences with the justice system or feel that it is too traumatic for them to continue the process.

"However, not all people find the justice system negative.

"Some people even feel that they gain a lot by laying a charge against their assailants.

"This may be because of their personality, circumstances or because they were fortunate to be dealt with by people in the justice system who addressed their needs well."

Ms Gall said taking part in such a study gave victims a voice without exposing themselves to any negativity.

Participating in the research entailed completing a confidential questionnaire that took around one hour to complete.

Participants could remain anonymous and infonnation would be held in the strictest confidence.

On completion of the study, the infonnation will be available to police makers in the justice system, therapists and people who have been sexually assaulted themselves.

Anyone who has been sexually assaulted after the age of 16 wanting to take part in the study can call Ms Gall on 9400-5529.

Stirling Times Community Newspaper
"Appeal to sex abuse victims"
September 11, 2001
Circulation: 46,296

Researchers from Edith Cowan University's Joondalup campus want sexual abuse victims to talk about their experiences in the hope of improving the justice system.

Associate Professor Alfred Allan, a lawyer and forensic psychologist, and PhD student and psychologist Stacy Gall are gathering information of use to policy makers, therapists and victims.

They want to find out why victims do not report sexual assaults to police and how people who do report such incidents find their experience of the justice system.

Professor Allan said that for many years he had wanted to find ways to make the justice system help rather than hinder sexual assault victims adjust to their situation.

"Doing research in this area is very difficult because the only people who can provide the necessary information are those women and men who have been abused," he said.

"Many of them find it very difficult to share their experiences with researchers.

"This seems to be particularly true of those who did not report incidents. There is consequently still a lack of knowledge in this area, especially in WA.

"This makes it difficult to introduce some of the more subtle changes that are necessary to make the justice system more therapeutic for victims."

Prof. Allan said both he and Ms Gall had worked with people who had been sexually abused and appreciated how difficult it was for them to talk to relative strangers.

"We realise it takes a lot of courage to participate in a project of this nature," he said.

"At the same time, we feel it is appropriate to approach them because a study of this nature is vitally important to society."

Prof Allan said that for victims of both genders, sexual abuse was an experience that could have grave consequences.

"It also affects the victim's family and friends as well as society as a whole.

"All attempts should be made to prevent sexual abuse and to help victims adjust after being abused."

Professor Allan said medical and counselling support services had improved and most victims found police and lawyers dealing with their cases well trained, sympathetic, and caring.

Despite this, victims still found it difficult to report incidents to police and often those who did later chose not to proceed with a charge.

Anyone who had been sexually assaulted or abused could call Ms Gall anonymously at ECU on 9400-5529.

Appendix E

The Questionnaire Package

Sexual Assault/Abuse Study Information

Thank-you for your interest in my study. I am currently doing PhD research in Psychology at Edith Cowan University. My goal is to get a better understanding of the impact of sexual assault/abuse in order to help those who are sexually assaulted/abused in the future. If you have experienced sexual assault/abuse (either recently or many years ago) your experiences are very valuable and I invite you to take part in this research if it is something you feel you would like to do. Whatever you decide, and for whatever reasons, your decision is respected. All information is confidential, nobody will know if you participate or not.

The questionnaires usually take about 1 hour to complete. Participants are free to withdraw from the study at any time without any kind of negative consequence. For those also willing to participate in a briefinterview (10-20 minutes) directly after completing the questionnaires, this would also be helpful in the research but participants are free to decide not to participate in an interview. This is a confidential survey. The information provided in this study will be used in my research project and may be used in a publication, though individual participants will *not* be identified.

Participating in this study means thinking about the assault/abuse and this may lead some people to feel distressed. Participants who are distressed about the assault/abuse are encouraged to contact the Sexual Assault Resource Centre (SARC) to speak with a counsellor. SARC has a 24hr crisis telephone line for people who have experienced sexual assault/abuse and are feeling distressed about these issues. The SARC crisis number is (08) 9340-1828 or country 1800-199-888. SARC also has in-person counselling regarding sexual assault/abuse issues if this is what you wish to do. Please see the attached SARC pamphlet for more details. Also, Crisis Care is another 24hr crisis line, (08) 9325-1111, where people can speak to a counsellor about crisis matters of any kind (not necessarily regarding sexual assault/abuse).

This project has been approved by the Ethics Committee of Edith Cowan University. Any questions or concerns can be directed to me, Stacy Gall, at Edith Cowan University, on (08) 9400-5529. If you have any concerns about the project and would like to talk to a more independent person, you may contact my Supervisor, Associate Professor Alfred Allan, at Edith Cowan University on (08) 9400-5536. If you call, you only need to tell us that you want to make inquiries regarding the *Sexual Assault Study* (you do not need to give your name).

If you would like to participate in this research, please make sure you ask any questions you have before starting to complete the following questionnaires. Completing the questionnaires and returning them to me implies consent to take part in this research. As such you should read this form carefully as it explains fully the intention of this project. Please feel free to keep this sheet.

Thank-you for your time and I wish you well,

Stacy Gall
Registered Psychologist
School of Psychology, Edith Cowan University
Tel: (08) 9400-5529

Anonymous Questionnaire

****Please do not put your name or any other identifying marks on any sections of the questionnaire.**

Please enter in your details in the boxes on the right.	⇩
What is your current age?	
What is your relationship status? Please write a number in the box. (1)=single, (2)=married, (3)=de facto, (4)=divorced, (5)=separated, (6)=widowed, (7)=serious relationship but not married or de facto	
Are you male or female? (1)=male (2)=female	

Please state how old you were when the abuse/assault occurred. **For abuse, an approximate age range may be appropriate.**

INSERT HERE:

HOSPITAL ANXIETY AND DEPRESSION SCALE (HADS)

Please write a number from 1 to 7 to indicate how much you agree with each statement.

1	2	3	4	5	6	7
/	/	/	/	/	/	/
Disagree			Neutral			Agree

___ 1. I can usually achieve what I want if I work hard for it.

___ 2. In my personal relationships, the other person usually has more control than I do.

___ 3. Once I make plans, I am almost certain to make them work.

___ 4. I have no trouble making and keeping friends.

___ 5. I prefer games involving some luck over games requiring pure skill.

___ 6. I'm not good at guiding the course of a conversation with several others.

___ 7. I can learn almost anything if I set my mind to it.

___ 8. I can usually develop a personal relationship with someone I find appealing.

___ 9. My major accomplishments are entirely due to my hard work and ability.

___ 10. I can usually steer a conversation toward the topics I want to talk about.

___ 11. I usually do not set goals because I have a hard time following through on them

___ 12. When I need assistance with something, I often find it difficult to get others to help.

___ 13. Bad luck has sometimes prevented me from achieving things.

___ 14. If there's someone I want to meet, I can usually arrange it.

___ 15. Almost anything is possible for me if I really want it.

___ 16. I often find it hard to get my point of view across to others.

___ 17. Most of what happens in my career is beyond my control.

___ 18. In attempting to smooth over a disagreement, I sometimes make it worse.

___ 19. I find it pointless to keep working on something that's too difficult for me.

___ 20. I find it easy to play an important part in most group situations.

Below is a list of statements dealing with your general feelings about yourself. Please circle the appropriate response.

SA= Strongly agree	**A**=Agree	**D**=Disagree	**SD**=Strongly disagree

1. I feel that I am a person of worth, at least on an equal basis with others. SA---A---D---SD
2. I feel that I have a number of good qualities. SA---A---D---SD
3. All in all, I am inclined to feel that I am a failure. SA---A---D---SD
4. I am able to do things as well as most other people. SA---A---D---SD
5. I feel I do not have much to be proud of. SA---A---D---SD
6. I take a positive attitude toward myself. SA---A---D---SD
7. On the whole, I am satisfied with myself. SA---A---D---SD
8. I wish I could have more respect for myself. SA---A---D---SD
9. I certainly feel useless at times. SA---A---D---SD
10. At times I think I am no good at all. SA---A---D---SD

Directions: **A number of statements that people have used to describe themselves are given below. Read each statement and circle the appropriate response to indicate how you feel *right now*. Do not spend too much time on any one statement but give the answer which seems to best describe your present feelings.**

Not at all	Somewhat	Moderately so	Very much so
1	2	3	4

1.	I am furious	1-----2-----3-----4
2.	I feel like banging on the table	1-----2-----3-----4
3.	I feel angry	1-----2-----3-----4
4.	I feel like kicking somebody	1-----2-----3-----4
5.	I feel like breaking things	1-----2-----3-----4
6.	I am mad (infuriated)	1-----2-----3-----4
7.	I feel irritated	1-----2-----3-----4
8.	I feel like hitting someone	1-----2-----3-----4
9.	I feel annoyed	1-----2-----3-----4
10.	I feel like swearing	1-----2-----3-----4

TOSCA

Below are situations that people are likely to encounter in day-to-day life, followed by several common reactions to those situations.

As you read each scenario, try to imagine yourself in that situation. Then indicate how likely you would be to react in each of the ways described. We ask you to rate all responses because people may feel or react more than one way to the same situation, or they may react different ways at different times.

For example:

A. You wake up early one Saturday morning. It is cold and rainy outside.

a) You would telephone a friend to catch up on news. [1]----2------3------4------5
not likely very likely

b) You would take the extra time to read the paper. 1------2------3------4----[5]
not likely very likely

c) You would feel disappointed it's raining. 1------2----[3]---4------5
not likely very likely

d) You would wonder why you woke up so early. 1------2------3----[4]--5
not likely very likely

In the above example, I've rated ALL of the answers by circling a number. I circled a "1" for answer (a) because I wouldn't want to wake up a friend very early on Saturday morning – so it's not at all likely that I would do that. I circled a "5" for answer (b) because I almost always read the paper if I have time in the morning (very likely). I circled a "3" for answer (c) because for me it's about half and half. Sometimes I would be disappointed about the rain and sometimes I wouldn't – it would depend on the what I had planned. And I circled a "4" for answer (d) because I would probably wonder why I had awakened so early.

Please do not skip any items – rate all responses.

1. You make plans to meet a friend for lunch. At 5 o'clock, you realize you stood him up.

a) You would think: "I'm inconsiderate." 1------2------3------4------5
not likely very likely

b) You would think: "Well, they'll understand." 1------2------3------4------5
not likely very likely

c) You would try to make it up to him as soon as possible. 1------2------3------4------5
not likely very likely

d) You would think: "My boss distracted me just before lunch." 1------2------3------4------5
not likely very likely

2. You break something at work and then hide it.

a) You would think: "This is making me anxious. I need to either fix it or get someone else to." 1------2------3------4------5
not likely very likely

b) You would think of quitting. 1------2------3------4------5
not likely very likely

c) You would think: "A lot of things aren't made very well these days." 1------2------3------4------5
not likely very likely

d) You would think: "It was only an accident." 1------2------3------4------5
not likely very likely

3. You are out with friends one evening, and you're feeling especially witty and attractive. Your best friend's spouse seems to particularly enjoy your company.

a) You would think: "I should have been aware of what my best friend is feeling." 1------2------3------4------5
not likely very likely

b) You would feel happy with your appearance and personality. 1------2------3------4------5
not likely very likely

c) You would feel pleased to have made such a good impression. 1------2------3------4------5
not likely very likely

d) You would think your best friend should pay attention to his/her spouse. 1------2------3------4------5
not likely very likely

e) You would probably avoid eye contact for a long time. 1------2------3------4------5
not likely very likely

4. At work, you wait until the last minute to plan a project, and it turns out badly.

a) You would feel incompetent. 1------2------3------4------5 not likely very likely

b) You would think: "There are never enough hours in the day." 1------2------3------4------5 not likely very likely

c) You would feel: "I deserve to be reprimanded." 1------2------3------4------5 not likely very likely

d) You would think: "What's done is done." 1------2------3------4------5 not likely very likely

5. You make a mistake at work and find out a co-worker is blamed for the error.

a) You would think the company did not like the co-worker. 1------2------3------4------5 not likely very likely

b) You would think: "Life is not fair." 1------2------3------4------5 not likely very likely

c) You would keep quiet and avoid the co-worker. 1------2------3------4------5 not likely very likely

d) You would feel unhappy and eager to correct the situation. 1------2------3------4------5 not likely very likely

6. For several days you put off making a difficult phone call. At the last minute you make the call and are able to manipulate the conversation so that all goes well.

a) You would think: "I guess I'm more persuasive than I thought. 1------2------3------4------5 not likely very likely

b) You would regret that you put it off. 1------2------3------4------5 not likely very likely

c) You would feel like a coward. 1------2------3------4------5 not likely very likely

d) You would think: "I did a good job." 1------2------3------4------5 not likely very likely

e) You would think you shouldn't have to make calls you feel pressured into. 1------2------3------4------5 not likely very likely

7. You make a commitment to diet, but when you pass the bakery you buy a dozen donuts.

a) Next meal, you would eat celery to make up for it. 1------2------3------4------5
not likely very likely

b) You would think: "They looked too good to pass by." 1------2------3------4------5
not likely very likely

c) You would feel disgusted with your lack of will power and self-control. 1------2------3------4------5
not likely very likely

d) You would think: "Once won't matter." 1------2------3------4------5
not likely very likely

8. While playing around, you throw a ball and it hits your friend in the face.

a) You would feel inadequate that you can't even throw a ball. 1------2------3------4------5
not likely very likely

b) You would think maybe your friend needs more practice at catching. 1------2------3------4------5
not likely very likely

c) You would think: "It was just an accident." 1------2------3------4------5
not likely very likely

d) You would apologize and make sure your friend feels better. 1------2------3------4------5
not likely very likely

9. You have recently moved away from your family, and everyone has been very helpful. A few times you needed to borrow money, but you paid it back as soon as you could.

a)You would feel immature. 1------2------3------4------5
not likely very likely

b) You would think: "I sure ran into some bad luck." 1------2------3------4------5
not likely very likely

c) You would return the favor as quickly as you could." 1------2------3------4------5
not likely very likely

d) You would think: "I am a trustworthy person." 1------2------3------4------5
not likely very likely

e) You would be proud that you repaid your debts. 1------2------3------4------5
not likely very likely

10. You are driving down the road, and you hit a small animal.

a) You would think the animal shouldn't have been on the road. 1------2------3------4------5 (not likely / very likely)

b) You would think: "I'm terrible." 1------2------3------4------5 (not likely / very likely)

c) You would feel: "Well, it was an accident." 1------2------3------4------5 (not likely / very likely)

d) You would probably think it over several times wondering if you could have avoided it. 1------2------3------4------5 (not likely / very likely)

11. You walk out of an exam thinking you did extremely well. Then you find out you did poorly.

a) You would think: "Well, it's just a test." 1------2------3------4------5 (not likely / very likely)

b) You would think: "The instructor doesn't like me." 1------2------3------4------5 (not likely / very likely)

c) You would think: "I should have studied harder." 1------2------3------4------5 (not likely / very likely)

d) You would feel stupid. 1------2------3------4------5 (not likely / very likely)

12. You and a group of co-workers worked very hard on a project. Your boss singles you out for a bonus because the project was such a success.

a)You would feel the boss is rather short-sighted. 1------2------3------4------5 (not likely / very likely)

b) You would feel alone and apart from your colleagues. 1------2------3------4------5 (not likely / very likely)

c) You would feel your hard work paid off. 1------2------3------4------5 (not likely / very likely)

d) You would feel competent and proud of yourself. 1------2------3------4------5 (not likely / very likely)

e) You would feel you should not accept it. 1------2------3------4------5 (not likely / very likely)

13. While out with a group of friends, you make fun of a friend who's not there.

a) You would think: "It was all in fun; it's harmless." 1------2------3------4------5
not likely very likely

b) You would feel small...like a rat." 1------2------3------4------5
not likely very likely

c) You would think that perhaps that friend should have been there to defend himself/herself. 1------2------3------4------5
not likely very likely

d) You would apologize and talk about that person's good points. 1------2------3------4------5
not likely very likely

14. You make a big mistake on an important project at work. People were depending on you, and your boss criticizes you.

a) You would think your boss should have been more about what was expected of you. 1------2------3------4------5
not likely very likely

b) You would feel like you wanted to hide. 1------2------3------4------5
not likely very likely

c) You would think: "I should have recognized the problem and done a better job." 1------2------3------4------5
not likely very likely

d) You would think: "Well, nobody's perfect." 1------2------3------4------5
not likely very likely

15. You volunteer to help with the local Special Olympics for handicapped children. It turns out to be frustrating and time-consuming work. You think seriously about quitting, but then you see how happy the kids are.

a) You would be feel selfish and you'd think you are basically lazy. 1------2------3------4------5
not likely very likely

b) You would feel you were forced into doing something you did not want to do. 1------2------3------4------5
not likely very likely

c) You would think: "I should be more concerned about people who are less fortunate." 1------2------3------4------5
not likely very likely

d) You would feel great that you had helped others. 1------2------3------4------5
not likely very likely

e) You would feel very satisfied with yourself.. 1------2------3------4------5
not likely very likely

INSERT HERE:

COPING SCALE FOR ADULTS (CSA), AND

TRAUMA SYMPTOM INVENTORY (TSI)

The next set of questions relate specifically to the sexual assault/abuse you experienced. If you experienced more than one sexual assault/abuse, feel free to specify this in the blank space on the right.

When did the sexual assault/abuse occur?	✓
(1) Within the last week	
(2) Between 1 week and 1 month ago	
(3) Between 1 month and 1 year ago	
(4) Between 1 year and 2 years ago	
(5) Between 2 to 5 years ago	
(6) Between 5 to 10 years ago	
(7) Between 10 to 20 years ago	
(8) More than 20 years ago	

What were you forced to engage in?	✓
Fondling	
Kissing	
Vaginal penetration with penis (intercourse)	
Vaginal penetration with digit (finger) or object	
Anal penetration	
Oral sex	
Other, please specify:	

What was your relationship to the perpetrator(s) at the time of the assault/abuse?	✓
(1) A stranger	
(2) We just met that day/night	
(3) An acquaintance	
(4) My friend	
(5) My partner	
(6) My ex-partner	
(7) Family member, please specify:	
(8) Other, please specify:	

How much do you feel that the following are to blame for the sexual assault/abuse? Please circle a number that corresponds to how you feel about each item. **The assault/abuse happened because...**	**Please circle a number.** **1=don't believe at all** **7= believe strongly**
... there is something wrong with the person/people who assaulted me	1-2-3-4-5-6-7
... there is something wrong with me	1-2-3-4-5-6-7
... I did something I shouldn't have	1-2-3-4-5-6-7
... of bad luck (i.e., being in the wrong place at the wrong time)	1-2-3-4-5-6-7
... of someone else (not the perpetrator/s)	1-2-3-4-5-6-7
... there is something wrong with the society we live in	1-2-3-4-5-6-7
... of other factors, please specify here:	1-2-3-4-5-6-7 orN/A

On the scale of 1 (never) to 7 (always), please circle how often you think about *why* you were sexually assaulted/abused.

(Never) 1-2-3-4-5-6-7 (Always)

On the scale of 1 (no control) to 7 (complete control), please circle how much control you feel you had in being able to prevent the sexual assault/abuse.

(No control) 1-2-3-4-5-6-7 (Complete control)

On the scale of 1 (no control) to 7 (complete control), please circle how much control you feel you have in being able to prevent *future* sexual assaults.

(No control) 1-2-3-4-5-6-7 (Complete control)

On the scale of 1 (never) to 7 (always), please circle *how often* you feel *angry* (in general, not necessarily about the assault/abuse).

(Never) 1-2-3-4-5-6-7 (Always)

Did you ever report the sexual assault/abuse to the Police?		✓
	Yes	
	No	

- **If NO,** you have now finished the questionnaire. Thank-you very much for participating in this study. Your information is valuable and will be put to good use.
- **If YES,** please continue.

On the scale of 1-7, please rate how strongly you feel the following reasons played a role in your decision to participate in the Justice System.	**Please circle a number.** **1= not strong** **7= very strong**
To obtain justice	1-2-3-4-5-6-7
To obtain revenge	1-2-3-4-5-6-7
To feel safe from the perpetrator(s)	1-2-3-4-5-6-7
To make others/ the community safer from the perpetrator(s)	1-2-3-4-5-6-7
To get the perpetrator(s) help/treatment	1-2-3-4-5-6-7
To put the perpetrator(s) in prison	1-2-3-4-5-6-7
To take the pressure off me – someone was pressuring/forcing me to report it to the police	1-2-3-4-5-6-7
To fulfill my duty to report it because it was a crime	1-2-3-4-5-6-7
If other, please specify here:	1-2-3-4-5-6-7 or N/A

On the scale of 1-7, please rate how much going through the Justice System process has satisfied your reasons above. **Participating in the Justice System satisfied my wish to.....**	**Please circle a number.** **1= not much** **7=very much**
..obtain justice	1-2-3-4-5-6-7
..obtain revenge	1-2-3-4-5-6-7
..feel safe from the perpetrator(s)	1-2-3-4-5-6-7
..make others/ the community safer from the perpetrator(s)	1-2-3-4-5-6-7
..get the perpetrator(s) help/treatment	1-2-3-4-5-6-7
..put the perpetrator(s) in prison	1-2-3-4-5-6-7
..take the pressure off me – someone was pressuring/forcing me to report it to the police	1-2-3-4-5-6-7
..fulfill my duty to report it because it was a crime	1-2-3-4-5-6-7
..(what you specified in the last question)	1-2-3-4-5-6-7 or N/A

This is the last question. I would like to know what stage your case is presently at in the Justice System. For example, you recently reported and haven't heard back from the Police, or the charges were dropped against the accused person, or the trial has finished. You have a choice of whether to write it in the space below or discuss it with me and I can write it down.

This is the end of the questionnaire package. Thank-you very much for participating in this study. Your information is valuable and will be put to good use.

Appendix F

Information about participants who were quoted in Chapters 7 and 8

Participant #	Age at time of participation	Gender	Sexual victimisation in childhood only, adulthood only or both	Contact With the Justice System?
1	41	F	Both	Yes
2	39	F	Adulthood only	Yes
4	38	F	Adulthood only	Yes
5	30	F	Adulthood only	Yes
6	20	F	Adulthood only	Yes
7	41	F	Both	Yes
8	53	F	Childhood only	Yes
9	40	F	Childhood only	No
11	30	F	Childhood only	Yes
12	32	F	Adulthood only	Yes
13	30	F	Childhood only	No
15	65	F	Childhood only	No
16	30	F	Adulthood only	Yes
17	46	M	Childhood only	No
18	47	F	Both	Yes
19	37	F	Childhood only	Yes
20	41	F	Childhood only	No
21	42	F	Both	Yes
23	25	F	Adulthood only	No
25	33	F	Childhood only	Yes
27	48	F	Both	No
29	30	F	Adulthood only	Yes
30	29	M	Childhood only	Yes
31	24	F	Adulthood only	No
32	30	M	Childhood only	Yes
33	51	F	Both	Yes
34	41	M	Childhood only	No
35	25	F	Childhood only	Yes
38	35	F	Both	No
39	57	F	Childhood only	Yes
40	42	F	Childhood only	No
41	30	F	Childhood only	Yes
42	36	F	Childhood only	No
43	42	F	Both	Yes
45	27	F	Adulthood only	Yes
46	43	M	Childhood only	Yes
49	40	F	Both	Yes
56	33	F	Both	Yes
62	18	F	Both	No
63	46	F	Childhood only	No
64	31	F	Childhood only	Yes

Participant #	Age at time of participation	Gender	Sexual victimisation in childhood only, adulthood only or both	Contact With the Justice System?
66	37	F	Both	Yes
67	35	F	Childhood only	No
72	21	F	Childhood only	No
77	51	F	Childhood only	Yes
81	34	F	Childhood only	Yes
85	44	F	Childhood only	No
86	19	F	Adulthood only	Yes
88	37	F	Both	No
98	43	F	Both	No
111	37	F	Adulthood only	Yes
114	56	F	Childhood only	Yes
117	17	F	Childhood only	No
121	42	F	Childhood only	No
127	27	F	Childhood only	No
130	20	F	Adulthood only	Yes