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# Revictimization and Recovery From Sexual Assault: Implications for Health Professionals

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Twenty-seven adult females' responses from an online qualitative questionnaire were analyzed to explore their views on being recovered from an experience of sexual assault, and identify aspects of their postassault health service encounters that facilitated or impeded their recovery process. Being recovered involved accepting the experience, being freed from negative states, regaining control and trust, and receiving help from and being believed by others. Participants predominantly reported negative experiences with health services. Factors perceived as impeding the recovery process include health professionals' inexperience in dealing with survivors of sexual assault, adhering to rape myths and stereotypes, and disrespectful or inconsiderate treatment of survivors. We argue that these postassault negative experiences revictimized survivors. Addressing these factors may reduce revictimization, facilitate recovery, and decrease assaulted women's long-term use of health services.

Keywords: abuse; violence; medical services; qualitative methods; thematic analysis; online research

In 2003, the British Crime Survey estimated 190,000 incidents of serious sexual assault, such as rape or other attempts at nonconsensual sexual activities, against women (Walby & Allen, 2004). Sexual assaults not only carry high risk of physical injury but the experience can also effect great psychological difficulties that prolong recovery (Davidson, Hughes, George, & Blazer, 1996; Department of Health, 2010; Gilmartin, 1994; Lovett, Regan, & Kelly, 2004), and some never recover (Home Office, 2010). Sexually assaulted women report more medical conditions and experience poorer health compared to women without such an experience (Golding, 1994; Resnick et al., 2000; Tønnesen, Lundh, & Heimer, 1999). Some researchers, therefore, speculate that postassault timely medical care can prevent long-term medical problems (Resnick et al., 2000). Postassault health care, however, could have negative consequences. In a study conducted by Campbell and colleagues (1999), females who were sexually assaulted by a perpetrator known to them and who had received few medical services but experienced subsequent secondary victimization from such services had elevated post-traumatic stress (PTS). The authors concluded that postassault negative experiences with medical services can have damaging effects and be predictive of PTS.

Sexual assault referral centres (SARCs) provide an integrated forensic, medical, support, and advocacy service. Lovett and colleagues (2004) carried out an extensive evaluation of SARCs and identified being believed, having a female (rather than male) examiner, having a sexual assault nurse examiner, follow-up support, and advocacy as factors representing good service. The intention of their study, however, was to evaluate SARC services; there was no investigation into how these factors relate to recovery from sexual assault. Other studies have

highlighted professionals' disbelieving responses to disclosures of sexual assault as a likely cause of revictimization (Campbell et al., 1999); however, positive and negative factors in relation to health services need not necessarily or automatically facilitate or impede recovery.

To date, most research on recovery from sexual assault has been conducted quantitatively by predefining "recovery" in terms of an absence of trauma symptoms and depression (Neville & Heppner, 1999; Valentiner, Foa, Riggs, & Gershuny, 1996) and by using various adjustment scales (Harvey, Orbuch, Chwalisz, & Garwood, 1991). Although valuable, this method of researching the effects of sexual violence, using "'objective' psychological tests" (Kelly, 1988, p. 159), has been criticized (Draucker et al., 2009; Kelly, 1988). Campbell and Wasco (2005; Wasco, 2003) suggest that although the emergence of post-traumatic stress disorder as a clinical diagnosis advanced sexual violence research, the concept may nonetheless not capture all relevant aspects of survivors' reactions to the aftermath of sexual assault. As such, quantitatively investigating recovery from sexual assault solely in terms of PTS may prevent an exploration of the full scope of what constitutes recovery.

Although qualitative studies have been conducted that examine women's experiences of abusive relationships and the consequences thereof (Sleutel, 1998), and factors that lead survivors to seek help (Symes, 2000), studies that explicitly investigate individuals' own perceptions of their recovery process and what recovery means for the individual are scarce (Draucker et al., 2009). This study aims to address this omission and extend the qualitative literature by exploring participants' own accounts of recovery from an experience of sexual assault, and to identify factors that they perceived as facilitating or impeding their recovery process.

## METHOD

### Recruitment and Participants

We recruited participants who had experienced sexual assault<sup>2</sup> and considered themselves as having "recovered" via British organizations that address sexual assault, for example, "Safeline," "The Roofie Foundation," and "End Violence Against Women."<sup>3</sup> Either we or an organization staff member posted the recruitment details on the organizations' website or forum and provided a link to an online qualitative questionnaire.<sup>4</sup> Such methods have been found to be ideally suited for researching sensitive topics because they ensure confidentiality and convenience for participants who can complete the questionnaire in their own time and in a familiar environment (such as one's home; DiLillo, DeGue, Kras, Di Loreto-Colgan, & Nash, 2006; Gosling, Vazire, Srivastava, & John, 2004; Reips, 2000). Participants were anonymous and received no remuneration.

Qualitative data sacrifice large samples in favor of more detailed analyses of phenomena and individuals' own experiential accounts and are arguably most appropriate for inductive in-depth research (Crouch & McKenzie, 2006; Myers, 2000). We initially aimed to recruit approximately 20 participants for our study. Our inclusion criteria were adult women (18 years or older), with a self-defined experience of sexual assault after the age of 13 years, and who considered themselves as recovered from the experience. Where the perpetrator had been a partner, to ensure all parties' safety, the relationship needed to be terminated to enable participation.

Thirty-six participants completed the questionnaire. One was excluded because the participant stated that she had not recovered; 6 were excluded because the assault began before the age of 13 years; and 1 was excluded because the information provided was too vague for analysis. In one situation, two responses were identified as being from the same

participant, and these responses were merged to form a single response. We therefore included 27 participants in our analysis. Twenty of them completed the questionnaire fully; the remaining 7 participants only completed the section on recovery, although 3 of them also noted that they had not received any postassault medical care.

The 27 women ranged between 18 and 62 years ( $M = 31.59$  years,  $SD = 10.81$ ). Age at first assault reported ranged from 13 to 34 years ( $M = 17.78$  years,  $SD = 6.16$ ), and years since last assault reported ranged from 0 to 27 years ( $M = 10.00$  years,  $SD = 8.13$ ). Because the questionnaire was open to anyone, no response rates are available.

There are two main ways in which the sample could exhibit volunteer bias. Certain kinds of individuals may have been more likely to participate in the study; for example, those who were particularly positive and, hence, more likely to deem themselves as having recovered from the assault. Alternatively, the sample could represent individuals who had a particularly difficult recovery process and wanted an opportunity to report their negative experiences to generate improvements. Despite these potential biases, a patient or clinical sample would not have been suitable because the aim of our study was to investigate the experiences of individuals who considered themselves recovered; a patient/clinical sample would most likely not have resolved their traumas. Taking into account the large number of women survivors of sexual assault who seek long-term and frequent medical care (e.g., Resnick et al., 2000), we believe our sample is useful for gaining information from those who have managed to “get out of” the cycle to help those who are still experiencing difficulties.

## Procedures

The online qualitative questionnaire was created using SelectSurvey.NET 2.8.3 via the University of Manchester’s Faculty of Medical and Human Sciences’ website. Participants were first provided with an information page and support contact details. Informed consent was given electronically before completing the questionnaire. All responses were anonymous and confidential and stored on an online, password protected account and later downloaded individually for analysis. Participant numbers were allocated according to order of submission of responses.

The full questionnaire investigated recovery from sexual assault with a focus on the medical, legal, and social aspects of the recovery process. In this article, we present the findings from the medical section only because these have implications for clinical practice within health services. The questionnaire began with a demographics section asking for current age, age at time of assault, and relationship to the perpetrator. For recovery, we asked about participants’ definition of recovery and how they believe this was best achieved. For the medical section, we asked participants about their encounters with health professionals, to describe their positive and negative experiences, how they perceived these in relation to their recovery process, and what they would have liked to be different. A final section allowed participants to provide additional information and comments and their feelings of having participated in the study. Each main question had several follow-up prompts that encouraged participants to elaborate on their experiences and their relevance to their recovery process. Participants were asked to provide as much information as possible but, to respect their privacy, they did not have to answer a question if they did not wish to do so. We sought to ask questions that would encourage detailed qualitative descriptions of participants’ positive and negative experiences and how these facilitated or impeded their recovery. Given the predominance of negative experiences reported, it is plausible to suspect that, perhaps, the wording of some questions (e.g., the final question, “Thinking about your medical encounters, what would you have liked to be different?”) may have introduced a bias in favor of the reporting of such experiences. The impact of this possible bias, however, is mitigated by responses that indicate

that the wording of these questions did not necessarily or automatically lead to accounts of negative experiences. Thus, where our participants had no negative experiences to report, they would state that, for example, “[i]t’s nice to see a survey being done focussing [sic] on the positive—and on recovery—rather than on the really negative experiences of abuse.”

### Analytic Technique

We used an essentialist, inductive thematic analysis approach, influenced by Braun and Clarke(2006), which involved reporting participants’ experiences and identifying patterns in the data. First, after reading and familiarizing ourselves with the data, the data corpus was searched to identify and inductively code keywords and phrases that were relevant to answering the research questions, and extracts for each code were collated. Next, using the list of all identified codes, we grouped those that were similar to create categories. Finally, we collated those categories that represented patterns to form themes. Themes, thus, reflect broader aspects of participants’ experiences that they perceived as relevant to their recovery process.

Two external coders coded responses from the medical section of a random subsample (20%) of the fully completed questionnaires. They were instructed to “Please highlight words and phrases which you believe answer these questions: (a) What is your definition of recovery/being recovered from sexual abuse? (b) What factors facilitated or impeded your recovery process?” They identified 106 out of the 130 codes identified by us. More importantly, only in one case did the external coders identify one code that we had not considered. After deliberation, we decided to include this code in our analysis. Since coding was inductive, the external coders did not receive any particular training in coding or on the topic; such training is believed to increase intercoder agreement (Holsti, 1969; Rubin, 2007; Woodward & Franzen, 1948). Because participants were anonymous, we were unable to consult them to verify our analysis.

For the full study (24 questions) across all 27 participants, we identified 682 codes of which approximately 95% (648) were included in the final analysis. Codes that were excluded from the analysis related to idiosyncratic statements. The analysis of participants’ accounts on being recovered yielded three themes. The analysis of participants’ experiences with health services resulted in a further three themes, all of which represent factors perceived by participants as impeding their recovery process.

TABLE 1. Number of Incidents Reported as Committed by Perpetrators Either Known, Unknown, or as Acquaintances Prior to the Assault

Type of perpetrator	n
Total number of incidents reported	41
Known perpetrator prior to first assault	20
Unknown perpetrator prior to first assault	14
Acquaintance perpetrator prior to first assault	7
Total number of ongoing incidents reported	15
Known perpetrator prior to first assault	14
Unknown perpetrator prior to first assault	1
Acquaintance perpetrator prior to first assault	0

Total number of one-off incidents reported	26
Known perpetrator	6
Unknown perpetrator	13
Acquaintance perpetrator	7

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## RESULTS

Participants wrote an average of 840 words (SD 5 580) and reported 41 incidents, of which 15 were ongoing incidents and 26 were one-off incidents. Table 1 shows the type of perpetrator for all reported incidents.

### Achieving “Recovery” From Sexual Assault

Participants generally believed recovery from an experience of sexual assault is possible but that, perhaps, the word itself may not be right because it implies a complete return to what once was. Despite feeling recovered, participants nonetheless felt different. Instead, they suggested that being recovered means “learning to live with the experience.” Participants reported that being recovered involved accepting the experience, being freed from negative states, regaining control and trust, and receiving help from and being believed by others.

*Accepting the Experience.* Our participants frequently alluded to the idea that “overcoming denial is the first step”; accepting what had happened, by acknowledging the experience, was a significant part of their definition of recovery: “I consider myself recovered as I am now able go on with life.” Acceptance, however, did not mean “surrendering” and the experience was not considered to define them; they were more than merely victims. Acceptance simply meant having processed issues related to the experience so it was no longer intruding on their daily lives and was “no longer the entire focus from the time [they] get up until [they] go to bed at night.” They were, thus, able to live without constantly thinking about the experience. Participants felt “healed.”

Participants frequently noted that recovery takes time and patience. Time was required to, first, realize what had happened and define it as a sexual assault: “I couldn’t even really admit to myself that it was rape until several months after it happened.” Thereafter, time was required to acknowledge the experience and accept it as a part of the self as “it just took time to heal.” Despite their harmful experiences, recovery meant participants could see ways out of a bad situation; rather than trying to change the past, the past was accepted and efforts were instead made to create a good future.

*Being Freed From Negative States, Regaining Control and Trust.* Participants expressed various kinds of negative emotional states, such as guilt and fear, and their definition of being recovered involved overcoming these and being able to “go through life without being constantly afraid.” Overcoming self-blame, and rather placing blame with the perpetrator, was vital to participants’ recovery process and was frequently mentioned: “I think that the most important aspect of recovery from sexual abuse is the realization, both intellectually and emotionally, that it was not my fault. That I deserve none of the blame.” Removing blame removed participants’ guilt so they could forgive and consequently stop punishing themselves for what happened.

For most participants, recovery also meant being free from the trauma symptoms associated with the experience and being able to “move on with [their] life without having anxiety

attacks, nightmares, flashbacks.” Many participants had experienced depression as a consequence of the assault and recovery also meant being free from depressive symptoms and living a life “not dominated by depression or post-traumatic stress disorder any more [sic].” Once freed, participants became more optimistic about life in general.

Participants’ definition of recovery involved regaining the autonomy that had been violated as a result of the sexual assault by “reclaiming [their] life and emotions” and regaining a “sense of (tentatively) being able to trust people in general.” Having experienced such a violation, participants expressed a general loss of trust and regaining a sense of control over their present and future lives, emotions, and bodies was important to feel recovered: “the rapes are no longer preventing me from living the life i [sic] choose to.” Regaining trust was also important to enable fulfilling sexual relationships. Participants also questioned “who can you trust when you cannot trust yourself to make wise and safe decisions” and thus expressed distrust toward themselves, particularly when the assault was committed by a partner.

Once participants had overcome the debilitating negative states, thoughts of the assault were no longer overpowering and they could feel in control of their lives again.

*Receiving Help From and Being Believed by Others.* Participants frequently emphasized the importance of “not being alone” throughout their responses; feeling lonely hindered recovery and thus the help of others was important:

So I wasn’t alone and this really helped me to recover quicker. That was a big obstacle in my recovery, because feeling very alone increased my depression. If no-one believes you, you will never come out of the mental cycle of blaming yourself, feeling alone and the depression.

Despite wanting control over their own lives, participants generally also wanted help from others although they were not always able to ask for it: “I would have liked someone to say, is someone doing something to you you don’t like? I could have answered yes but I couldn’t bring it up myself!” Help mainly came from professionals such as counsellors, friends and relatives, and other survivors with similar experiences. Voluntary organizations were also instrumental in some respondents’ recovery process: “Even when you do disclose, they [“normal counsellors”] don’t understand like rape crisis [sic] do. They just don’t have the experience or the know-how.”

Receiving support and help from others was validating to participants because it produced a sense of belief that removed feelings of guilt and blame and helped participants to accept their experiences. Participants strongly asserted that being believed by others was vital in facilitating recovery: “Just to be believed and supported was so instrumental in removing my guilt.” Once participants perceived they were believed, the guilt was gone and they were free and able to overcome other negative states.

These findings further support our argument that researching recovery from sexual assault solely via quantitative trauma scales is not sufficient. Although overcoming trauma symptoms is part of the process of recovering from sexual assault, it does not provide a complete explanation for recovery. For our participants, recovery also involved accepting the experience and regaining control and trust, and this process took time. Participants who reported having received medical care also reported, to a greater extent, the significance of help from and a believing response by others to their recovery process. Being believed and supported by other people was important because recovering alone was a difficult task. These findings extend previous research (Atkeson, Calhoun, Resick, & Ellis, 1982; Draucker et al., 2009; Lovett et al., 2004; Symes, 2000; Temkin, 1999; Ullman, 1999) by showing that factors such as belief and social support are not only positive responses to disclosures of sexual assault but are also perceived by survivors themselves as affecting the recovery process.

## Aspects of Health Services Perceived as Impeding the Recovery Process

Eleven of the 27 participants mentioned that they encountered health services (excluding counselling) at some point after their experience(s). Nine reported receiving no medical care, and five responses were left blank. Four participants reported having received medical care immediately after their experience(s), mainly as a result of having reported the experience to social authorities. Most reported having sought medical care later for other health issues related to their experiences, which is consistent with previous research (Resnick et al., 2000; Tønnesen et al., 1999). Participants were most likely to see a general practitioner (GP) and commonly approached health services for medical tests or for help with depression (n 5 5), PTS symptoms (n 5 3; two further participants reported “traumatic mode” and “confusion between grief and trauma”), and associated problems such as sleep difficulties and suicidal ideation. The responses, however, did not clarify whether these were actual clinical diagnoses, or just a colloquial use of the terms.

Participants predominantly reported negative postassault encounters with health services and how these impeded their recovery process; positive experiences were also reported although the negative accounts dominated the responses. We identified three themes describing factors that impeded their recovery processes: health professionals inexperience in dealing with survivors of sexual assault; health professionals’ adhering to rape myths and stereotypes; and disrespectful or inconsiderate treatment of survivors.

*Health Professionals’ Inexperience in Dealing With Survivors of Sexual Assault.* Despite sexual crimes being a widespread social problem (Walby & Allen, 2004), participants’ accounts conveyed a wish for health professionals to receive more training in dealing with women who have experienced sexual assault:

I think physicians need more training in dealing with victims, not just ER [Emergency Room] and gyn [sic] doctors but PCPs [Primary Care Physicians]. They say we don’t deal with this often but that is not true they just do not know they are dealing with the victims.

Another participant stated, “I’m glad this study is being done and I hope it helps people who deal with rape and sexual abuse survivors become better educated about the relevant issues and better equipped to provide compassionate assistance.” Participants reported that the apparent inexperience of health professionals impeded their recovery. In particular, participants criticized two aspects of this inexperience: failure to understand disclosures of assault and failure to act appropriately on disclosure. First, to articulate that one had been sexually assaulted was a difficult task, and became increasingly so as time passed. Participants generally wanted to disclose the assault, and be encouraged to do so, but instead they experienced that health professionals failed to inquire about and expose sexual assault. Participants complained that health professionals neither identified signs such as self-harm or being traumatized by an STD screening nor understood when participants sought help for other medical issues, or tried to disclose how these issues were related to the assault: “My attempts to hide it didn’t help either—but the encouragement to talk was not there either. Other medical problems always seemed to get in the way as well.”

Second, participants’ perception of inexperienced health professionals prevented them from feeling like victims. Participants sometimes wanted to feel like a victim because it made them feel as if they had “a right to tell and to ask for help.” Although “victim” was initially seen as labelling, and therefore replaced by the more empowering “survivor,” more recently the advantages of victim have been recognized and the word reclaimed (see Jones & Cook [2008]



and Kelly [1988] for discussions on terminology). Once disclosed, participants wanted health professionals to take a proactive and holistic approach that would involve recognizing various aspects of recovery and making referrals to receive help from other relevant sources rather than treating recovery purely in terms of overcoming acute PTS: “Just that there’s very little time to talk to a GP about such things and all the counselling I found was off my own back. The GP treated my depression but I’d like him to have been able to refer me somewhere.” Instead, respondents felt their experiences were brushed aside or trivialized on disclosure, which felt invalidating. Participants’ perceptions of health professionals’ inexperience in dealing with issues of sexual violence consequently resulted in participants having negative experiences with health services, which discouraged them from further disclosure, contact with health professionals, and uptake of treatments: “The GP’s attitude did not help my recovery process as it put me off from seeing the psychologist she referred me to . . . I was too upset and scared I would be treated in the same manner.”

Thus, as well as fearing the perpetrator and coping with a diminishing trust in people, the negative experiences with health services made participants wary of health professionals, which exacerbated their aforementioned distrust and fear. They became anxious of procedures such as smear tests but the fear stretched as far as including dental procedures. This fear sometimes resulted in participants avoiding seeking necessary medical help, which allowed irreversible physical damage to occur as a result of a violent assault. More commonly, however, participants reported psychological damage as a consequence of their negative medical encounters. On the whole, there was a reluctance to seek any kind of further treatment or service. As a result, participants’ recovery process was impeded by such a response.

*Health Professionals’ Adhering to Rape Myths and Stereotypes.* Despite decades of sexual trauma research, it appears rape myths and stereotypes (Kelly, Lovett, & Regan, 2005; Williams, 1984) are still present and participants reported this as impeding their recovery. Some participants reported that health professionals engaged in stereotyping and generalizing: “they should have treated me as what I was, a scared and traumatized 13-year-old, instead of how I think they perceived [sic] me—an unstable and possibly lying slut.” Conceptions regarding what constitutes a “real” sexually assaulted individual seemed prevalent and those who did not fit the “rape victim” stereotype were met with scepticism:

One doctor was difficult—she would not accept the level of distress I presented with, and seemed to think I was unrealistic and attention seeking. However, given the prevalence of BPD [Borderline Personality Disorder] among abuse survivors, I think she was overgeneralising rather than deliberately negative.

In terms of rape myths and stereotypes, participants mainly reported concerns of not being believed or of being blamed by health professionals. The fear of disbelief was a major worry for participants because it influenced if and how much they talked about the experience: “His disbelief in what I was trying to say was very hurtful and made me retreat into a shell . . . In later events the choice was made not to seek any help. There was a big fear of not being believed.” What respondents appreciated was for their disclosures of assault to be accepted and taken at face value. On the contrary, participants reported that they were either blamed or feared they would be blamed and judged by health professionals. They noted, for example, suspicions about what part in the assault the individual played, judging responses when perceiving an individual’s preassault behavior as questionable, or blaming for any subsequent events:

I was also told by a psychiatrist that I should have fought harder, yelled louder, etc. Because I was blamed by two doctors who are suppose [sic] to help me—I began to blame myself and question maybe they are right. I still have difficulty overcoming this blame.

When respondents felt that their conduct was questioned, they subsequently felt judged and blamed as if they deserved what happened to them. Given how central being freed from feelings of guilt was to participants' concept of being recovered, this impeded their recovery.

*Disrespectful or Inconsiderate Treatment of Survivors.* Disrespectful or inconsiderate treatment was another aspect of health services frequently referred to by participants as impeding their recovery: "This has been one of the more difficult aspects of my trauma to deal with, because I see no reason why they needed to treat me so disrespectfully." Disrespectful treatment can occur as a result of health professionals' inexperience in dealing with survivors of sexual assault, but these are nonetheless distinct features. Disrespectful treatment can occur among health professionals "experienced" in sexual violence issues and, likewise, inexperience in such cases does not automatically cause disrespectful or inconsiderate treatment of others. Furthermore, although adhering to rape myths and stereotypes may be examples of disrespectful or inconsiderate treatment, these are not the only ways of demonstrating such treatment.

Participants reported sometimes feeling overlooked and treated as a liability when they really wanted to be treated respectfully like a responsible adult. Moreover, despite wanting help, participants did not like being pressured: They wanted the right to make their own choices and to have their decisions respected. Even though participants often wanted to disclose or talk about the experience, they may not have always been ready to do so. For example, being coerced into reporting the assault, or having medical staff reporting without consent (which medical employees sometimes are willing to do; see, e.g., Åström & Scamioti, 2004), was perceived as a negative experience. Furthermore, although participants wanted to be offered medical services and treatments, they did not want to be forced into accepting these. They simply wanted to maintain their autonomy:

. . . threatened to have me committed, tied down and a rape exam forced . . . She called me crazy and incompetent [sic] for refusing to report the assault . . . eventually treated my injuries but offered no other support since I was refusing to go to the emergency room for a rape kit.

For respondents, respect was also an important aspect of medical procedures. Participants portrayed respectful treatment as sensitive and gentle care during medical examinations or evidence collection rather than "painful and humiliating"; respectful treatment removed their feelings of shame and blame. Most reports, however, illustrated disrespectful, inconsiderate, and inappropriate treatment, such as "the GP I spoke to was not friendly . . . and did not seem to listen to what I had said . . . asking inappropriate questions." Participants perceived a lack of consideration for their experiences: They felt that employees across different health-related professions did not recognize the sensitive nature of their work and were not being attentive to their own lack of awareness of people's past. Anyone presenting to them could have had prior experiences that still affect them in ways that become relevant to the (physical) work that needs to be undertaken. One participant reported how a midwife had pulled her legs apart, which "was very triggering," and made her birth experience a difficult one. Participants found this lack of consideration upsetting and expressed concerns about medical staff becoming "callous," which they perceived as something negative that impeded their recovery process.

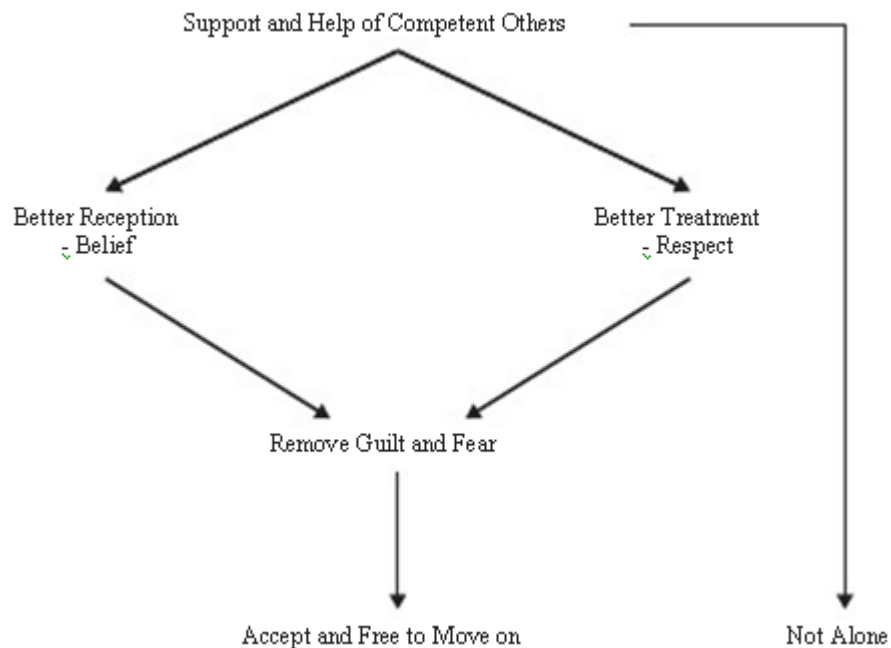
In summary, participants expressed difficulties with disclosing sexual assault and highlighted the negative effects of health professionals being inexperienced in dealing with such a disclosure. The subsequent disbelief, blaming, and disrespectful treatment of survivors of sexual assault by health professionals were perceived as impeding their recovery process. These findings extend previous research by highlighting belief and support as positive factors in relation to health services (Lovett et al., 2004; Temkin, 1999; Tønnesen et al., 1999) and by showing that these factors are an important part of the recovery process as perceived by individuals who have experienced sexual assault.

## DISCUSSION

This study explored 27 women's views on being recovered from an experience of sexual assault and aspects of health services that were perceived as facilitating or impeding the recovery process. Achieving recovery involved having accepted the experience, being freed from negative states and having regained control and trust, and being believed and receiving help from others. In terms of health services, participants overwhelmingly reported negative experiences. Participants perceived health professionals' inexperience in dealing with survivors of sexual assault, adhering to rape myths and stereotypes, and disrespectful or inconsiderate treatment as impeding their recovery. Figure 1 offers a substantive theory (Strauss & Corbin, 1998) of recovery from an experience of sexual assault based on participants' accounts. Our findings suggest that competent and experienced help from others will offer individuals better reception on disclosure, particularly in terms of belief and a more respectful and caring treatment. These factors can remove guilt and fear, which are major obstacles to recovery, and help individuals to accept their experiences, free them from the trauma, and enable them to move on with their lives. Support and help from others further contribute to individuals' not feeling alone, which was also of importance to respondents.

Unlike existing studies that tend to predefine recovery from sexual assault in terms of an absence of trauma symptoms and depression (Neville & Heppner, 1999; Valentiner et al., 1996), our qualitative study investigated recovery as defined by participants themselves. The results suggest that while being freed from trauma symptoms was included in participants' definition of being recovered, recovery entailed more than the absence of PTS; thus, solely researching recovery from sexual assault quantitatively in terms of, for example, PTS is not sufficient. Future studies should take concepts such as acceptance, control, and trust into account. Failure to address recovery from sexual assault beyond PTS may have negative implications for research as well as treatment (Wasco, 2003). Our qualitative study further identified factors that participants themselves explicitly reported as facilitating or impeding their recovery process. Identifying such factors is important, first, because faster recovery may prevent long-term psychological sequelae and other medical problems, and, concurrently, preventing long-term psychological sequelae and other medical problems may result in faster recovery. Second, we have already discussed the significance and implications of blame in the recovery process. Blame, together with other negative treatment, made respondents question themselves and their reactions to the assault, which in turn made them feel worse. Thus, in addition to dealing with the negative experience(s) of assault and the negative feelings this entailed, they also had to deal with the difficult experience of their encounters with health services. Accounts of revictimization have been prevalent in sexual violence research (Jansson, 2002), which has shown that it may lead to poorer health outcomes (Campbell et al., 1999). By identifying aspects of health services that participants themselves perceived as impeding their recovery process, this study highlights ways in which health services may revictimize individuals who have experienced sexual assault. These areas may serve as

starting points for the focus of attention and resources of health policies and training in efforts to address postsexual assault revictimization.



*Figure 1.* A substantive theory of recovery from an experience of sexual assault based on participants' accounts.

Participants perceived that the failure of health professionals to attend to or believe disclosures of sexual assault (whether intentional or not) prevented them from receiving necessary medical care and trivialized their experiences. It must be noted here that although participants wanted to have the right to feel like victims, this is not to say that they wanted to be revictimized. The former is a response to the perceived trivializing of their experiences: because participants had already been violated, they wanted access to the appropriate response and help that a “rightful victim” deserves. The latter is what they perceived instead: they were reviolated and, thus, revictimized as a result of inadequate and inappropriate responses.

Finally, disrespectful treatment also risks revictimizing individuals who have experienced sexual assault when such treatment violates survivors' autonomy or makes them feel like a liability. Despite previous research showing that medical staff believe that assaulted patients, in particular, would like to be received with respect and understanding (Åström & Scamioti, 2004), our study shows that our participants still sometimes received disrespectful health care. Perhaps respectful treatment is viewed as such an obvious matter that it is sometimes taken for granted and even overlooked. By qualitatively comparing service users' accounts with health professionals' reports, such discrepancies can be highlighted. The results thus serve as a useful reminder: simple respectful caring should not be forgotten or underestimated in a health service context.

Our study has some limitations. First, several participants reported anxiety disorders, such as depression. We do not know the extent to which negative encounters with health services derive from such disorders as opposed to the experience of assault, and future research might usefully be addressed to such questions. Second, this was a retrospective study and our findings are based on a small, self-selected, nonclinical sample. Our findings, however, can serve as the basis for developing coding schedules that future qualitative studies may use to assess our conclusions using larger sample sizes. Finally, there was no assessment of respondents' nationality. As sexual violence differs across cultures in various aspects, for

example, in terms of attitudes toward such violence (Williams, 1984), there may be cultural differences affecting the results. Future studies may investigate such potential differences.

To facilitate recovery from sexual assault, it is crucial that aspects of health services that risk revictimizing survivors are addressed, especially because postsexual assault forensic medical examinations are becoming increasingly significant in the legal process (Ansell & Stegeryd, 2008; Home Office, 2010). Training of health professionals may thus benefit from an engagement with the first-hand accounts of individuals who have experienced sexual assault and subsequent medical encounters. Conclusively, our findings have the potential to contribute to reducing revictimization of individuals after an experience of sexual assault. Reduced revictimization may, in turn, facilitate recovery from the trauma and decrease assaulted women's long-term use of health services.

## NOTES

1. We define sexual assault as any sexual act against a nonconsenting person; however, we did not want to impose our definition onto our participants, who were recruited based on a self-defined experience of sexual assault.

2. We acknowledge that a sample recruited from such sources may be biased in terms of how far recovery has come but it is viable to suppose that some who have achieved "recovery" remain in the online community and forums to assist others who are still experiencing difficulties.

3. Available from the corresponding author upon request.

4. Thus, if participants left an answer box blank, it was not possible to determine whether the participant simply did not wish to discuss the matter or whether they did not encounter that particular service. Only where participants explicitly stated not having received a service were such conclusions drawn.

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