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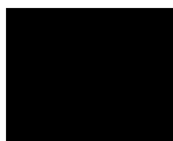
Student's signature: .................. Date: ........**14th July 2013**.................................

**Service responses to survivors of sexual violence:**

**Perspectives of National Health Service**

**and voluntary sector professionals on**

**inter-agency working with survivors**

**by**

**Sarah M Bishop**

A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Clinical Psychology

Universities of Coventry & Warwick,

Department of Clinical Psychology June 2013

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## Acknowledgements

This thesis would not have been possible without the input and support from the services who took part. I am grateful to supervisors Helen Liebling-Kalifani, Ian Hume and Tom Patterson for their help and support throughout the project.

I would like to acknowledge the administrative, academic and technical support of the Universities of Coventry and Warwick as well as Coventry and Warwickshire Partnership Trust for their financial and other support.

Last, but by no means least; I would like to thank my friends and family. In particular, I would like to express my gratitude to Steven, Claire, John, Cliff and Rob for their help and support with proof reading my papers.

## Declaration

I confirm that I am the principal investigator and author of this work. It has not been submitted for any other degree at another university and is all my own work. The thesis has been supervised by Dr Helen Liebling-Kalifani. All chapters of this thesis have been prepared for the *Psychology of Women Quarterly* (see Appendix G).

For the purposes of confidentiality, all names and identifiable information relevant to participants and services have been made anonymous.

**Summary**

The first chapter of this thesis critically reviews the existing literature on Restorative Justice (RJ) for crimes of sexual violence. It considers whether RJ has a contribution to make to the psychological wellbeing of survivors, provides clinicians working in the field of sexual violence with an insight into the potential strengths, weaknesses and gaps in the evidence base for RJ for sexual violence and makes recommendations for further research. The reviewed literature revealed some evidence that supports the use of RJ for crimes of sexual violence. In particular, survivors and professionals who had experienced RJ first-hand reported positive outcomes. However, due to the sensitive nature of sexual violence and the potential for re-traumatisation of the survivor, it was clear from the reviewed papers that RJ needed to be approached with caution. Indeed, where RJ was employed, extensive preparation was consistently identified as a key element to its success.

The aim of the second chapter is to gain an in-depth understanding of the perspectives of staff on inter-agency responses to survivors of sexual violence. Professionals from the National Health Service and voluntary sector were interviewed using focus group methodology. Data from focus groups was analysed using thematic analysis. The results highlighted that individual and organisational barriers impacted on services' ability to work together and respond effectively to survivors.

The final chapter provides a reflective account of the process of conducting a qualitative research study with professionals who work with survivors of sexual violence. Reflections focus on the impact of emotions on sexual violence research. The account considers both personal and epistemological factors relevant to the research process.

## Abbreviations

| | |
|---|---|
| DOH | Department of Health |
| CJS | Criminal Justice System |
| CSC | Canada Correctional Service |
| CVSAC | Centre for Victims of Sexual Assault in Copenhagen |
| GP | General Practice/Practitioner |
| GUM | Genito-Urinary Medicine |
| ISVA | Independent Sexual Violence Advisor |
| NHS | National Health Service |
| RESTORE | Responsibility and Equity for Sexual Transgressions Offering a Restorative Experience program |
| RJ | Restorative Justice |
| RJC | Restorative Justice Council |
| UK | United Kingdom |
| WHO | World Health Organisation |

# Chapter One

Restorative Justice for Sexual Violence:

A literature review

(Words: 9,169, exclusive of references)

Prepared for submission to

Psychology of Women's Quarterly

(See Appendix G)

**Abstract**

The present paper critically examines the existing literature on Restorative Justice (RJ) for crimes of sexual violence. It aims to consider whether RJ has a contribution to make to the psychological well-being of survivors and provide clinicians working in the field of sexual violence with an insight into the potential benefits, disadvantages and gaps in the evidence base, as well as make recommendations for further research.

The reviewed literature revealed some evidence that supports the use of RJ for crimes of sexual violence. In particular, survivors and professionals who had experienced RJ first-hand reported positive outcomes. However, due to the sensitive nature of sexual violence, it was clear from the reviewed papers that RJ needed to be approached with caution. Indeed, where RJ was employed, extensive preparation was consistently identified as a key element to its success.

## 1. Introduction

Large-scale studies on sexual violence are rare and definitions for inclusion vary. However, recognition of the importance of research in this area has increased over the last ten years. Sexual violence is defined by the World Health Organisation (WHO) as:

> Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting including but not limited to home and work.
>
> (WHO, 2010, p.11)

This definition includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object, however it is recognised by several authors that the legal definition of rape may vary in different countries (Heise and Garcia-Moreno, 2002; Jewkes, Sen and Garcia-Moreno, 2002).

Existing research suggests that there is a link between the experience of sexual violence and mental health problems in both women and men (WHO, 2010). However, sexual violence is much more likely to be perpetrated against women by men (Greenfield, 1997). The Department of Health (DOH) paper 'Women's Mental Health: Into the Mainstream' (2002), highlighted that women make up over half of the general population, play a significant role in the workforce and assume the major responsibility for home making and family care. Nevertheless, Greenfield (1997) argued that social isolation and poverty are much more common in women, as is the experience of child sexual abuse, domestic violence and sexual violence. The complex interactions of all these factors can have a huge impact on

women's mental health and have wider repercussions as a consequence of the variety of roles that women adopt in our diverse communities.

In 2008/9 12,129 rapes of women were reported to the police (Stern, 2010). However, Tjaden and Thoennes (2006) argued that most women who have experienced sexual violence do not disclose it and therefore it is likely that police reports are unreflective of the number of rapes actually committed. Although it is recognised that sexual violence is relatively common, conviction rates do not reflect this (Women's Aid, 2008). The need to increase the prosecution rate of offenders is consistently documented in the literature (Stern, 2010).

Payne (2009) argues that one reason why prosecution matters is because it legitimises the survivor's ordeal. Although criminal justice is important for survivors, trials can be stressful (Campbell, 2008). Nevertheless, Jordan (2001) stated that despite the distressing nature of the trial process, a key factor that motivated survivors to continue with legal proceedings was to protect others from suffering a similar ordeal. Furthermore, Stern (2010) reported that some survivors see the criminal justice process as a potential "therapeutic intervention" (p. 101) as it can enable survivors to speak out about their ordeals. Stern (2010) further highlighted that survivors feel going to court "proves…that they have recovered enough of themselves to face the court and go through the process" (p. 101). Thus, it appears that the criminal justice system (CJS) could play an important role in the survivor's psychological recovery. However, not only is sexual violence underreported, cases which are reported rarely obtain justice due to high attrition rates and lack of evidence (Seidman and Vickers, 2005).

**1.1 Responses to Sexual Violence**

The post-crime response to sexual violence is similar in many ways to the procedures for other crimes (Orth and Maecrker 2004). Nevertheless, there are important differences in the reactions to survivors by criminal justice personnel, friends, family and the community as a

whole. According to Campbell (2005; 2008), well-documented, widely held myths and attitudes towards sexual violence cast survivors as partially responsible for being assaulted and thus undeserving of the sympathy and justice response that would be given to a "legitimate" crime survivor. Self-blame is the single most important determinant of the severity of post-rape distress and the length of recovery (Koss and Figueredo, 2004). A poll for Amnesty International (2005) found that a third of people in the United Kingdom (UK) believed women who flirt are partially responsible for being raped and more than a quarter of people (thirty per cent) said that a woman was partially or totally responsible for being raped if she was drunk. Amnesty International (2005) asserted that these findings should act as a wake-up call to the government to urgently tackle the triple problem of the high incidence of sexual violence, a "sexist blame" culture and low conviction rates.

It has been documented that in the aftermath of sexual violence, survivors have multiple needs. According to Nancarrow (2006), survivors reported that satisfying their need for justice rested on the extent to which they:

1) Contribute to key decisions and remain informed about their case;
2) Receive response with minimal delay;
3) Tell their story without interruption by adversarial and sometimes hostile questioning;
4) Receive validation;
5) Shape a resolution that meets their material and emotional needs;
6) Feel safe.

Unfortunately however, research demonstrates that these needs are rarely met and secondary re-traumatisation of survivors by health and criminal justice personnel is widespread

(Campbell, 2008). Seidman and Vickers (2005) reported that despite improved training and criminal justice reforms over the last thirty years, survivors' satisfaction with service responses has not improved and sexual violence remains the "least reported, least indicated and least convicted" criminal act (p. 472). It is possible therefore that there should be a change in the way justice for survivors is administered. Restorative Justice (RJ) offers a potential alternative for survivors of sexual violence. RJ will be discussed in further detail in the following section.

### 1.2 Restorative Justice

RJ may offer an alternative option to traditional justice proceedings for survivors of sexual violence. The Restorative Justice Council (RJC) asserts that RJ processes:

> Bring those harmed by crime or conflict, and those responsible for the harm, into communication, with the aim of enabling those affected by a particular incident to play a part in repairing that harm and finding a positive way forward.
>
> (RJC, 2012).

In this way, RJ may allow survivors to tell perpetrators the impact of their crime and get answers to questions that they may have. It may also enable perpetrators to understand the impact of their behaviour on survivors and assist them to take responsibility for their actions; by holding the perpetrator to account, personally and directly (RJC, 2012).

### 1.3 Restorative Justice for Sexual Violence

The literature on RJ is large and includes a range of severe crimes such as homicide. In contrast, existing research on the use of RJ specifically for sexual violence is minimal. Sexual violence has some unique features in comparison to other crimes, including survivors

reporting intense shame and severe emotional distress, including anxiety and depression (Koss, 2010).

Empirical literature explaining symptom severity has established that even after taking into account personal history and social characteristics, sexual violence provokes more serious psychological distress than other crime (Breslau, Kessler, Chilcoat, Schultz, Davis and Andreski, 1998). Since most survivors know the perpetrator (Kelly, Lovett and Reagan, 2005) and the act is an intimate bodily invasion, sexual violence can be conceptualised as a more severe violation of personal trust than any other crime. It is clear therefore that RJ for sexual violence requires separate consideration and should not be likened to crimes of a different nature.

Koss and Achilles (2008) presented an overview of RJ for sexual violence focused on survivor needs and available restorative interventions. The authors' (Koss and Achillies, 2008) broadly documented various studies and programmes of RJ for sexual violence; however, there was a lack of critical evaluation of the studies that were included in the article. The present review aims to build on the work by Koss and Achilles (2008) to present an up-to-date, critical evaluation of the literature in this area.

## 2. Rationale for current review

The evidence to date demonstrates that survivors of sexual violence frequently do not obtain justice for the crimes committed against them. Research available suggests that RJ is effective across a range of crimes; however thorough evaluation of its use for crimes of a sexual nature is still in its infancy. The aims therefore of the present review are to:

1) Critically examine the existing literature on RJ for crimes of sexual violence;

2) Consider whether RJ has a contribution to make to the psychological wellbeing of survivors;

3) Provide clinicians working in the field of sexual violence with an insight into the potential strengths, weaknesses and gaps in the evidence base, as well as make recommendations for further research.

These aims will be achieved by reviewing survivor and advocate experiences and perceptions of RJ for sexual violence and identifying the strengths and weaknesses of RJ approaches to sexual violence for survivors.

## 3. Search strategies

Literature searches were carried out between September 2011 and August 2012. The databases Psychinfo, Web of Science, EMBASE, Westlaw and Lexisnexis were used to search for relevant articles from peer-reviewed journals. Search terms included 'sex*' (denoting anything beginning with 'sex') or 'rape' and 'restorative justice'.

The following inclusion criteria were used:

1) The review only included research from the last ten years in order to highlight recent and current findings in this area;
2) Only studies written in English were used;
3) Studies dealing with the subject of child sex offences were excluded.

The following exclusion criterion was used:

1) Studies focused only on sexual violence offenders' experiences of RJ were excluded.

Due to the limited research in the area of RJ applied to sexual violence, internet searches and anecdotal accounts were also included. Limitations of these information sources were considered. The database searches revealed 71 published articles. A secondary search was conducted by manually checking the reference lists on studies and book chapters found in the original search. In addition, internet searches found two individual survivor reports of RJ published online and one anecdotal account of RJ from a professional perspective. Due to the lack of peer reviewed studies regarding the use of RJ for sexual violence, these anecdotal articles were considered to make a valuable contribution as well as adding to the originality of the paper.

**Review Process**

Abstracts were read to determine relevance to the topic. Papers were considered relevant if they included the examination of RJ in relation to the subject of sexual violence. Papers which examined RJ in general but which had elements that focused on RJ for sexual violence were also included. With the exception of anecdotal articles, papers were considered to be of an acceptable standard if they were original and published in peer reviewed journals.

Use of this criteria resulted in seven qualitative studies; one quantitative study and three anecdotal reflections of RJ to be included in this review. Following examination of these papers, emergent concepts relevant to the appropriateness of RJ for sexual violence were noted and combined into themes. The review is structured into the following four themes:

1) What survivors and their advocates think about RJ;
2) RJ and legal systems;
3) RJ in the community and healthcare practices;
4) Anecdotal accounts.

Table 1 summarises the articles included in this literature review.

**4. Table 1: Research Articles Included in Review**

| Authors | Study Title | N | Study methods |
|---|---|---|---|
| Lewis-Herman, (2005). | Justice from the victim's perspective | 22 | Interviews with twenty-two survivors of violent crime. Eleven had been sexually abused in childhood, five had been sexually assaulted as adults or adolescents. Two were interviewed as the primary support person for a wife or sister who had been raped. |
| Proietti-Scifoni and Daly, (2011). | Gendered violence and RJ: The views of New Zealand opinion leaders | 19 | Interviews with nineteen participants on the appropriateness of restorative justice for partner, family, and sexual violence, and child sexual abuse. Ten participants were women, and nine were men. They were government officials (five), managers or directors of victim service organizations (seven), ministers (two), judicial or legal officials (two), and RJ facilitators (three). |
| Daly, (2005). | RJ and sexual assault: An | 400 | Archival study of 400 cases of youth sexual assault: |

| | | | |
|---|---|---|---|
| | archival study of court and conference cases | | investigating processes of case referral to court or RJ conference. |
| Curtis-Fawley & Daly, (2005). | Gendered violence and RJ: The views of survivor advocates | 15 | Interviews with representatives of fifteen survivor advocacy organisations in South Australia and Queensland. |
| Bletzer & Koss, (2012). | From parallel to intersecting narratives in cases of sexual assault | 16 | Discourse analysis of apology letters written to survivors from perpetrators. |
| Mika, Achilles, Halbert, Stutzman, Amstutus & Zehr, (2002). | The Listening Project | 120 | Focus groups with survivors, advocates and practitioners in the field of RJ. |
| Julich, Buttle, Cummins & Freeborn, (2010). | Project: An exploratory study of RJ and sexual violence | 10 | Focus groups with clinical team, interviews with survivors, perpetrators and support workers. |
| McGlynn, Westmarland & Godden, (2012). | "I just wanted him to hear": sexual violence and the possibilities of RJ | 3 | Interviews of participants of an RJ conference (survivor, advocates, and police). |

| | | | |
|---|---|---|---|
| Restorative Justice Council: Nodding, (2011). | The Meeting | 1 | Anecdotal account: Video recorded interview of Jo Nodding who experienced RJ in the UK. Published on Restorative Justice Council website. |
| Chung, (2011). | RJ in a case of serious sexual assault | 1 | Anecdotal account: Article written by Claire Chung who experienced RJ in the UK. Published on Correctional Service Canada website. |
| Madsen, (2004). | Mediation as a way of empowering women exposed to sexual coercion. | 1 | Anecdotal account: Counsellor from rape crisis centre in Denmark documents her experience of working with survivors who have used RJ approaches. |

N = Number of participants

# 5. Literature Review

## 5.1 What survivors and their advocates think of restorative justice

Lewis-Herman (2005) conducted interviews regarding perspectives of justice including RJ, with a convenience sample of twenty-two survivors of sexual violence in North America. Participants were recruited through attorneys, survivor witness advocates, or by word of mouth. Two participants were African-American, one was Asian-American, and two identified, in part, as Native American; the remaining participants were white American. Eleven of the participants had been sexually abused in childhood, five had been sexually assaulted as adolescents or adults and two participants were interviewed as the primary support person for a wife or sister who had been raped. Participants were asked open ended questions about what would constitute justice for them. The interviews were conducted long distance by telephone and email. Most interviews were tape-recorded; however, in two cases handwritten notes were taken.

Eleven participants in the Lewis-Herman (2005) study had filed a criminal complaint, resulting in four convictions and three prison sentences. Ten participants made informal attempts to reach some kind of resolution with offenders. Only one of these attempts resulted in a resolution that fully satisfied the participant. Three others sought to restore communication with an offender after a civil or criminal complaint was resolved. For all participants, only a minority were satisfied with the outcome.

Interestingly, the authors found that the vision of justice which emerged from the interviews differed substantially from conventional views around punishment of the perpetrator. Participants priority was safety; for themselves and others. Lewis-Herman (2005) highlighted that justice from the perspective of the participants combined retributive and restorative elements in the process of healing a damaged relationship; not between the

survivor and the offender, but between the survivor and their community. In this way, appropriate community responses, such as acknowledgement and condemnation of the crime appeared to be of more value to survivors compared with criminal justice proceedings. Therefore, restorative elements in the findings were most apparent in participants' focus on the harm to them and society, rather than on the abstract violation of the law.

Nevertheless, Lewis-Herman (2005) argued that because crimes involving sexual violence shame and stigmatise the survivor, a RJ model which relied on traditional community standards would be unsuccessful for the same reason that the CJS fails. She suggested that community standards for sexual violence were conflicted, ambiguous and demonstrated the influence of patriarchy; she stated that this is as true in highly westernised modern states as it is in non-westernised and indigenous communities. The findings therefore demonstrated complexities at both individual and community level of developing RJ programs that meet the needs of survivors. Findings further highlighted that recovery is a long process, which may be aided by personal de-shaming from appropriate community responses; which could be achieved via restorative processes.

Since the method of analysis used to examine the interviews was not described explicitly, it is difficult to tell whether the claims from the study are the hypotheses of the author or whether they are grounded in the findings of the paper. Furthermore, although the study utilises a relatively large sample size of twenty-two, only five of the participants experienced sexual violence as adults, meaning that the relevant sample size was small. The findings should therefore be interpreted with caution as it is not clear how representative of survivor preferences around justice they are. Finally, the study used a mixed method to interview participants combining email, telephone and hand written notes. A consistent approach to interviewing in which all interviews were audio recorded and transcribed verbatim would have improved the reliability of this study.

Proietti-Scifoni and Daly (2011) interviewed nineteen professionals who worked in survivor service organisations, government and RJ facilitation in New Zealand's major cities in order to investigate their perceptions of the appropriateness of RJ for gendered violence (including sexual violence). The sample used in the study was generated by contacting knowledgeable researchers, academics, and policy makers who were asked to nominate people with well-formed views on justice, who reflected a range of positions. This process produced fifty-eight names, with twenty-two that emerged repeatedly as exemplary opinion leaders in the area of RJ. The final sample was chosen to reflect professional diversity, geographical representation, and well-formed views. Particular attention was paid to representing both positive and negative positions towards RJ. Ten participants were women and nine were men; their cultural backgrounds included fifteen Pakeha, three Maori and one Tongan. All interviews were conducted face to face. Data obtained was analysed using content analysis.

From the data, the authors identified three groups; Supporters, Sceptics and Contingent Thinkers. Each group reported varying degrees of support for RJ; there was not uniform support or opposition. For example, Supporters identified limitations; Sceptics saw benefits and Contingent thinkers focused on contexts of practice and cultural relevance. All participants however were concerned with survivor safety and voluntariness in participating, and all noted the difficulty of power dynamics in relationships that were on-going between survivors and offenders. Participants views were complex; they reflected on the question of appropriateness pragmatically, contextually, and experientially rather than taking a principled stance based on 'for' or 'against' conceptions.

Supporters and Contingent Thinkers argued that sexual violence would be more suitable for RJ if the offence was a discrete event and did not take place within an on-going

abusive relationship. Participants across the three groups noted that some contexts were more favourable to RJ: in relationships of roughly equal status, when offenders had little or no previous offending and when the survivor and perpetrator wished to maintain a relationship. Each participant rated sexual violence as being appropriate for RJ in ‘some’ or ‘many’ cases.

The participants of the Proietti-Scifoni and Daly (2011) study were chosen to reflect a range of well-informed views; they were professionals with extensive experience in the field of RJ, meaning that they were well placed to comment on the contentious and sensitive area of sexual violence. The purposive sampling approach and small sample size does however limits the generalisability of this study. Nevertheless, the study contributes to the literature on RJ for sexual violence by its careful attention to how people reflect on the question of appropriateness, and whether their views varied by the type of gendered violence. It also adds support to the argument that although some types of sexual violence may not be appropriate for RJ (e.g. within the context of an abusive relationship) others may be (e.g. discrete offenses).

**5.2 Restorative Justice and the Legal System**

Daly (2005) presented the first quantitative study on RJ in comparison to traditional criminal justice court proceedings for youth sexual offences. The investigation was based on the comparison of the process and outcomes of 385 cases of sexual violence in Australia. Analysis of the data demonstrated that fifty-nine per cent of cases were referred to criminal court and thirty-one per cent were referred for RJ style conferencing. The remaining ten per cent of cases received formal cautions.

Daly (2005) found that for those, whose cases were finalised in court, perpetrators were more likely to have offended before; they lived in more disadvantaged areas, more often sought legal advice, and were less likely characterised by the police as being cooperative or

remorseful. Intra-familial offences were more likely to be referred for an RJ conference. Of the conferences, ninety-four per cent were finalised by an admission to a sexual offence.

Of the 226 cases that went to court, Daly (2005) found that only 115 were convicted of committing a sexual offence, eight were convicted of committing a non-sexual offence, 100 were dismissed or withdrawn and three cases were acquitted. In addition to high rates of attrition, court cases took longer to finalise and shifted jurisdiction more frequently compared with conference cases. The average number of times a court date was set was six and ranged from one to twenty-nine hearings. It can be seen therefore that court cases were associated with less admissions to an offence and a long, complicated process that regularly did not end in a conviction.

Daly's (2005) design focused on documenting the series of decisions taken in the legal process. The research highlighted that RJ conference cases provided more admissions of guilt from offenders compared with court cases. As is well documented, an admission of guilt is important to survivors and may contribute to their psychological recovery (e.g. Payne, 2009). The study also documented the increased length of time associated with court cases as opposed to conference cases; it was reported that it took over twice as long to finalise court cases than conference cases. The increased length of time required for court cases is likely to be associated with increased levels of distress for the survivor (see Campbell, 2008).

Unfortunately, Daly's (2005) study is limited to information contained in legal documents. In this way, it could not explore what was said in the courtroom or conference, or interview participants about their experiences. It did, however, take a wider view of how the established CJS responded to sexual assault by identifying factors associated with referral to court or RJ conference. Importantly, it also highlighted some of the benefits of RJ.

Curtis-Fawley and Daly (2005) conducted semi-structured interviews with participants from fifteen survivor advocacy organisations in South Australia and Queensland.

Each participant was experienced in working with survivors of sexual violence in the legal system. All but three study participants were women, nine were coordinators or directors of the organisation and the remainder were service providers. Most had considerable experience of working in the field; on average ten years.

Participants were described as speaking with exasperation on the deficiencies of the CJS, observing that even after decades of legal reform; much work still remained to be done. Participant concerns were that survivors were systematically re-traumatised by their experiences within the CJS. Sexual violence was perceived as underreported. Furthermore, when cases did proceed to court the focus was perceived to shift from the offence to the survivor's credibility and behaviour. Curtis-Fawley and Daly (2005) used the following extracts to illustrate the advocate's views:

> "I get called out and see these women who have been recently raped, and I think to myself, if I were in their position, knowing what I know, I wouldn't take it to court, I wouldn't pursue it."
> "The way the system is structured so women are not believed...The onus is upon them to prove that an assault took place...That's degrading and humiliating. So (is) the act (of sexual violence), and the court process further perpetuates that."
>
> (Curtis-Fawley & Daly, pp. 615-616)

Curtis-Fawley and Daly (2005) found that despite the widespread view that the CJS routinely harms survivors, most participants believed the CJS remained the best service for dealing with sexual violence. It is interesting to note, participants' reports of persistent investment in legal systems, despite their contradictory reports of CJS failure. The authors suggested that

this puts sexual violence advocates in the flawed position of continuing to defend and support a system that they know fails most survivors.

Evident in the interviews was a lack of clarity over what constituted RJ. Some participants were also concerned that the government's interest in RJ was driven by a need to reduce the costs of administering justice. Several expressed a positive understanding of RJ but felt that its scope should be restricted to adolescent offending. Findings highlighted that those expressing the greatest opposition to RJ were also those who lacked knowledge about what it was. Exposure to RJ was reported to reassure participants that it had potential for survivors. One of the most frequently mentioned benefits was that RJ provided a clear alternative to CJS and enabled survivors to have a voice.

However, eight of the fifteen participants in Curtis-Fawley and Daly's (2005) study believed that survivors could be re-traumatised by RJ practices, particularly if it involved a face-to-face meeting with the offender. The authors countered this argument by noting that traditional court processes also created similar risks for survivors. Those who had worked in the field the longest were more likely to hold positive views of RJ, appeared more disillusioned with the traditional CJS response, less optimistic that it could be sufficiently reformed and more receptive to expanding the options for survivors. Overall, of the fifteen advocates, five were generally positive toward RJ; seven were cautiously positive and three were generally negative, seeing the negative consequences as outweighing any benefits. To summarise, although mixed views were generated by this study, Curtis-Fawley and Daly (2005) demonstrated that most participants were open to the use of RJ for sexual violence and were able to conceptualise its potential benefits.

The study used professionals from a variety of roles who were well experienced in the field of justice for sexual violence, this therefore adds to the richness and triangulation of the data. Participants were however based only in South Australia and Queensland; therefore the

ability of the findings to generalise to other communities may be limited. The study would have benefited from using a larger sample size and the inclusion of survivor perspectives. Importantly, the article failed to describe explicitly how the interview data was analysed and so appeared to contain a purely descriptive presentation of the data obtained. This could be improved by further analysis of the interviews, using a more rigorous scientific methodology.

### 5.3 Restorative Justice for Sexual Violence in Community and Health Care Practices

Bletzer and Koss (2012) evaluated a RJ program in south-western United States through discourse analysis of apology letters prepared by offenders who had successfully completed an RJ intervention programme (Responsibility and Equity for Sexual Transgressions Offering a Restorative Experience programme, RESTORE) and letters written by survivors.

In the analysis, Bletzer and Koss (2012) presented an interpretive assessment of the expression of empathy that appeared in letters written by sixteen sexual violence offenders across the course of the programme. Each offender who completed the one-year programme appeared to have accepted responsibility in a manner markedly different from initial letters prepared before enrolment. Pre-enrolment letters characteristically reflected doubt of responsibility for the sexual violence, denial of harm caused to the survivor and absence of a need to make amends. Exit letters written at the end of the programme demonstrated notable expressions of empathy and significant shifts in attitudes, for example acknowledgement of harm caused to the survivor. In each closing letter all but one offender included positive remarks about the restorative programme and commented on the participatory benefits.

In the cases presented by Bletzer and Koss (2012), the type of sexual violence was associated with the intensity of remorse displayed by the offender. Empathetic concern and perspective taking were most evident in cases of sexual assault and rape. In contrast, perpetrators of indecent exposure personalised reasons for being 'sorry' such as

embarrassment to their family or personal stress, and often failed to make links to the consequences of their actions to the survivor.

Although Bletzer and Koss' (2012) analysis is limited by the small sample size, a strength of the study is that it included a series of reports that demonstrated parallel viewpoints from an offender and survivor which later intersected by the offenders apology in the exit letter. The study also included a range of sexual assaults. The findings on the association of severity of sexual assault and level of empathetic concern and perspective taking suggest that RJ may be more suited to particular types of sexual violence. A larger sample size would have increased the reliability of these interesting findings. In addition, since research on RJ has suggested that remorse is important for survivors (RJC, 2012), data on the actual impact of the apology letter's progression and the survivor's recovery may have been interesting to note.

Mika, Achilles, Halbert, Stutzman, Amstutuz and Zehr (2002) conducted the "Listening Project" with 120 professionals active in the survivor community field and the field of RJ. Participants included advocates, practitioners and survivors from seven states in America including, Vermont, Ohio, Washington, Texas, Missouri, Wisconsin and Florida. The authors aimed to propose an action plan to create more responsive RJ programs and beneficial outcomes for survivors. The project was designed to confront what the authors termed the "significant deficiencies" (p. 3) of RJ practice pertaining to survivor participation, their advocates and the survivor services generally. Mika et al., (2002) sought to achieve this through amplifying the voices of survivors, survivor advocates and survivor services through focus groups and structured dialogues between the various parties. Although RJ was considered in general, the presented findings demonstrated some consideration by participants of RJ for sexual violence specifically. The following quotation is taken from the report by Mika et al. (2002):

> “When you are talking about restorative justice, you are talking about restoring justice to a community that for the most part...already thinks they (survivors of sexual violence) are making it up. If you are talking about going back to community standards, quite honestly community standards around rape are lousy, and the criminal justice process is not much better.”
>
> (Mika et al., 2002, p. 16)

The extract above demonstrates participant concerns that RJ would be inappropriate in cases of sexual violence due to poor community responses to such crimes. It also however alludes to similar concerns regarding the CJS. The authors’ emphasised the difficulty in applying RJ to sexual violence, but acknowledged that their findings should not suggest finality to the discussion, deliberation and debate around the use of RJ. Indeed, although the study benefited from using a large sample size, it considered RJ in a general light rather than focusing on the issue of sexual violence specifically; it therefore cannot be used as conclusive evidence that sexual violence is inappropriate for RJ.

The analysis presented by Mika et al., (2002) is based on a synthesis of a broad representation of study participants, and is presented in summary format with no description of how the analysis was performed. A detailed exposition of the data is unfortunately absent from the report which makes it difficult to comment on the quality of the conclusions made by the authors. However, the concerns raised by participants about community responses to sexual violence are in line with much of the existing feminist literature (see Hopkins and Koss, 2005).

Julich, Buttle, Cummins and Freeborn (2010) conducted an exploratory study of a restorative programme for sexual offences based in North America. The research aimed to elicit participant’s views and expectations of the RJ process. Two focus groups consisting of

an RJ facilitator, a survivor specialist, an offender specialist, and a clinical supervisor were carried out. Individual interviews were conducted with three survivors, one perpetrator, one survivor specialist and one perpetrator specialist. All interviews were recorded and transcribed verbatim. Data was analysed used descriptive thematic analysis.

Findings by Julich et al. (2010) highlighted that survivors and perpetrators may enter the RJ process with different agendas; however, this was not necessarily detrimental. The authors found that by experiencing the RJ process, offenders could develop important insights that might impact on the future behaviour patterns of perpetrators. They pointed out however, that if the expectations of the survivor and perpetrator differed significantly there was a risk of re-traumatisation for the survivor. Consequently, it was highlighted that preparation was essential to reduce the gap between survivor and perpetrator goals. Preparation was in the form of therapeutic intervention for both the survivor and perpetrator.

Julich et al. (2010) reported that the project was found to have elicited a high satisfaction rate from both survivors and perpetrators, although it was not clear from their study how this was quantified. The kind of benefits for survivors included restoration of family of social networks, changes in attitudes, the development of new insights, the progression along a journey of recovery, the strength to speak about the incident and a more positive self-image:

> "Being in such a small place I have just kept quiet...but now it's out…it's given me...the strength...to say that I won't be quiet. The fact that the abuse was talked about and not kind of under the carpet and that it wasn't seen as my problem that it was seen as going back to the actions of the offender I felt like I had justice. "
>
> (Julich et al., 2010; p. 57)

The above extract highlights that a sense of justice was achieved through enabling the survivor to have the opportunity to speak about her experience; she was heard and the perpetrator was held accountable.

The study by Julich et al. (2010) included the cross-examination of a range of participants including professionals, perpetrators and survivors. This multi-method, qualitative approach adds to the richness of the data obtained by supplementing data sources with one another. The study is however limited by the relatively small sample size. The perspectives obtained are consequently limited to a certain extent, therefore findings cannot be generalised to all survivors and perpetrators of sexual violence who have experienced RJ. Additionally, the sample was not random but purposive, as not all those who took part in the programme wanted to be interviewed. The authors reported that it appeared as though those who declined wanted to move past the event and not revisit it; this could be a factor which is common to other research in this sensitive area.

McGlynn, Westmarland and Godden (2012) focused in greater depth on a UK based RJ practice, and investigated the experiences and expectations of four participants involved in a RJ conference, utilising a case study approach. Their case study addressed historic child rape and other forms of sexual abuse, which were entered for a RJ conference by the survivor as an adult. The male perpetrator was a family member. The experiences and expectations of the conference participants were investigated in order to explore the conference process, its outcomes and to make recommendations for other survivors. The participants of the conference were the survivor ("Lucy"), her rape crisis counsellor, the conference facilitator and the senior police officer involved in the case. The perpetrator was invited but did not wish to participate in the study. Consequently, the full picture of the conference is

unfortunately incomplete. However, some insights into his participation and experience were gained through data provided by the other participants.

McGlynn et al. (2012) stated that Lucy had reported the rape and sexual abuse to the police, who issued a caution to the perpetrator which Lucy learned of through a third party. It is reported that this experience left Lucy feeling “completely discounted” and McGlynn et al. (2012) highlighted that Lucy wanted to “confront” the perpetrator, stating: "I just wanted him to hear me" (p. 2). The rape crisis counsellor who was interviewed placed emphasis on preparing Lucy for the worst and best case scenarios; power dynamics and potential feelings which may be provoked during the conference were also cited by the rape crisis counsellor as being important to consider in the preparation for conference. Interestingly, the senior police officer who was interviewed by McGlynn et al., (2012) reported that survivors of sexual violence should be given the option of RJ and that not doing so was “patronising” as it implied that survivors were unable to “make a rational choice” (p. 3).

During the conference the perpetrator acknowledged responsibility for the offence and explained his actions. McGlynn et al. (2012) reported that Lucy described the conference as:

> “a big turning point...instead of having this whole episode of my life that I couldn't do anything with, I could stop hating myself and put the blame where it should be”
>
> (McGlyn et al., p. 3).

Lucy acknowledged however that the conference left her “drained” and “dangerously unhinged” yet “enabled me to resolve a lot of conflict” (p. 3). It appeared therefore that psychological support could have had a vital role to play during restorative processes.

McGlynn et al. (2012) concluded that there needed to be different ways of securing justice for survivors of sexual violence. They asserted that RJ is one possibility to be debated

as it may have a role to play in meeting some of the needs of survivors by giving them a voice, granting a measure of control, honouring their experience and treating them seriously such that survivors gain some measure of justice. Additionally, they recognised the challenges of offering RJ in cases of sexual violence as these cases required greater scrutiny, preparation, risk assessment and therefore more time and resources.

The study by McGlynn et al., (2012) is limited as it is focused on only one case; however, case-study methodology provided an opportunity to understand detailed accounts from participants and the benefits for the survivor are clear and well-documented. The survivor's account also gives an important insight into the potential need for psychological support during the process. The involvement of different professionals in the design of the study added to the triangulation of the data. In-depth data on the nature and process of an RJ conference which deals with sexual violence is extremely rare and so the study provides a valuable contribution to the literature.

## 6. Anecdotal Accounts

Individual accounts of RJ from the perspective of survivors and their advocates are rare, moreover as the present review has demonstrated, there are few empirical studies investigating this. For this reason, internet search engines (Google, BING and Yahoo) were used to find anecdotal accounts of RJ for sexual violence. Three anecdotal articles were found which will be reviewed in this section.

The RJC website has published one case in which RJ has been used for sexual violence. This is the case of Jo Nodding (2011), who was the first woman in the UK to speak publicly about her experience of RJ following rape. Nodding (2011) took part in a film recording entitled "The Meeting" (RJC, 2011) in which she talked about her experience of RJ. The quotations used in the section that follows were taken from the video recording.

During the interview, Nodding (2011) reported that since an admission of guilt from an offender means that the survivor does not have to give a statement in court, she was left feeling frustrated and unheard:

> "But I wanted to go to court, because I thought that was my only opportunity to face him and I wanted to face him. I wanted to show him that I could face him".
>
> (Nodding, 2011).

The above quotation exemplifies Nodding's (2011) certainty that she wanted the chance to confront the perpetrator. She further described the impact on her of the Judge's final comments in court:

> "(The judge) finished the court case by telling (the perpetrator) that he had ruined my life and I didn't want (the perpetrator) to go through life thinking that because I didn't want him to think that he had that power and control over me."
>
> (Nodding, 2011).

Nodding (2011) described how she had been frequently informed that the perpetrator was engaged in survivor empathy work; she appeared exasperated in the interview as she asked:

> "But how could anybody tell him how I felt that day? How he made me feel? How he made my family feel? Apart from me. Nobody knows what it's like to be raped, unless they have been raped."
>
> (Nodding, 2011).

Nodding’s (2011) frustration and disillusionment with the court process compelled her to participate in an RJ conference with her perpetrator. Nodding (2011) described her experience during the RJ conference as a “change of roles”. She reported that the perpetrator was “in tears” as she explained how she thought he was going to kill her:

> “I don't think that ever crossed his mind and it had a huge impact on him. One thing he did say was sorry and when I say sorry, I mean a proper sorry. I promise you that I won't do this again. I never went for a sorry, I didn't expect a sorry but it did seem really sincere.”
>
> (Nodding, 2011).

An apology is a documented factor in assisting survivor recovery (RJC, 2011). Overall, Nodding's (2011) report of her experience of RJ was extremely positive; it appeared that RJ made a significantly positive impact on her psychological recovery so that she was able to “move on” with her life and was no longer a “victim”.

The RJC have not published any cases where RJ for sexual violence has been unsuccessful, however this does not mean that locally this has not been the case. Clearly, the publication of a single successful case by the RJC is not sufficient to draw conclusions about the appropriateness of RJ for sexual violence. Additionally, since Nodding's (2011) experience of RJ following sexual violence was used to publicise the work of the RJC, the positive trajectory should be interpreted with caution.

Chung (2011) published an article on the Correctional Service Canada (CSC) website in which she described her personal experience of RJ in the UK following rape. Since the perpetrator pleaded guilty, she expressed her view that, like Nodding (2011), she was unable

to have her voice heard in court. She reported that in court "nobody looked at me and nobody heard me" (p. 1).

In the article, Chung (2011) described the collateral damage that had been done to herself, her family and her friends following her experience of sexual violence. She reported that she had "un-ending" questions which she felt only the perpetrator could answer. She cited the "careful preparation" and "clear explanations of possible outcomes" by the mediators as what made the process effective and as safe as possible for both parties. She, like Nodding (2011), also described her shock at the role reversal of the situation:

> "When we finally met, the offender was shaking, sweating and wary of my actions. I was in the perverse position of asking him if he was alright!"
>
> (Chung, p. 1).

In addition, Chung (2011) normalised the process of RJ reporting that it is "human" to want to feel understood.

> "At last I felt like I counted. I was able to voice the feeling of hurt, abandonment and the damage wreaked on my family and I as my life slowly fell apart in the months after his conviction"
>
> (Chung, p. 1).

The above quotation reinforces how the impact of sexual violence continues long after traditional criminal justice proceedings have come to a closure. Chung (2011) emphasised the need for a for a more holistic approach to sexual violence, one that acknowledged the degree

and spread of harm while engaging those affected in rebuilding their future. She reported that this was preferable in comparison to "a society of silent survivors" (p. 1).

The publication by Chung (2011) is not specifically publicising the work of any particular RJ service and therefore could be regarded as more independent in comparison to Nodding's (2011) account. Although Chung's (2011) personal account is not an empirical investigation, this should not detract from her views of her own experience; as these views are likely to be the same regardless of the method used to investigate them. A case study approach to Chung's experience of RJ would however have been more useful in developing a high quality evaluation of the restorative process that she encountered.

Madsen (2004) worked as a counsellor at the Centre for Survivors of Sexual Assault in Copenhagen (CVSAC). She published an article detailing her reflections on how RJ is conducted at the CVSAC. She highlighted that many survivors did not feel that justice was being restored by the CJS in the aftermath of sexual violence and that RJ processes could serve to renew their sense of justice. She reported that face-to-face dialogues between survivors and perpetrators were rare due to the reluctance of the perpetrators; more frequently a dialogue took place through written correspondence. Madsen (2004) cited the following reasons for survivors to seek RJ at the centre:

a) The perpetrator was the only other person present during the event itself and he is the only person, who might be able to supplement her story of what happened;
b) The perpetrator is the only one to answer the question of why it happened, although he cannot reverse his actions he can take responsibility for them - even when he does not consider the survivor to have been subjected to coercion;
c) Agreements can be made about how to interact in the future.

Madsen (2004) highlighted that fear of meeting the offender could be overwhelming for survivors, particularly in those cases where the offender was already known to the survivor. She emphasised therefore that it was important for the survivor to make arrangements in order to feel safe by obtaining new possibilities for interaction and in this way, overcoming victimisation.

Madsen (2004) wrote that it was not the purpose of mediation to agree on what happened or why, nor was it to reach reconciliation, rather both parties should be able to tell their story and the impact and implications of what happened. She suggested that an apology from the perpetrator to the survivor was often what was most needed and effective. Interestingly, Madsen (2004) reported that "the dialogue in itself seems to humanise the offender to an extent where (the survivor) can let go of her fears and come to a closure" (p. 60). This exemplifies how significant the RJ meeting can be in aiding the survivor's recovery.

In conclusion, Madsen (2004) argued that RJ is challenging, but for some survivors it was a way to reclaim a position as "an active and acting woman obtaining justice for herself" (p. 60). In the report, Madsen (2004) made astute reflections on her personal experiences at the CVSAC which demonstrated positive outcomes of the use of RJ. The report also highlighted the potential difficulty in getting perpetrators to participate in RJ. The report however appears to be based only upon the subjective perceptions of the author; a more rigorous scientific evaluation of work at the centre which takes into account a greater number of staff perspectives and survivor views would be needed in order to generate more accurate conclusions about the effectiveness of RJ for crimes of sexual violence.

## 7. Strengths and Weakness of Restorative Justice for sexual violence

In light of the reviewed literature, strengths and weakness of RJ for sexual violence are now summarised.

### 7.1. Strengths of Restorative Justice for Sexual Violence

In cases where RJ has been employed, there is evidence that survivors and professionals alike have been found to benefit from the restorative process (Madsen, 2004; Curtis-Fawley and Daly, 2005; Lewis-Herman, 2005; Julich et al., 2010; Chung, 2011; Nodding, 2011; Proietti-Scifoni and Daly, 2011). In particular, studies have shown that RJ may be more suitable for acquaintance rape and one off incidents of sexual violence (Bletzer and Koss, 2012; Proietti-Scifoni and Daly, 2011).

The reviewed literature demonstrated that RJ usage in cases of sexual violence may be beneficial in the following ways:

1) *The power imbalance that was present during the original offence changes.*

Available data on survivor experiences of RJ demonstrated a "role reversal" between perpetrator and survivor (McGlynn et al., 2012; Chung, 2011; Nodding, 2011.). In this way, survivor's found that they were no longer in a powerless position and gained a sense of control over the process (Madsen, 2004). This was in stark contrast to survivor's experiences with the traditional CJS (e.g. Campbell, 2008).

2) *The survivor is able to tell her story and to ask questions.*

The importance of the perpetrator hearing the survivor's account from her perspective may be important for survivors' recovery as it allows the survivor to "be heard" (Madsen, 2004; Nodding, 2011, Chung, 2011; McGlynn et al., 2012). In traditional criminal justice cases, the survivor is unable to give her account in court if the perpetrator pleads guilty which can have negative implications for the survivor (Daly, 2005; Nodding, 2011, Chung, 2011; McGlynn, et al., 2012).

3) *More admissions of guilt from offenders.*

The reviewed studies highlighted that RJ conference cases provided more admissions of guilt and apologies from offenders compared with court cases (Daly, 2005; Nodding, 2011; Bletzer and Koss; 2012). As is well documented, an admission of guilt is important to survivors and may contribute to their psychological recovery (e.g. Payne, 2009). Madsen's (2004) article also reflected this.

4) *RJ can allow the survivor and perpetrator to make agreements about how they may interact in the future.*

Fear of meeting the perpetrator can be debilitating for the survivor, RJ therefore gives the survivor opportunity to make arrangements with the perpetrator in order to feel safe (Madsen, 2004). Similarly, Julich et al., (2010) reported that RJ was useful for survivors who wanted to work to restore the family of networks lost as a result of sexual violence which would in turn aid progression to recovery. Proietti-Scifoni and Daly (2011) found RJ to be potentially beneficial when the survivor and perpetrator wanted to maintain a relationship.

5) *Less time and re-arrangement associated with RJ in comparison to court cases*

Daly (2005) documented the increased length of time associated with court cases as opposed to conference cases; it was reported that it took over twice as long to finalise court than conference cases. The increased length of time required for court cases is likely to be associated with increased levels of distress for the survivor (see Campbell, 2008.

Additionally, RJ may also give the perpetrator the opportunity to gain insight on the impact of their actions which is important in terms of the relationship between survivor and perpetrator as well as the community (Lewis-Herman, 2005). This type of survivor-empathy work may also have important implications for reducing reoffending.

**7.2 Weaknesses of Restorative Justice for Sexual Violence**

Uncertainty about the use of RJ in cases of sexual violence was common in the reviewed studies, due to concerns about the power imbalance between the survivor and perpetrator, safety concerns and the potential for re-traumatisation (Mika et al., 2002). These concerns however appeared to be limited to those who had little knowledge and experience of the use of RJ for sexual violence (Proietti-Scifoni and Daly, 2011). It is important to note that these risks are also present in traditional CJS proceedings.

Interestingly, Cutis-Fawley and Daly (2005) found that some professionals in the field of sexual violence feared that the protections and penalties which are part of traditional CJS would be lost in RJ practices and that RJ may also trivialise violence against women. The concern therefore is that RJ may offer less protection to women and may also have implications for how sexual violence is perceived by society as a whole.

Importantly, the research critiqued highlighted that RJ is less suited to acts of sexual violence within abusive relationships and in cases of indecent exposure (Bletzer and Koss, 2012). However, in cases of acquaintance rape or isolated incidents of abuse RJ was perceived to be more appropriate (Bletzer and Koss, 2012; Proietti-Scifoni and Daly, 2011). In line with this, two anecdotal survivor accounts included in the review which reflected positively on the use of RJ were acquaintances rapes.

The review highlighted that where survivors and offender had vastly different goals for the process, RJ was deemed inappropriate (Madsen, 2004). Preparation to prevent such

discrepancy between parties was considered key to effective RJ (Madsen, 2004; Chung, 2011; Nodding, 2011; McGlynn, 2012). However, preparation appeared to be time consuming in the cases of RJ reviewed (Chung, 2011; Nodding, 2011; McGlynn, 2012) which may have significant implications for under-resourced services.

Furthermore, there was uncertainty about the role of the community in RJ in responding to sexual violence (Lewis-Herman, 2005; Mika et al., 2002). This may be of particular relevance when communities are under resourced or when community standards may reinforce rather than challenge sexually aggressive behaviour. Additionally, Madsen (2004) highlighted the difficulties in engaging perpetrators in RJ processes.

Finally, it is important to highlight that when an RJ program is employed but is unsuccessful, there may be further need for the use of legal interventions. This may be further traumatising and time consuming for the survivor.

## 8. Conclusion

Since RJ is not practiced regularly in cases of sexual violence it is difficult to draw conclusions about its effectiveness and appropriateness. Furthermore, there is little empirical evidence on the practice of RJ for crimes of sexual violence; this was demonstrated by the lack of quantitative research in the area. However, the studies reviewed here, which were largely qualitative, revealed that there is some evidence that RJ may be useful in the psychological recovery of survivors of sexual violence. This must however be considered alongside evidence that views on the subject are mixed.

In terms of survivor advocates, police and health professionals involved with survivor care, the reviewed studies demonstrated that on the whole there was a mixture of support and cautious curiosity towards the use of RJ for crimes of sexual violence. Proietti-Scifoni and Daly (2011) demonstrated these views well with their study, which highlighted the

complexity of viewpoints on the subject. Their results suggested that overall professionals saw potential benefits to RJ processes however some strongly disagreed with the use of RJ for sexual violence, suggesting that it would put survivors at risk of harm or a "watered down" justice response (Mika et al, 2002; Proietti-Scifoni and Daly, 2011). Curtis-Fawley and Daly's (2005) study highlighted however that it was largely professionals who had not taken part in RJ who held negative views on its usage and those who had actually taken part appeared to view the process more favourably and therefore had seen, or would expect to see RJ yield positive results. Madsen (2004) for example, who published an anecdotal article on her experiences of RJ as a professional, highlighted that such processes can help survivors to feel empowered, which may in turn aid their recovery.

Bletzer and Koss's (2012) analysis of restorative apology letters from perpetrators suggested that restorative processes can be helpful in enabling the perpetrator to develop empathy, admit guilt and apologise. Admissions of guilt are well documented in aiding recovery from violent crime and Daly's (2005) empirical review of traditional court cases compared with RJ conference cases highlighted that conference cases provided more admissions of guilt from perpetrators compared with court cases; as well as finding that RJ conferences took less time to finalise and were not rearranged as often. It appears therefore that there are some clear benefits of RJ over traditional criminal justice approaches.

Studies and articles representing survivor views demonstrated interesting findings. Firstly, Lewis-Herman (2005) found that survivor views of justice differed substantially from traditional criminal justice approaches; survivors were concerned with the harm done to them personally in relation to their community, rather than the abstract violation of the law. McGlynn, Westmarland and Godden's (2012) case study highlighted how RJ allows the experience of sexual violence to be honoured through giving the survivor a voice, a measure of control and a sense of justice by being taken seriously. Similarly Julich et al., (2010)

reported benefits of RJ identified by survivors included the development of the strength to speak about the incident and also a more positive self-image.

Survivor stories that were published anecdotally online (Nodding, 2011; Chung, 2011) revealed positive experiences of RJ. These reports were particularly positive when contrasted with the wider literature on survivor's experiences of traditional CJS procedures (for example, Campbell, 2008). In light of this, there is clear scope for the further investigation and evaluation of RJ and its potential benefits for survivors of sexual violence.

Finally, cases of RJ being used for crimes of sexual violence in the United Kingdom are rare; moreover there are no official statistics for this. For the purposes of the current review, contact was made with the Restorative Justice Council (RJC) in order to shed light on the reasons for this. An Assistant Director (anonymous) of the organisation acknowledged the difficulty in determining the prevalence of RJ in cases of sexual violence due to the information not being recorded centrally. In addition, the Assistant Director added that where services do use RJ for crimes of sexual violence they tended not to publicise it due to the "highly sensitive nature of such cases and unpredictable media response" (RJC, email, April 2, 2012). Systematic recording of the usage and success of RJ for sexual violence is required if any conclusions are to be drawn based on survivor experiences.

## 9. Methodological Considerations of the Literature Review

Since much of the methodology utilised in the reviewed literature was qualitative, participants were able to provide data in their own words, and individuals were studied in greater depth. RJ for sexual violence is not easily quantifiable and research into the area is, at this point, still in its infancy. However the qualitative approach of the majority of the studies included in this review has enabled an introductory investigation of this complex matter.

The majority of the studies reviewed utilised small sample sizes. It is likely that the sensitive nature of this subject area may deter people from participating. This may be related

to high levels of shame and guilt associated with sexual violence (Frazier, 2003). Furthermore, those who have been traumatised by sexual violence may well use avoidance and dissociation as a coping method (Ullman, Townsend, Filipas and Starzynski, 2007) and as such may not wish to participate in research. Much of the research therefore has a lack of statistical power, which would be associated with a more rigorous empirical design. Since sexual violence can be experienced by any individual across age, race, class or gender (WHO, 2010), it is difficult to draw conclusions on the basis of a research literature that covers a fairly limited range of individuals, particularly when such small sample sizes are used.

Since the majority of studies within the area are qualitative it is more difficult to determine the validity and reliability of the research that is available. Furthermore, since some of the studies neglected to report explicitly the employed method of analysis, it is harder to determine the extent of influence that the researcher had over the results (e.g., through researcher bias). That is, there is more subjectivity involved in analysing the data which may in turn have impacted on the reported results.

Studies located for the purposes of the current review are focused on women survivors due to the low ratio of men who participate in sexual violence research and the under-reporting of this phenomenon (Greenfield, 1997). However, the results of this review may differ substantially for male survivors. Therefore there is a clear need to address very sensitively the gender differences that may exist in the design of RJ programmes, as otherwise programmes may neglect the differing needs of women and men survivors.

The research discussed originates from a range of countries. Cultural differences across and within countries may play a significant role the perception of RJ’s appropriateness and effectiveness for cases of sexual violence. RJ can offer a practical way for families and communities to respond to crimes; in this way it can be seen to enrich democracy. However,

in communities where levels of anger and hostility are high, for example as a result of poverty, war and gender inequalities, the community responses to RJ are likely to be very different. Additionally, the results are difficult to generalise given that the research reviewed originates from the UK, America, Copenhagen, Australia and New Zealand where there may be significant cultural differences.

When considering important cultural differences in the implementation of RJ, it is of note that just as RJ practices are not immune to cultural influences, neither are CJS practices. In this way, for any justice practice to meet the needs of the community, cultural influence needs to be carefully considered.

Finally, some studies neglected to include survivor perceptions and experiences of RJ. Many studies for example utilised professionals including advocates, counsellors and police officers as participants. There is therefore a potential bias introduced with respect to people reporting the experiences of others, particularly related to instances of a sexual nature which are considered to be private.

## 10. Clinical implications and areas for future research

The use of RJ processes for sexual violence is rarely implemented and is an under researched area. Studies suggest however that RJ processes may benefit survivors and assist their recovery. There are some examples of excellent RJ outcomes however these are demonstrated mainly by isolated cases. With no national data on how often RJ is used in cases of sexual violence in the UK, it is difficult to comment upon its effectiveness overall. As a starting point, it would be useful for future research to have greater access to data on the use of RJ processes and procedures in cases of reported sexual violence. This would include where it is being used, under what circumstances, how it is being implemented and how effective it is at meeting survivor's needs. In this way, future research could address RJ’s effectiveness for survivors by implementing rigorous scientific methodology, perhaps

through quantitative studies or mixed-method approaches to evaluate and gain more knowledge regarding the concerns raised by some professionals over its usage.

Preparation for RJ processes was considered key to successful implementation. This may have important implications for care packages available to survivors following sexual violence. Investigation into what constitutes effective preparation and evaluation of such methods may be beneficial to the planning and delivery of RJ interventions. Indeed, findings from the present review suggest that further education on RJ processes and specialist support is required for those multi-agency services that work with survivors and perpetrators if professionals are to implement RJ effectively.

Finally, similar to the shortcomings of the CJS, RJ is influenced by societal perceptions of sexual violence. As is well documented (Campbell, 2005; 2008) widely held myths about sexual violence can lead to under reporting, case attrition and low conviction rates. Unfortunately, improvements in training and legal reforms have been shown to be insufficient in improving the response to survivors of sexual violence (Stern, 2010). It has been argued (e.g. Chasteen, 2001), that two chief components of socio-cultural influence which perpetuate sexual violence include male entitlement to sex and the perception of women as subordinate, resulting in severe gender inequalities. These factors are made all the more poignant when sex is seen as a taboo subject that cannot be discussed. Consequently, the harm caused by sexual violence becomes hidden and is therefore ultimately accepted and left unpunished. RJ may offer encouragement for the discussion of these issues. Ulitmately however, if we are to improve justice outcomes for survivors then cultural and societal perceptions of women, men, children and sexual violence need to be addressed. This could partly be accomplished through sexual violence education in schools and for communities, more versatile representations of masculinity and femininity in the media and the de-

stigmatisation of the subject. This could be achieved through community based schemes involving awareness raising and education on sexual violence.

## 11. Summary

The reviewed literature has revealed some evidence that supports the use of RJ for crimes of sexual violence. In particular, survivors and professionals who had experienced RJ first-hand reported positive outcomes. However, due to the sensitive nature of sexual violence and the potential for re-traumatisation of the survivor, it was clear from the reviewed papers that RJ needs to be approached with caution. Indeed, where RJ was employed, extensive preparation was consistently identified as a key element to its success.

At a time where public policy denotes that collaborative working between services is beneficial, justice and health agencies should be supported to work together in their responses to survivors. This may help to ensure that the process of obtaining justice for survivors of sexual violence through RJ or by traditional means, is as helpful as possible for survivors in their journey to recovery.

**References**

Amnesty International UK. (2005). *ICM opinion poll*. Retrieved September 10, 2010, from http://www.amnesty.org.uk/news_details.asp?NewsID=16618

Bletzer, K., & Koss, M. (2012). From parallel to intersecting narratives in cases of sexual assault. *Qualitative Health Research, 22*(3), 291-303.

Breslau N., Kessler R., Chilcoat H., Schultz L, Davis G., & Andreski P. (1998). Trauma and posttraumatic stress disorder in the community: The 1996 Detroit Area Survey of trauma. *Archives of General Psychiatry, 55,* 626–632.

Campbell, R. (2005). What really happened? A validation study of rape survivors' help seeking experiences with the legal and medical systems. *Violence and Victims, 20*, 55-68.

Campbell, R. (2008). The psychological impact of rape victims experiences with the legal, medical, and mental health systems. *Psychology of Women Quarterly*, *31,* 357-370.

Chasteen, A. (2001). Constructing rape: Feminism, change and women’s everyday understandings of sexual assault. *Sociological Spectrum, 21*(2), 101-139.

Chung, C. (2011). *Restorative justice in a case of serious sexual assault.* Retrieved April 5, 2012, from http://www.csc-scc.gc.ca/text/rj/rj2011/pdf/11-eng.pdf

Curtis-Fawley, S. & Daly, M. (2005). Gendered violence and restorative justice the view of victim advocates. *Violence against Women, 11*(5), 603-638.

Daly, K. (2005). Restorative justice and sexual assault. An archival study of court and conference cases. *British Journal of Criminology*, *46,* 334-356.

Daly, K., & Stubbs, J. (2006). Feminist engagement with restorative justice. *Theoretical Criminology, 10* (1), 1362-4806.

Department of Health. (2002). *Women's mental health into the mainstream*. London: department of Health.

Department of Health. (2010). *Taskforce on the health aspects of violence against women and children: Report from the sexual violence against women subgroup.* London: Department of Health.

Frazier, P. (2003). Perceived control and distress following sexual assault: A longitudinal test of a new model. *Journal of Personality and Social Psychology, 84,* 1257–1269.

Greenfield, L. (1997). *Sex Offenses and Offenders: An Analysis of Data on Rape and Sexual Assault.* Washington: U.S. Department of Justice, Bureau of Justice Statistics.

Heise, L. & Garcia-Moreno, C. (2002). Violence by intimate partners. In E. Krug (Ed.) *World report on violence and health* (pp. 87–121). Geneva: World Health Organization.

Home Office. (2007). *Cross Government Action Plan on Sexual Violence and Abuse.* Retrieved July 20, 2010 from http://webarchive.nationalarchives.gov.uk/+/homeoffice.gov.uk/documents/sexual-violence-action-plan.html

Home Office. (2010). *The Stern Review.* London: Government Equalities Office.

Hopkins, C. & Koss, M. (2005). Incorporating Feminist Theory and Insights Into Restorative Justice Response to Sex Offenses. *Violence against Women, 11*(5), 693-723.

Jewkes, R., Sen, P. & Garcia-Moreno, C. (2002). Sexual violence. In: Krug EG et al., eds. *World report on violence and health*, pp. 149–181. Geneva, World Health Organization.

Jordan, J. (2001). Worlds Apart? Women, rape and the police reporting process. *British Journal of Criminology*, *41,* 679-706.

Julich, S., Buttle, J., Cummins, C., & Freeborn, V. (2010). *Project restore: An exploratory study of restorative justice and sexual violence.* New Zealand: AUT University.

Kelly, L., Lovett, J., & Regan, L. (2005). *A gap or a chasm? Attrition in reported rape cases.* Child and women abuse studies unit. London: Home Office.

Koss, M., (2010). Restorative justice for acquaintance rape and misdemeanour sex crime. In J. Ptacek (Ed.), *Restorative justice and violence against women* (pp. 218-238). Oxford: University Press.

Koss., M. & Achilles, M. (2008). *Restorative justice responses to sexual assault.* Retrieved March 26, 2012 from http://www.vawnet.org/

Koss, M.P., & Figueredo, A.J. (2004). Change in Cognitive Mediators of Rape's Impact on Psychosocial Health Across 2 Years of Recovery. *Journal of Consulting and Clinical Psychology, 72*(6), 1063-1072.

Lewis-Herman, J. (2005). Justice from the victim's perspective. *Violence against Women, 11*(5), 571-602.

Madsen, K, S. (2004). Mediation as a way of empowering women exposed to sexual coercion. *NORA, 1*(12).

McGlynn, C., Westmarland, N., & Godden, N. (2012). "I just wanted him to hear me": sexual violence and the possibilities of restorative justice. *Journal of Law and Society, 39,* 327-351.

Mika, H., Achilles, M., Halbert. E., Stutzman Amstutz, L., & Zehr, H. (2002). *Taking victims and their advocates seriously: A listening project.* Akron, PA: Mennonite central committee.

Nancarrow, H. (2006). In search of justice for domestic and family violence: Indigenous and non-indigenous Australian women's perspectives. *Theoretical Criminology*, *10,* 8-106.

Nodding, J. (2011) *The meeting.* Retrieved April 5, 2012 from http://www.restorativejustice.org.uk

Orth, U. & Maecrcker, A. (2004). Do trials of perpetrators re-traumatize crime victims? *Journal of Interpersonal Violence, 19,* 212-227.

Payne, S. (2009) *Redefining Justice. Addressing the individual needs of victims and witnesses*. Retrieved September 10, 2010 from http://www.justice.gov.uk/sara-payne-redefining-justice.pdf

Proietti-Scifoni, G & Daly, K (2011). Gendered violence and restorative

justice: the views of New Zealand Opinion Leaders. *Contemporary Justice Review. 14*(3), 269-290.

Restorative Justice Council. (2011). *The meeting: Jo's story, surviving rape.* Retrieved April 5, 2012, from http://www.restorativejustice.org.uk/resource/the_meeting_jos_story__surviving_rape_/

Restorative Justice Council. (2012). *What is restorative justice?* Retrieved April 5, 2012 from http://www.restorativejustice.org.uk

Seidman, I., & Vickers, S. (2005). The Second Wave: An Agenda for the Next Thirty Years of Rape Law Reform. *Suffolk University Law Review, 38*, 467-492.

Stern, V. (2010). *The Stern Review.* Home Office: London.

Tjaden, P., & Thoennes, N. (2006). *Extent, Nature and Consequences of violence against women: Findings from the National Violence Against Women Survey.* United States: Washington, DC.

Ulman, S., Townsend, S., Filipas., H. & Starzynski, L. (2007). Structural models of the relations of assault severity, social support, avoidance coping, self-blame, and PTSD amongst sexual assault survivors. *Psychology of Women Quarterly, 31*, 23–37.

World Health Organisation. (2009). *Fact sheet No 239 Violence against Women.* Retrieved June 5, 2010, from http://www.who.int/mediacentre

World Health Organization. (2010). *Preventing intimate partner and sexual violence against women: taking action and generating evidence.* Retrieved April 25, 2012, from http://whqlibdoc.who.int/publications/2010/9789241564007_eng.pdf

Women's Aid. (2008). *Violence Statistics*. Retrieved September 30, 2010, from http://www.womensaid.org.uk/domestic_violence_topic.asp?section=0001000100220022§ionTitle=Sexual+violence

## Chapter Two

Service responses to survivors of sexual violence:

Perspectives of National Health Service and

Voluntary Sector professionals on

Inter-agency working with survivors.

(Words: 8,937, exclusive of references)

Prepared for submission to

Psychology of Women's Quarterly

(See Appendix G)

## Abstract

There is growing evidence that the National Health Service (NHS) and voluntary sector could provide more responsive services to survivors of sexual violence if there was more effective communication and inter-agency working. However, it is still reported that this does not always occur. The present paper aims to gain an in-depth understanding of the perspectives of professionals who work with survivors of sexual violence on the difficulties of inter-agency working. Healthcare professionals from the NHS and rape crisis centre professionals from the voluntary sector were recruited for the study and interviewed using focus group methodology.

Data from focus groups was analysed using thematic analysis. Results highlighted individual barriers to inter-agency working; five primary themes were identified: survivor needs being ignored; an avoidance of addressing sexual issues; training on sexual violence not being taken seriously; negative attitudes towards sexual violence professionals and a lack of empathy displayed by staff towards survivors. Themes of organisational factors affecting inter-agency working and effective service provision were also identified. Three primary themes related to organisational factors centred upon competition between services, incompatible approaches to treatment and the need for enhanced networking.

# 1. Introduction

The present study sets out to explore staff perceptions of inter-agency working with survivors of sexual violence. This will be achieved through exploring the perspectives of inter-agency working of National Health Service (NHS) healthcare professionals and Voluntary sector rape crisis centre professionals who work with survivors of sexual violence.

## 1.1. Background and Rationale for the Current Research

Sexual violence is a significant global health problem, which in addition to being a violation of human rights, profoundly damages the physical, sexual, reproductive, emotional, mental and social well-being of individuals, families and communities (WHO, 2010). It is defined by the World Health Organisation (WHO) as:

> Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting including but not limited to home and work.
>
> (WHO, 2010, p. 11)

The above definition includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object. The legal definition of rape however varies in different countries (Heise and Garcia-Moreno, 2002; Jewkes, Sen and Garcia-Moreno, 2002).

It has been consistently suggested that sexual violence is a common crime that can be perpetrated against any women, men or children under many different circumstances (WHO, 2009). However, Greenfield (1997) argued that most sexual violence is perpetrated by men

towards women. In terms of disclosure of sexual violence, Rennison (2002) has argued that women who have been sexually assaulted by strangers are more likely to report the assault to the police, but they are less likely to alert authorities if they know the perpetrator. Only a small proportion of rapes are however categorised as 'stranger rapes'; Povey, Coleman, Kaiza and Roe (2009), for example, give a figure of twelve per cent for serious sexual assault. For survivors of serious sexual assault over the age of sixteen years, the most common perpetrator was found to be a current or former partner (Povey et al., 2009) or acquaintance (Feist, Ashe, Lawrence, McPhee and Wilson, 2007). The fact that 'stranger' rapes are uncommon but are the most disclosed reflects how few rapes are reported.

Despite extensive legal reform, several authors have argued that rape continues to be understood by society as being committed by strangers, involving weapons and with documented injury (Myhill and Allen, 2002; Kelly, Lovett and Reagan, 2005 and Konradi, 2007). Indeed, Amnesty International (2005) conducted a poll of 1,095 British adults and found that a third of those asked believed "women who flirt" are partially responsible for being raped; a quarter said that they thought a woman was partially or totally responsible for being raped if she was wearing revealing clothing and more than a quarter said that a woman was partially or totally responsible for being raped if she was drunk. Amnesty International (2005) asserted that these findings should act as a wake-up call to the government to urgently tackle the problem of the high incidence of rape, low conviction rates and what they described as a "sexist blame" culture.

Research reveals that survivors of sexual violence frequently do not tell their families or seek health care and are also hesitant to speak to friends (Tjaden and Thoennes, 2006). Understanding how services can best respond to survivors is crucial in helping survivors to receive the support they urgently need, yet rarely seek. Receiving sensitive and effective responses from services quickly is particularly important, as studies show that earlier

disclosure of experiences of violence contributes to a reduction in the rate of depression in survivors (Broman-Fulks, Ruggerio, Hanson, Smith, Resnick, Kilpatrick and Saunders, 2007).

The multiple damaging consequences of sexual violence require a range of social, justice, health, and welfare responses. The importance of inter-agency work in addressing the needs of this group of women has been identified in several reports including Department of Health guidance (DOH, 2010). It has been argued that an effective model of care for survivors can only be achieved through fostering communication and collaboration between services, which unfortunately is not common practice (Keel, 2005; Martin, 2003 and Taft, 2009). Stern (2010) reported concern over the failure of a range of agencies to view the survivors of sexual violence as their responsibility, which may in turn lead to a lack of effective responses from services. The Department of Health (2010) recommended that health services should improve their response to survivors by raising the awareness of specialist support available, by providing accessible information and by working with other agencies to ensure appropriate services are available. It is the third of these recommendations which is the focus of the present study.

### 1.2. The National Picture and Role of the NHS

Evidence suggests that sexual violence is a pervasive global health and human rights problem (WHO, 2010). In the United Kingdom (UK), the Cross Government Action Plan on Sexual Violence and Abuse (Home Office, 2007) found that the overall cost to society of sexual offences in 2003-04 was estimated at £8.5 billion with each rape costing over £76,000. The report stated that this cost was made up of lost output and costs to the health services that resulted from the long term health issues faced by survivors. The report (Home Office, 2007) also suggested that forty per cent of adults who are raped do not disclose to anyone. This

means that survivors in the UK frequently do not receive the comprehensive services and support they require to overcome the abuse they have experienced.

The extensive consultation document entitled 'Together we can end violence against women and girls' carried out by the Home Office (2009) highlighted a need for the NHS to improve its responses to survivors of violence and abuse. Alberti's (Home Office, 2010) report also emphasised the importance of the role of the NHS for the survivors of such violence, as one survivor reported:

> Health professionals see their role quite narrowly. You get the sense they don't see responding to violence against women as part of what they do...It has a huge impact on women's health, physically and mentally. Health services need to see their role more widely and offer a holistic approach.
>
> (Alberti, 2010. p. 15)

It is recognised that women utilise health care services thirty-three per cent more frequently than men (DOH, 2001). Research has also found that women who experience sexual violence are more likely to have had eight or more doctor visits during the past year (Pilchta and Falik, 2001). Furthermore, research has suggested that seventy per cent of women who are psychiatric inpatients have experienced sexual violence and eighty per cent of women in forensic settings have a history of physical and sexual violence (Women's Aid, 2008). There is therefore an important opportunity for professionals to respond to survivors' needs and to offer support at numerous points in service delivery.

Given the high health-related cost of sexual violence, the Government action plan on sexual violence (Home Office, 2007) recognised that NHS services have an important role to play in survivor care. Alberti (2010) reported that where the NHS fails to provide an effective

response to survivors the impact can be devastating. The following quotation from a survivor illustrates this:

> Health services don't believe you when you try to get help. I was raped and went to my doctor. He was useless, and made me feel like I was to blame. The GP wrote "raped" in inverted commas on my notes, which said everything about his attitude to women who've been raped. But then this affects everything else too. When my case went to court, it got thrown out on the basis that the GP didn't believe me! I was really upset, I still am.
>
> (Alberti, 2010; pp. 16-17).

Importantly, Alberti (2010) reported that more effective communication between services was needed as this was important to survivors and ultimately impacted on their recovery. There is an established literature on the benefits and challenges of inter-agency working (for example: Crawford, 1997; Hughes, 2007) however inter-agency working on sexual violence has been given less attention.

Robinson, Hudson and Brookman (2008) recognised this gap and conducted a study of multi-agency staff working within a Sexual Assault Referral Centre (SARC) in Cardiff, Wales. SARC centres have been developed in some areas of England and Wales to improve with medico-legal response to sexual violence. Findings from Robinson et al., (2008) demonstrated positive aspects of inter-agency work in the response to survivors' medical and legal needs, as well as the continuing challenges that the SARC faced including sustaining multi-agency participation, diverse agency cultures, competing agendas, funding and staffing issues (Robinson, Hudson and Brookman, 2008).

## 1.3. Local voluntary support

### 1.3.1 Rape Crisis Centres

It is recognised that local voluntary sector organisations have first-hand experience of working with survivors. These organisations include rape crisis centre and their services focus on three critical areas: 24-hour crisis hotlines, individual and group counselling (often on a short-term basis only), and legal and medical advocacy (Campbell and Martin, 2001). These services are well placed to identify and meet survivor needs effectively and are crucial to the delivery of support to survivors. In community studies, rape crisis centres are rated as most helpful out of a range of support sources by survivors seeking help after assault (Ullman and Fillipas, 2001).

In 2008, thirty-five of thirty-eight rape crisis centres in the United Kingdom responded to an in-depth survey conducted jointly by the Women's Resource Centre and Rape Crisis (Corry, Pouwhere and Vergura, 2008). The survey revealed that eighty-five per cent of survivors were identified as having 'complex needs'. The centres had a combined annual income of £3,570,912 in 2006-07. Sixty-three per cent of rape crisis centres had an annual income of £100,000 or less. The average income was £81,598, only marginally more than the cost to the state of one rape. The survey found that securing funding for the centres was a relentless and constant challenge; often resulting in low staff morale and in the worst case scenarios, the 'freezing' or closure of services, resulting in survivors not receiving the support they needed. Many centres stated that they felt compelled to keep costs low in funding applications, such as costing salaries well below the market value, in order to improve their chances of receiving funding. Sixty-nine per cent of centres said they were 'unsustainable' in the future. Sadly, this is in line with Koss and Harvey's (1991) report which highlighted that women cannot access the resources that they need.

As well as the provision of direct services, the voluntary and community sector is an important source of information and training for statutory agencies on preventing and responding to sexual violence. The government has recommended that the expertise and knowledge of the voluntary sector should be drawn upon in the development of local strategies and action plans (Stern, 2010). However, research by the Equality and Human Rights Commission and the End Violence against Women Coalition (Coy, Kelly and Foord, 2007), found that all geographical areas in the United Kingdom are vastly under-served in the provision of services for survivors. Unlike domestic violence, sexual violence support services have not been afforded strategic positioning in national and local policy until relatively recently (Coy, Kelly and Foord, 2007).

Evaluations of rape crisis centres have demonstrated that the positive effects (Campbell, 1999) of accessing support benefits not only on survivors, but also their loved ones and their communities; Corry et al., (2008) for example reported that survivors described outcomes including improved mental well-being, a reduction in self-harming behaviours, better inter-personal relationships, an ability to return to work or study and to reduce and stop medication. Unfortunately however, despite the many positive benefits of rape crisis centres, there are low levels of awareness about the work of these centres as well as about sexual violence in general among the public (Amnesty International, 2005). Government reports consistently state that funding must be secured for the future of these centres. Stern (2010) argues however that support and commitment from other agencies, such as the NHS, is also imperative to the chances of sustained success.

## 2. Rationale and study aims

It is important to conduct research into collaborative efforts to help survivors of sexual violence in the UK, because research in the United States has shown that when done well,

multiagency collaboration can decrease the severity of the negative consequences associated with experiencing sexual violence (Preston 2003).

Previous research has also suggested that survivors have complex needs and recommended that the expertise and knowledge of the voluntary sector should be drawn upon in the care of survivors and multi-agency services should collaborate more (Stern, 2010). There is however evidence to suggest that, in practice this does not always happen (Alberti, 2010; Coy, Kelly and Foord, 2007) and much of the existing research has detailed findings from the United States (e.g. Ullman and Townsend, 2007) which may not be directly applicable to United Kingdom contexts.

Hence, the focus of the present study is to build on the existing limited evidence base to achieve the following aims:

1) To explore the perceptions of professionals from NHS and voluntary sector specialist services regarding inter-agency responses to sexual violence, at a local level in the UK.

2) To gain an understanding of factors that participants perceive as influencing the ability of services to engage with survivors of sexual violence and to meet their needs.

## 3. Methodology

### 3.1. Ethical considerations

Ethical approval was granted by the National Research Ethics Service, Coventry University Ethics Committee and the West Midlands South Comprehensive Research Network; Research and Development (see Appendix A).

### 3.2. Participants

Fifteen professional members of staff were recruited from both a local NHS service and a local voluntary sector rape crisis centre to participate in the present study.

### 3.3. Inclusion criteria

Professionals working within a rape crisis centre or the NHS who had experience of working with survivors of sexual violence were included in the study. Those who did not have any experience of working with survivors were not included.

### 3.4. Recruitment

Recruitment of voluntary sector professionals took place at a rape crisis centre (n=6). The centre manager and the researcher met to discuss the process of the research. The staff team were then briefed about the research and posters providing information about the study (see Appendix B) were displayed at the centre. Professionals who were interested in taking part in the study contacted the researcher using the details from the poster. The researcher liaised with the centre manager to set an appropriate date and time to run the focus group.

NHS healthcare professionals (n=9) were recruited from services that were considered the first point of potential contact for women survivors including primary care services, gynaecological urinary medicine clinics and accident and emergency departments. Professionals from these services were recruited from a working group that had been established as part of a NHS training event on sexual assault referral pathways. The researcher liaised with the lead professional of this working group to convey information on the study and to arrange an appropriate time and place to conduct the focus group.

### 3.5. Data collection

Given that the study aimed to investigate the subjective views and experiences of professionals in such a sensitive subject area, a qualitative methodology was deemed appropriate. Qualitative methodology enabled the collection of in depth and varied data which could be analysed in a manner that would reflect the complex nature of the subject area.

A focus group methodology was selected on the basis that the group process can help participants to explore their views and to generate ideas in ways that could be more difficult in individual interviews (Kitzinger, 1996). Two focus groups were carried out. One focus group consisted of six professionals from the rape crisis centre. Of the professionals who consented to participate in the study; three were counsellors and three were Independent Sexual Violence Advocates (ISVA's). The other focus group consisted of nine NHS healthcare professionals and took place at a sexual violence training event. The NHS professionals were from a variety of services including sexual health, pharmacy, community services, accident and emergency services, ambulance services and midwifery.

### 3.6. Materials

Focus group topic areas for discussion were developed, in line with the study aims, drawing upon the existing published literature on sexual violence. An additional researcher with expertise in the area of sexual violence and a clinical psychologist working in the area also reviewed the semi-structured interview schedule. Following the review, feedback was given as to the wording of the topic areas, in order to improve clarity and ease understanding for participants. The interview schedule was edited accordingly (see Appendix C).

### 3.7. Information for participants

All potential participants were provided with an information sheet containing a written summary of the research (see Appendix D) and had the opportunity to discuss any further questions with the principal investigator. Participants were informed that they could withdraw from the study at any time without their professional role being affected. Verbal and written informed consent was obtained from participants by the principal investigator prior to the focus groups taking place. Participants who consented to taking part signed two copies of the consent form (see Appendix E), and retained one for their own records.

### 3.8. Interview Procedure

One focus group was conducted with participants at the local rape crisis centre, in a private meeting room in February 2012. The second focus group of NHS participants was held at a rape and sexual assault pathways event in March 2012. This focus group also took place in a private meeting room. Participants were informed that the focus groups would be recorded and transcribed verbatim and that transcripts would not contain any identifying information.

### 3.9. Confidentiality and data storage

The principal investigator ensured that the Data Protection Act (Office of Public Sector Information, 1998) was adhered to throughout the research process. Information from the focus groups that might have allowed identification of the participants, the rape crisis centre, survivors, perpetrators or family members was not transcribed. The data was accessed by the principal investigator and research supervisors only.

## 4. Data Analysis

Focus groups were audio-taped and transcribed verbatim. The data was then analysed using Thematic Analysis. Thematic Analysis is a method for identifying, analysing and reporting

patterns or themes within the data (Braun and Clarke, 2006). This method was particularly suited to the phenomenon under investigation, as the research focused on the subjective viewpoints of service responses to sexual violence. Thematic analysis is essentially independent of theory and epistemology and therefore provides a flexible and useful research tool providing a rich and detailed, yet complex account of data (Braun and Clarke, 2006). The principal investigator was however particularly influenced by models rooted in feminist and critical realism theory, which it is acknowledged may have influenced the research process in particular the identification of themes stemming from the data.

The principal investigator used a reflexive journal as advocated by Henwood and Pidgeon (1992) that documented each step of the project. This included the researcher's reflections and thoughts about the research process, context and any important influences and emerging themes. It is important to acknowledge the researcher's own personal processes as well as theoretical position and values since data coding cannot take place within an epistemological vacuum (Braun and Clarke, 2006). At the time of the interviews, the principal investigator was employed as a trainee clinical psychologist by a local health service trust.

The analysis was principally guided by the work of Braun and Clarke (2006) which clearly outlined the phases of thematic analysis. After the data was transcribed, it was read and re-read and ideas about the meaning of the data were noted down. Initial codes were then generated by coding features of the data that were recurring and interesting in a systematic fashion across the entire data set; data relevant to each code was then collated. The terminology of the code labels was developed from participant responses and sexual violence literature (e.g. "taboo"). The generated codes were then collated into potential themes by gathering all data relevant to each potential theme. The themes were then checked to see if they worked in relation to the coded extracts. An independent investigator then read one

transcript and labelled the text with preliminary codes. Coding was compared and was consistent; with codes relating closely to the preliminary themes. Any anomalies were resolved through discussion. On-going analysis to refine the specifics of each theme then enabled the generation of clear definitions and names for each theme. The final analysis consisted of a selection of extracts that were analysed and related back to the research question with a focus on understanding the factors or issues that were perceived by participants as influencing the ability of services to respond to survivors and meet their needs, including issues relating to effective inter-agency working on sexual violence.

An extract of an analysed transcript, can be found in Appendix F.

### 4.1. Support of Principal Investigator

The study took steps to ensure the principal investigator's wellbeing. Details of sexual violence experiences were not asked about directly; however the risk of emotional impact on the principal investigator was evident. Issues arising from this were discussed during supervision sessions and also reflected upon and processed through writing the reflexive journal. The principal investigator also participated in supervision and peer support groups along with other trainee clinical psychologists who used qualitative methods for their research.

### 4.2. Credibility of Analysis

In order to enhance the reliability of the analysis one of the research supervisors reviewed the preliminary lists of codes and themes. Input and supervision was gained throughout the research process by the research supervisors who were experienced working within the area of sexual violence. Finally, an independent investigator also involved in conducting qualitative research read one transcript and labelled text with preliminary codes and themes.

All themes and ideas were closely linked and any disputes were resolved via discussion. This offered the opportunity to compare thoughts and ideas with a researcher who was free from bias and prior assumptions about the data. Consequently, the wording of two of the subthemes was altered for greater clarity.

Braun and Clarke (2006) suggested the development of thematic maps to aid the generation of themes. These helped the principal investigator to visualise and consider the links and relationships between themes. Further details on the analytic process, in the form of thematic maps are displayed in Figure 1 and Figure 2.

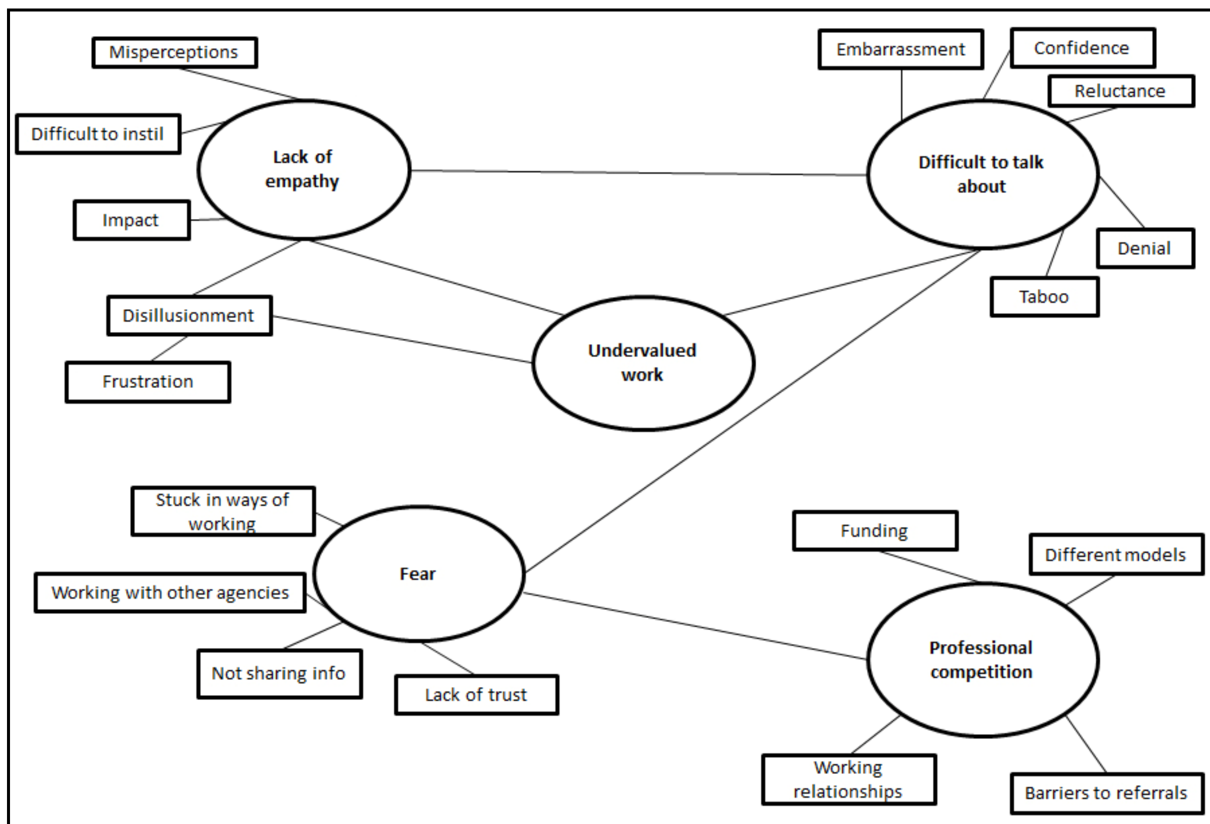



**Figure 1. Map of initial themes**

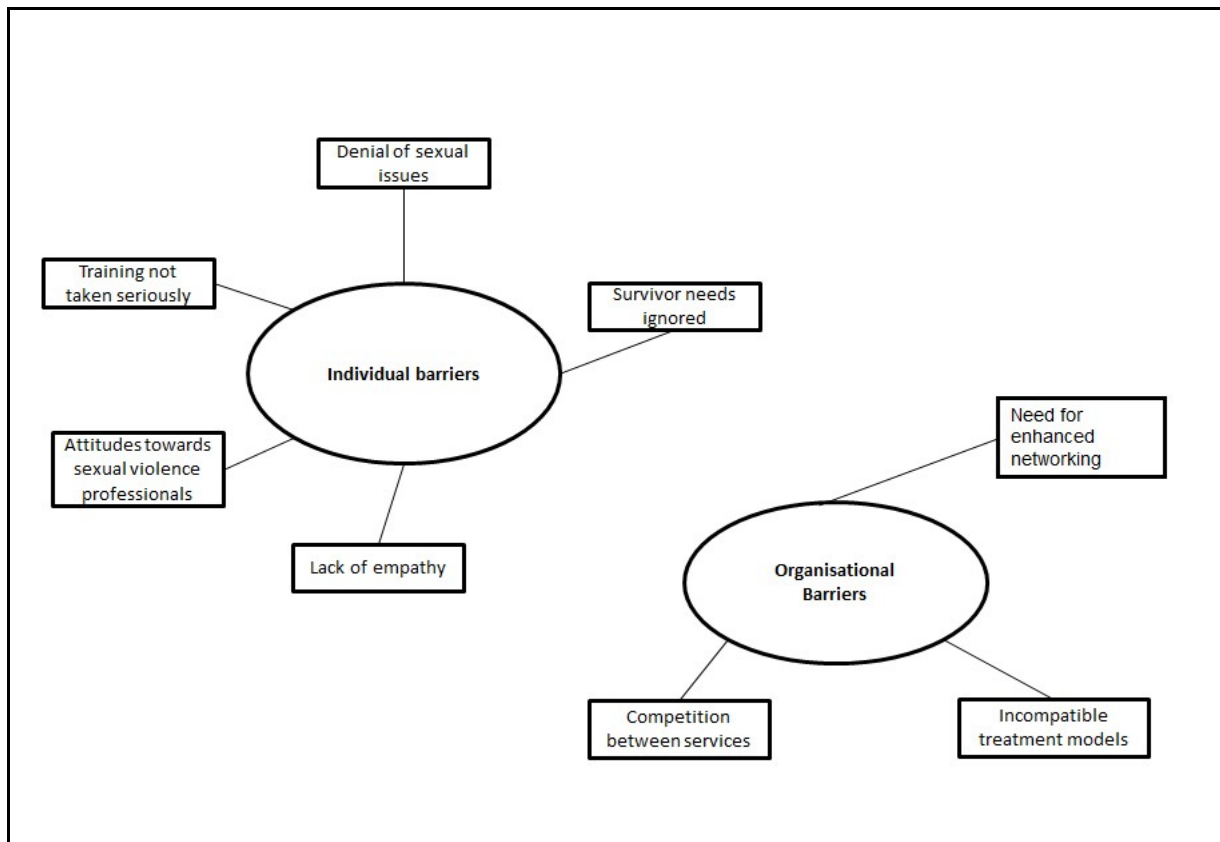



**Figure 2. Map of refined themes**

## 5. Results

Thematic analysis of the interview data elicited eight key concepts that were evident in the data. Refinement of these concepts revealed two broad key themes influencing inter-agency service responses to survivors of sexual violence. These compromised individual barriers and organisational barriers. These themes are viewed as essential in determining the experiences of all the participants.

These themes and their subthemes are now explored using verbatim extracts from the transcripts to illustrate each theme. The use of direct quotations in qualitative research is advocated by Elliott, Fischer and Rennie (1999) who suggested that this allows the reader to both appraise the analytic process and conceptualise possible alternative meanings and understandings of the interview data. Additionally, as advocated by Braun and Clarke

(2006), the data will be related to existing relevant literature in order to enhance the interpretative value of the analysis.

### 5.1. Individual barriers

Many participants spoke of the barriers they faced when working with individual staff members at various services accessed by survivors. Participants narrated their experiences of survivors' specific needs being ignored, an avoidance of addressing sexual issues, training not being taken seriously, negative attitudes toward sexual violence professionals and a lack of empathy displayed by staff.

#### 5.1.1. Survivor's needs ignored

A prominent theme that emerged from the focus groups was the perception that some staff did not seem to recognise and respond to the specific and unique needs of survivors. As one rape crisis participant reported:

> "I think they just thought, well, there's only a male doctor on today so that's who you can get, instead of looking at the bigger picture...and just having that understanding that having a female doctor is so important."
>
> (Rape Crisis Participant, 270-273).

The quotation above demonstrates the perceived reluctance to address the specific need of the survivor to have access to a woman doctor. All participants acknowledged that survivors have complex needs and having access to skilled women staff was considered particularly significant. This is in line with the findings of Chowdury-Hawkins, Maclean and Welch (2008), whose study of survivor preference in post sexual assault treatment found that seventy-seven per cent of survivors preferred to be treated by a woman doctor.

Participants felt strongly that survivor needs should be recognised but reported that this was often not the case:

> "It doesn't happen because…they (other professionals) think we're being a nuisance (making requests) but we are speaking as an advocate for that woman. We know what she needs but sometimes it's like they don't listen to us."
>
> (Rape Crisis Participant, 131-133).

All of the participants interviewed appeared to have a comprehensive understanding of survivors' needs. The wealth of experience demonstrated by rape crisis centre participants was evident throughout the data. The complex needs identified appeared however to be perceived as difficult for some staff to understand. Two participants in the present study reported that wider recognition of survivors' needs was increasing; however the consensus was that within wider services, survivors' needs, for example, treatment preferences were often overlooked.

Data analysis revealed that participants consistently valued and empathised greatly with survivors with whom they worked; however, analysis revealed that participants were disillusioned by the lack of recognition of survivor needs from others:

> "I just can't understand why some people don't want to listen to what (the survivor) needs. If they don't know then fine, find out. Whether it's us telling them or (the survivor) or someone else, what matters is that they hear it and do something about it"
>
> (NHS Participant, 156-158).

Another participant expressed similar disillusionment in response to the lack of recognition of survivor needs displayed by some staff:

> "Yeh, I don't know why (other professionals ignore survivor needs) because, I feel it. I can understand why (survivors) need these things. I don't understand why people don't. I wish they did."
>
> (Rape Crisis Participant, 344-345).

Various survivor needs were articulated by participants as being frequently overlooked by individual staff in some services these included the need to be listened to and believed by professionals. These were in line with survivor needs that have also been identified by existing research (e.g. Campbell, 2008). Participants in the present study were left with a sense of frustration and disillusionment as a result of these needs being overlooked.

**5.1.2. Denial of sexual issues**

Different participants spoke of their experiences of professionals being reluctant to acknowledge sexual issues in general; as one NHS participant reported:

> "(Staff) don't want to talk about sexual, anything to do with sexual health. There is reticence to address the issue, so they won't deal with it and pretend it's not happening...so disclosure could be dismissed out of hand because they are embarrassed...that happens quite a lot, even (doctors) unfortunately won't talk about sexual violence."
>
> (NHS Participant, 236-240).

Analysis of the interview data indicated that this reluctance was related to the subject of sex being "taboo" and that generally staff were perceived as being uncomfortable discussing it. Furthermore, this quotation demonstrates the wider repercussions of the denial of sexual issues whereby, worryingly, a disclosure of sexual violence may be dismissed altogether. The issue of staff being uncomfortable discussing sexual issues was not limited solely to discomfort regarding talking about sexual violence; as one participant described:

> "It happens quite a lot, as our mystery shopping young people tell us – who went and asked for condoms and got told 'no' just because of (the doctor's) own thoughts on the matter."
>
> (NHS Participant, 242-243).

In this example, a General Practitioner (GP) was described as "reluctant" (NHS Participant, 238) to discuss anything of a sexual nature with patients. The consensus amongst the focus group was that this was not uncommon. Existing literature by Rele and Wylie (2007) suggested that medical staff may be too embarrassed to mention sexuality or inquire about sexual problems in consultations with patients, for fear that they might be misunderstood or that such questions might be upsetting. There was a consensus amongst participants in the present study that staff needed to move on from their personal feelings of embarrassment to be able to address sexual violence appropriately:

> "They (doctors) are so concerned about being PC and about cringing but they really need to be asking the right questions, don't they?"
>
> (NHS Participant, 245-246).

The significance of staff confronting and responding to sexual violence, rather than denying its existence was considered imperative to responding and supporting survivors effectively in the first instance. Further, acknowledging sexual violence and its importance was considered imperative to enabling services to work together effectively following disclosure.

### 5.1.3. Training not taken seriously

A significant barrier to addressing sexual violence effectively that was frequently reported by participants was the difficulty in training staff. Participants across focus groups reported that medical staff and police in particular could be insensitive to issues of sexual violence at times and therefore difficult to deliver training to. These professional groups were perceived as "unreceptive" (Rape Crisis Participant, 279) to training. It was acknowledged by all participants in the present study that professionals needed the skills to address sexual violence with sensitivity when it arises, as one NHS participant pointed out:

> "It's the confidence to do it; we aren't just going to know what to do without training. Everyone needs it, but not everyone wants it or takes it seriously...(disclosure) is not going to happen every day but I suppose….that comes back to training doesn't it?"
>
> (NHS Participant, 347-350).

Training was perceived as a key factor in improving the sensitivity of responses to survivors. Analysis of the data however suggested that there was a perceived reluctance amongst some professional groups to fully engage with sexual violence training. Participants feared that a consequent lack of understanding of the associated issues then caused staff to convey attitudes to survivors that were perceived as detrimental to them. As one participant noted

when describing an incident which occurred with staff at a Genito-Urinary Medicine (GUM) clinic:

> "I don't think they take training seriously sometimes....if they're not conveying belief straight away or they're talking to them... just, well, the girl in particular we are talking about, they just spoke to her, it was horrendous really, they thought it was all down to alcohol and they blamed her that she had been drinking, they shouldn't make that assumption. They need to take a step back and think about what it is like for her coming into that place for treatment."
>
> (Rape Crisis Participant, 308-311).

This quotation demonstrates commonly held misperceptions around sexual violence. Amnesty International (2005) has also found that survivors of sexual violence tended to be "blamed" for their ordeals by the public. It was hoped by participants that training would help to dispel these types of unhelpful responses by staff.

It appeared that negative attitudes towards training were influenced by both some reticence to address sexual violence and an undervaluing of the work in this subject area. This was demonstrated through poor reactions to the training by staff. Inadequate training is recognised within the literature as one reason that medical staff fail to address difficulties of a sexual nature with patients (Gott, Galena, Hinchliff and Eleford, 2004). To address this, participants in the current study emphasised the importance of sexual violence training being compulsory and on-going. Participants felt this would indeed be necessary if services were to keep up to date on the latest policies, procedures and recommendations regarding sexual violence service provision.

### 5.1.4. Negative attitudes towards sexual violence professionals

Three participants from the rape crisis centre reported that their role was viewed as "unprofessional" by staff in some services as one participant explained:

> "They (GUM staff) need to start seeing (rape crisis staff) as professionals...if we phone up and complain about treatment of victims at the GUM clinic we should be taken seriously – we are being a voice for that person. It has been taken to the point where the client had to make a complaint for them to listen. Why didn't they listen to us before?"
>
> (Rape Crisis Participant, 474-478).

This finding was limited to rape crisis participants; many of these participants expressed that their roles were not taken seriously by other services. Analysis revealed that these participants felt that they often had to assert authority in order to make progress; as one participant described in her experience of working with the police:

> "(My experience) was with a police officer...he wouldn't speak with me and queried something about (my role) not being professional, he said he would speak to someone in a professional capacity, and I said well I am calling in a professional capacity, as this clients advocate."
>
> (Rape Crisis Participant, 481-484).

The range of training backgrounds and personal experiences of rape crisis participants was emphasised on several occasions as a potential underlying reason for the uncertainty over how "professional" their roles were perceived. In this way, career pathways for sexual

violence professionals were unclear. Interestingly, existing research shows no correlation of professional training with psychotherapeutic effectiveness (Luborsky et al., 1986; Stein and Lambert, 1984). Therefore the variety of backgrounds of sexual violence professionals is unlikely to be a justified reason for them to be viewed as less effective.

Analysis of the interviews revealed that the impact of being undervalued as a professional had a collateral effect on elements such as training and communication. This is illustrated by the following dialogue between participants in the rape crisis centre focus group:

> (a): They need to (see us as professionals) because if we are going to deliver training...they need to be thinking this is a professional service and these are professional people.
>
> (b): …Yes, we are all trying to work in the client's best interest and focusing on the client...rather than 'I don't want to speak to that agency because I don't see them as professional'. It's not up to us; it's about the client at the end of the day.
>
> (Rape Crisis Participants, 485-492)

It was clear that the rape crisis centre participants felt frustrated that their roles where often not viewed as "professional". The participants felt this often stemmed from a lack of understanding about sexual violence roles. One rape crisis participant exemplified this when talking about her working relationships with police officers:

> "Some are a bit reluctant...I think the problem occurs when they don't particularly understand our roles or what we are trying to do. They think we are just treading on

their toes and making a nuisance of ourselves by ringing up and wanting updates on cases."

(Rape Crisis Participant, 125-127).

Participants from the NHS focus group also expressed similar experiences when sexual violence protocols had been undervalued by staff:

"I've done loads of (sexual violence) protocols and they have end up in drawers and nobody has ever looked at them...for me, people need to own it and play their part in it"

(NHS Participant, 10-12).

This is also reflective of Stern's (2010) report which suggested a range of agencies fail to see sexual violence as their responsibility, as such there is therefore a lack of ownership in responding to survivor needs.

**5.1.5. Lack of empathy**

Empathy was identified as being a key factor in successful service responses to survivors. All participants expressed recognition of sexual violence as being an important and worthwhile issue to address in their work with survivors and expressed empathy towards the clients with whom they worked. This has implications for effective service provision for survivors as research by Frank and Frank (1991) argues that effective therapists and other support sources have qualities of warmth, empathy and genuineness. The present study found there was, however, a perceived lack of empathy from staff in a variety of other services, in particular by the police and medical services. This did not appear to de-motivate participants; rather it

appeared to leave them with a sense of disillusionment, which was a common theme that emerged from several of the participants. The disillusionment with the lack of empathy displayed by some staff was typified by one participant:

> "I think training is key, but the thing is, you can't teach empathy...you can go and train a room full of doctors and train them again and again and again, but how do you teach empathy?"
>
> (Rape Crisis Participant, 313-315).

Unfortunately, and despite training, it was raised by four of the participants that other professionals gave the impression of a having distinct lack of empathy towards survivors, as one participant described:

> "It's about conveying belief from the beginning...unfortunately some people don't – they give the impression they don't believe, which is hard on the victim and so they retract. We do training on this with them (police) but they think they know better than us."
>
> (Rape Crisis Participant, 138-140).

This quotation highlights the impact of lack of empathy towards the survivor, which in some cases caused them to cease criminal proceedings. A further eight participants gave examples of when other professionals appeared to lack empathy and the impact this had on the survivor:

> Interviewer: What do you think is making them struggle to have that empathy?

Participant: I guess it's about society, it's always victim blaming...they put the emphasis on the woman to keep herself safe...if a woman goes out drinking, wearing a short skirt and gets raped, well it's her fault according to society and so when the women goes to the GUM clinic to get a sexual health test...the doctor may have had some of those assumptions herself and she portrayed that to the client. The impact that has on the victim, who feels traumatized anyway, feels that she is probably to blame and thinks 'well the doctor thinks I am as well'.

(Rape Crisis Participant, 316-335).

Analysis of current focus group data revealed that the lack of empathy appeared to stem from misperceptions of sexual violence on the part of some professionals across various services. These misperceptions, appeared to be projected onto survivors; compounding their distress. This is perhaps unsurprising given that literature suggests that myths and misconceptions about sexual violence continue to be widely held amongst the general public as well as professionals (e.g. Bourke, 2007).

Empathy was perceived by all participants as being difficult to cultivate, as the following excerpt from a discussion between a rape crisis participant and the principal investigator revealed:

Interviewer: So how do you think that understanding can be fostered?

Participant: Well, we have delivered training to some (NHS) staff...but some of those doctors who were in that training are the ones you still experience haven't particularly got an understanding.

> Interviewer: So a doctor who may have attended one training session potentially has not taken your messages on board?
>
> Participant: The feedback I got was that it was a time of day where they had been very busy, so a particular nurse had fell asleep during the training and another doctor was talking during it…so I don't think they were listening as much as they should have been. I thought everyone had that caring side; obviously not.
>
> (Rape Crisis Participant, 288-312).

Participants were frustrated by the responses they received when attempting to foster empathy and understanding amongst staff as part of training. These findings have important implications for survivors as studies consistently show that such un-empathic reactions have harmful psychological effects on survivors (Campbell et al., 1999; Davis, Brickman, and Baker, 1991; Ullman, 1996; Ullman and Filipas, 2001). It was acknowledged by participants in the present study that some individuals may never develop an understanding of the issues and that this may therefore impact negatively on service interactions, however as one participant reported:

> "Some are not going to be sensitive and won't ever understand, but we can just go with the ones that do and just try to drip, drip the others".
>
> (NHS Participant, 79-80).

In summary, thematic analysis of the focus groups carried out revealed that the individual barriers to addressing sexual violence were perceived as having a negative impact on meeting survivor needs as well as on inter-agency working. The barriers identified were perceived to influence service responses in various ways, such as through playing down the needs of

survivors, being too embarrassed to ask questions regarding sexual issues, responding poorly to training and displaying a lack of empathy towards survivors. Overall, the analysis revealed that these factors were perceived as negatively affecting the ability of the NHS and voluntary sector staff to form effective inter-agency working relationships. As a result, participants were left feeling frustrated, disillusioned and worried about survivor needs not being adequately met.

**6. Organisational barriers**

In addition to individual barriers to addressing sexual violence, themes of organisational factors affecting inter-agency working and effective service provision were identified. Three primary themes related to organisational factors centred upon competition between services, incompatible models of treatment and the need for enhanced networking. These are explored below.

**6.1. Competition between services**

Participants spoke explicitly about the competition between different services, which they perceived as having a negative impact on the successful provision of a comprehensive response to survivors. This was exemplified by one participant:

> "I hate to say it...but I think there are organisational silos, people don't want to look outside of their organisation and don't want to refer as they worry that their money will be taken away if they refer out…Can I say that? Well it's true, it's like organisational grab, because they think oh, we're not going to send them there, we'll do it."
>
> (NHS Participant, 222-224).

The above quotation demonstrates participant concerns regarding financial constraints and pressures that in turn lead to competition between services. These concerns are in line with Stone's (2004) work in which the author refers to inefficiencies created by services working independently with their own functional interests and goals. In this way, collaborative working suffers and therefore responses for survivors are less effective.

A more fundamental reason for a lack of inter-agency working was articulated by one participant from the rape crisis centre focus group, who felt that some services had been operating in a particular way for a significant period of time, meaning that they found change particularly difficult. As the participant put it:

> "The thing that makes a difference is the atmosphere of (the service) and how developed and forward thinking (the service) are. Some are stuck in the dark ages and do what they want to do"
>
> (Rape Crisis Participant, 187-191).

Drawing on theory from organisational learning, it has been suggested that the failure of organisations to adapt is due to cognitive biases that favour existing routines over alternatives (e.g., Levitt and March, 1988). Perhaps in line with this, participants in the current study felt the services that were difficult to network with, in particular the police, justice and general practices, were so well established that their attitudes towards change were at times perceived by participants as dismissive and uncooperative.

It is interesting to note that services such as the police, justice and general practices are usually much larger and therefore well-resourced than rape crisis centres. Martin (2003) has suggested that smaller agencies may be less able to be responsive to survivors' needs

generally due to lack of resources; hence the increased need for working collaboratively between small and large agencies rather than in competition.

### 6.1.2. Incompatible models of treatment

The use of different models of treatment for survivors was a concern for participants. The conflicting priorities of services in terms of how support for survivors is approached, was felt to be potentially unhelpful for survivors. A participant from the rape crisis centre narrated her experiences:

> "It's a different way of working, the medical model compared to where we work. The medical model...is formulation then treatment; whereas we work with the whole person...you're taking the person for who they are and where they've come from and not just looking for a treatment."
>
> (Rape Crisis Participant, 365-380).

Survivors were acknowledged as having a complex range of needs; however fitting these needs into rigid service models rather than the service adapting to meet the survivors' needs was perceived as problematic at times. Participants described differences between services in the conceptualisation of survivor needs. The following extract from a participant from the rape crisis centre focus group highlights some of the difficulties faced in getting survivor needs met:

> "The (NHS) has very specific roles and remits and there is eligibility criteria. If our clients don't quite fit in, or if the service is oversubscribed or under-resourced and

> they know that (the survivor) is receiving a service from us then they push (the survivor) back rather than thinking more openly 'what can we also do'."
>
> (Rape Crisis Participant, 437-439).

As demonstrated by this quotation, participants frequently expressed that survivor needs were too complex to be met by a rigid treatment approach that was felt to be employed by some services. Many participants across focus groups emphasised the need for an integrated and holistic approach by services in order to provide the survivor with the most appropriate and effective service responses:

> "You are walking alongside them, trying to get them to a place where they will be ok. There are so many other bits that come into it, not just working with (sexual violence) you have to look at the whole person, you can't just stick to what one thing says."
>
> (Rape Crisis Participant, 376-378).

The difficulty in combining the different models of treatment employed by various services was clearly narrated. The preferred approach to treatment was considered to be a holistic one as this was felt to represent a model more complex and comprehensive than, for example, a purely medical approach that focussed on symptoms rather than underlying distress.

#### 6.1.3. The need for enhanced networking

The need for more effective communication between services in order to foster successful working relationships was a prominent theme amongst the focus groups. A call for "enhanced networking" to promote this was seen as key, as one participant described:

> “ It’s not just about going and presenting a PowerPoint, if you can have some real networking between the people so people can ask questions, that’s about making it real so that everyone is engaged.”
>
> (NHS Participant, 261-263).

There was a focus on communication as well as training being “on going” and “constant” as opposed to one-off events. It was felt that this would foster the kind of relationship that promoted effective inter-agency working. It was emphasised by participants that in order to foster such relations between services, trust needed to be present. As one NHS participant described:

> “It's about trust isn't it, being open and sharing the good news and the bad news. I think, holding your hands up when you've done something wrong and saying, yep we've done that and we need to learn from it...so we can build a relationship and not being defensive about what's happened. In the NHS, we're frightened to tell anybody anything.”
>
> (NHS Participant, 307-310).

The importance of trust in groups and organisations has long been noted by researchers (e.g., Golembiewski and McConkie, 1975; Kramer, 1999). Trust has been defined as the expectation that others' future actions will be favourable to one's interests, such that one is willing to be vulnerable to those actions (Mayer, Davis, and Schoorman, 1995; Robinson, 1996). Participants in the current study however felt that fostering trust between services in order to enhance working relationships was particularly difficult. Analysis of the interviews revealed that defensive actions such as not sharing information or being afraid to ask

questions were seen as a common and in turn impacted negatively on trusting and effective relationships between services. Some services in particular, including police services and GP's were considered to be more reluctant to network with other agencies, consequently communication and information sharing with these agencies was perceived as poor.

**7. Summary of findings and discussion**

The present study explored staff perceptions of inter-agency working in the response to survivors of sexual violence. A qualitative methodology, thematic analysis, was utilised to gain a more in-depth understanding of this sensitive subject. Two broad themes emerged from the analysis: 'Individual barriers' and 'Organisational barriers'. The findings will now be explored within the context of the theoretical literature on sexual violence.

The findings from the present study have highlighted a number of barriers to services being able to work effectively together in the provision of adequate and effective support for survivors. The first of these was the individual barriers of some staff to address sexual violence. It was clear in participants' narratives that some individuals were perceived as reluctant to acknowledge issues of sexual violence sensitively and therefore the needs of survivors went unrecognised and were seemingly ignored. This reluctance was perceived to be demonstrated by denial of the existence sexual issues by some staff, by training not being taken seriously, job roles related to sexual violence being perceived as unprofessional and by a lack of empathy displayed by some staff towards survivors.

Additionally, barriers at an organisational level were perceived to be a key factor in creating ineffective working relationships between services. Underpinning this was competition between services, whereby services were reluctant to refer to each other and communicate on behalf of the survivor for fear of losing out on the provision of service. Incompatible treatment models were also identified as detrimental to providing a

comprehensive and holistic treatment approach for survivors. Consequently, the need for enhanced networking was considered vital by participants in broaching the identified gap between the various services accessed by survivors.

Previous studies have found that survivors desire to be asked about sexual violence and those who have not experienced abuse of any kind do not mind being asked (Berenson, Stiglich, Wilkinson and Anderson, 1991; McLeer and Anwar, 1989; Rodriguez, Quiroga and Bauer, 1996). Participants in the present study reported that professionals within services however could be dismissive of sexual issues. This was displayed for example by refusing to issue condoms to young people or to speak about sexual issues. Similar issues have been reported in the wider literature; Buclar and Nolan (1999), for example found that Catholic hospitals were significantly less likely to provide emergency contraception to rape survivors. Worryingly, attitudes and beliefs about sexual issues were perceived to play a significant role in how professionals responded to reports of sexual violence in the present study. Similarly, in an American based study, Ullman and Townsend (2007) highlighted how broader societal attitudes to sexual violence may reflect in institutional responses.

Much of the literature suggests that many people continue to misunderstand the consequences of sexual violence and trivialise its horror and pervasiveness; Anderson, Cooper and Okamuras' meta-analysis of seventy-two studies revealed that attitudes accepting of sexual violence were correlated with being male, of older age and coming from a disadvantaged socio-economic background. Interestingly, participants in the present study frequently described difficulties working with services that were longstanding and traditionally male dominated, for example the police and medical professions. There is a vast body of empirical evidence that there exists a gendered order (or patriarchal society) which gives men a greater chance to succeed in these professions (e.g. Nelson and Burke, 2000). The present study therefore potentially highlights some of the negative repercussions of this.

The participants in the present study highlighted that professionals sometimes had difficulty in engaging with sexual violence training and in particular working closely with voluntary sector agencies due to not viewing them as “professional”. Stern (2010) has suggested that many professionals failed to view sexual violence as their responsibility. The “responsibility” therefore of getting to know sexual violence roles and services may not be a priority for professionals in wider services. Positive examples where sexual violence roles were viewed as professional were also described by some participants. However, the present research found that most often these relationships were with sexual violence professionals who had worked tirelessly to establish their professional roles; it seemed therefore that the default position of sexual violence roles was to be perceived as less important. Amnesty International (2005) has supported this claim highlighting that sexual violence is often overlooked by professionals and is frequently trivialised by the public.

Participants also narrated their experiences of professionals displaying a lack of empathy towards survivors. Participants felt frustrated and disillusioned with this. Interestingly, Cutis-Fawley and Daly (2005) reported similar findings and suggested that those who had been working in the field of sexual violence the longest experienced a greater level of disillusionment with professional responses to survivors. The inability to empathise with survivors may be related to attitudes and personal stereotypes about sexual violence held by the individual. Research has consistently demonstrated that many “rape myths” that dominated thinking regarding sexual violence historically are still widely held today (e.g. Amnesty International, 2005). The present study offers support to this worrying trend. Further, Groves, Augustyn, Lee and Sawires (2004) emphasise that in successful health care interactions professionals should be aware of their own personal assumptions regarding sensitive issues such as sexual violence. Encouragingly, the current study highlighted that

where participants experienced a lack of empathy from other professionals there was a determination to foster empathy through training and persistence in establishing sexual violence roles and protocols within their services. Unfortunately, the aforementioned difficulties in doing this were clearly described by participants.

Results from the present study suggested that organisational factors impacted on the ability of services to able to work effectively together. Participants perceived competition between services to be a significant a barrier to effective inter-agency working. Reasons for this competition included attempts to secure funding by adding value to the service and an "organisational silo" effect. An organisational silo is a term commonly used to refer to situations within organisations that create inefficiencies by working independently with their own functional interests and goals (Stone, 2004). If prevalent within the service, the silo can create significant inefficiencies for inter-agency working. Participants in the current study reported features of silos such as not sharing information, poor communication and not referring to appropriate agencies as being present across organisations that provided services for survivors. This was seen as being detrimental to a collaborative response from services. Interestingly, partnership working is not a new phenomenon; it has been an apparent element of British public policy since the late 1990's. Hunter, Perkins, Bambra, Marks, Hopkins and Blackman (2011) reported however that failures in public services are often blamed on malfunctioning partnerships. In line with this, participants in the present study exhibited similar concerns.

Participants expressed their dedication towards delivering training to services on sexual violence and building links between services; however, medical professionals were frequently cited as one of the most challenging professional group to train and communicate with. In a report by the sexual violence against women subgroup (DOH, 2010), it was recognised that there were effective services being provided by the NHS for survivors;

however, the response across the country was reported as inconsistent. The report recommended compulsory training on all forms of violence for all those working in healthcare settings and that training should involve local specialist support services. Rape crisis centre participants in the present study felt barriers to training and communication with medical professionals in particular were due in part to differences in the medical model approach to treatment, busy workloads and sometimes attitude towards sexual violence. As well as unhelpful attitudes towards sexual violence it is interesting to note that DeLahunta and Tulsky (1996) found that a lack of education on sexual violence; cultural beliefs about women and sexual violence; personal experiences of violence and not seeing sexual violence as part of their role, prevented professionals from responding to sexual violence appropriately. Studies suggest that improving relational factors by service providers, such as trust and sensitivity may enable survivors to overcome the barriers they face when disclosing sexual violence (Battaglia, Finley and Liebschutz, 2003) which importantly may in turn help them to access appropriate services. This was echoed by participants in the present study.

Related to organisational barriers to inter-agency working, there is often a culture of services being separate; this is an international issue resulting in a lack of co-ordinated responses to survivors of sexual violence (e.g. Liebling and Baker, 2010). Findings from this study also lend support to Payne's (2007) investigation which highlighted survivor advocate's difficulties when working with legal and health professionals and found that barriers included lack of understanding of roles, communication problems, funding and misunderstanding of sexual violence. The need for enhanced networking between services to address these problems was consistently described by participants in the present study. It was felt that networking should consist of on-going communication and regular training. The lack of appropriate communication and links between services left participants feeling that effective working relationships were more difficult to form. Barriers such as fear of losing

funding and being afraid to ask questions were felt to become more apparent when networking between services was poor. These findings support Robinson, Hudson and Brookman's (2008) Wales based study which found that challenges faced by agencies working with survivors of sexual violence included funding and staffing issues.

Finally, collaboration between services becomes all the more relevant when survivors have multiple needs. Indeed, all participants in the current study identified survivors as having a complex range of support needs following sexual violence. This is in line with research that consistently shows that survivors may suffer from psychological problems, including post-traumatic stress disorder, depression, low self-esteem, insomnia, and anxiety (Ullman and Fillipas, 2001). Survivors are also at risk of higher rates of maternal mortality, including gynaecological disorders such as pelvic inflammatory disease (Heise, Ellsberg, and Gottmoeller, 2002). The current study therefore reinforces the need for a holistic and multi-agency response to survivor needs (Alberti, 2010).

**8. Implications for Clinical Practice**

The findings from the current research have important implications, including the need to provide more responsive, sensitive and effective services that more closely meet the needs of survivors of sexual violence. Firstly, the results suggest that different services need to work more closely together in order to provide survivors with the comprehensive and holistic responses and treatment they require. In particular, the current research found that where staff within services were reluctant to address sexual violence and unhelpful organisational factors were present collaborative working is hindered and survivors may receive insufficient responses to their needs which in turn may well hinder their recovery process.

Secondly, professionals who work within the field of sexual violence need to be aware that unfortunately their roles may be viewed as "unprofessional" by other, more well-

established services including the police and medical professions. In light of this, work needs to be done to improve the status and recognition of sexual violence professional roles. This could be achieved by increasing professional qualifications associated with sexual violence roles and the advertisement of the work that is being done by sexual violence services.

Thirdly, staff within services accessed by survivors would benefit from being aware of their own assumptions regarding sexual violence, as this seems to impact upon the ways in which survivors are responded to. It would therefore be beneficial for up-to-date sexual violence awareness training to be compulsory for staff at all levels in NHS and voluntary sector services, not limited to medical professionals as is sometimes recommended. This is particularly important as a disclosure of sexual violence could occur at any point in service delivery.

Fundamentally, the findings of the present study point to the need for further strong leadership and a well-communicated vision of appropriate responses to sexual violence if services are to provide effective responses to survivors. It also requires a conscious effort to create and improve partnership working across different agencies, particularly between health, voluntary and justice services, with more regular cross-functional collaboration as has also been argued in responses to survivors internationally (Liebling and Baker, 2010). Liebling and Baker (2010) have argued that sexual violence is experienced simultaneously as a violation of the survivor's body and rights. The current research argues along with Liebling and Baker (2010) in a UK context and supports the view that there is real value in promoting increased collaboration and provision between sectors and services.

Finally, a priority aim could also be to use capacity building within NHS and voluntary services, to sensitively respond to and address the psychological needs of survivors. Sexual violence professionals from the voluntary sector could be supported to work across services, and more effective communication channels established. The latter recommendation

could include scheduled activities with a common purpose and clear, stated objectives linked to overall strategy. The study findings therefore have implications for the importance of developing more effective training across services, improvements to clinical supervision practices and consultation.

**9. Methodological considerations**

Participants in the current study were able to reflect on their experiences of services for survivors of sexual violence from their professional perspectives based on their experiences through the use of focus groups. The use of a qualitative research methodology proved to be an effective and appropriate approach to starting to gain an in-depth understanding of the participants' experiences. In particular, the ability of qualitative research methodology to capture the experiences and views of each individual participant seemed particularly appropriate given the diversity of participants and the complex nature of the subject area. The inclusion of a variety of professionals added to the triangulation of the data.

There are however a number of limitations of the current study that need to be considered. Firstly, it may be assumed that participants interviewed for this study already had an interest in sexual violence given that they were working with survivors. Their perceptions of barriers to effective inter-agency work were indeed insightful however it may have been helpful to interview participants who were not already engaged in work to do with sexual violence in order to ask them directly why this was and what barriers they might have faced. Additionally, a higher number of focus groups from a wider variety of services, especially police and justice may have provided greater insight into the difficulties of collaborative working.

Secondly, participants may have been reluctant to disclose their own shortcomings in contributing to potential barriers to inter-agency working for fear of being perceived as a poor

service. In order to try to overcome this limitation, the participants' confidentiality and anonymity was explained clearly both prior to consenting and again during the interview process. The researcher conducting the interviews was also independent of the services. When considering this limitation, it should be noted that the participants appeared to the researcher to provide very honest and open accounts of their experiences.

**10. Recommendations for future research**

As the focus of the present study was on participants' subjective experiences, it is not possible to draw any firm conclusions on the efficacy of services provided for survivors. Additionally, the small sample size used in this study means that it is also not possible to generalise the findings to other services and survivors. This could be addressed in future research by combining qualitative and quantitative methods together with service outcome measures and higher participant numbers in studies. Specifically, themes emerging from this study could be investigated further in combination with service outcome measures using combined quantitative and qualitative methods across a range of services. In addition, research could be focused on survivors themselves in order to ascertain their views and experiences of service responses.

Results from this study highlighted the importance of public sector professionals including the police and health services working more effectively with voluntary sector professionals. Further research on how working relationships between health, justice and voluntary agencies could be fostered within the arena of sexual violence would add to the current evidence base. It would also be helpful to evaluate services that do use a multi-agency approach and compare these to those that do not.

Finally, the present study has focused on responding to survivors following sexual violence disclosure, within the wider literature less attention has been given to the primary

prevention of sexual violence i.e. addressing the root causes of sexual violence with the aim of reducing the number of new cases. One of the theories to partly explain the continued perpetration of sexual violence is the maintenance of patriarchy and male dominance within a society (Taft, 2009). Patriarchal and male dominance norms reflect gender inequality and inequities at a societal level, and legitimisation of sexual violence against women, men and children (Russo and Pirlott, 2006). Whilst they are located at the societal level, these gender norms and attitudes as well as cultural factors have significant repercussions on community, relationship and individual behaviours. Further research in these areas is urgently needed if we are to reduce the high number of survivors who experience sexual violence.

**References**

Alberti, G. (2010). *Responding to violence against women and children - the role of the NHS: The report of the Taskforce on the Health Aspects of Violence Against Women and Children.* London: Department of Health.

Amnesty International. (2005). *ICM opinion poll*. Retrieved September 10, 2010, from http://www.amnesty.org.uk/news_details.asp?NewsID=16618

Battaglia, T.A., Finley, E., & Liebschutz, J.M . (2003). Survivors of intimate partner violence speak out. *Journal of General Internal Medicine*, *18*(8), 617-623.

Berenson, A. B., Stiglich, N. J.,Wilkinson, G. S.,&Anderson, G. D. (1991). Drug abuse and other risk factors for physical abuse in pregnancy among White non-Hispanic women. *American Journal of Obstetrics and Gynaecology*, *164*, 1491-1499.

Bourke, J. (2007). *Rape: Sex, Violence, History*. Emeryville, CA: Shoemaker & Hoard.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Broman-Fulks, J.J., Ruggerio, K.J., Hanson, R.F., Smith, D.W., Resnick, H.S., Kilpatrick,

D.G., & Saunders, B.E. (2007). Sexual assault disclosure in relation to adolescent mental health: Results from the national survey of adolescents. *Journal of Clinical Child & Adolescent Psychology, 36* (2), 260-266.

Buclar, L. & Nolan, D. (1999). Emergency contraception and catholic hospitals. *Conscience, 20*(1), 20-22.

Campbell, R. (2008). The psychological impact of rape victims experiences with the legal, medical, and mental health systems. *Psychology of women quarterly, 31,* 357-370.

Campbell, R., & Martin, P. Y. (2001). Services for sexual assault survivors: The role of rape crisis centres. In C. M. Renzetti, J. L. Edelson, & R. K. Bergen (Eds.), *Sourcebook on violence against women* (pp. 227-241). Thousand Oaks, CA: Sage.

Campbell, R., Sefl, T., Barnes, H. E., Ahrens, C. E., Wasco, S. M., & Zaragoza-Diesfeld, Y. (1999). Community services for rape survivors: Enhancing psychological well-being or increasing trauma? *Journal of Consulting and Clinical Psychology, 67,* 847-858.

Chowdhury-Hawkins, R., McLean, I., Winterholler. M, & Welch J. (2008). Preferred choice of gender of staff providing care to victims of sexual assault in Sexual Assault Referral Centres (SARCs). *Journal of Forensic and Legal Medicine 15*(6), 363-367.

Corry, D., Pouwhere, T. and Vergura, M. (2008). The Crisis in Rape Crisis: A survey of rape crisis (England and Wales) centres. *Women's Resource Centre.*

Retrieved July 20, 2010, from

http://www.thurrock-community.org.uk/sericc/pdf/wrc_crisis_full.pdf

Coy, M., Kelly, L. and Foord, J. (2007). Maps of Gaps: The postcode lottery of violence against women support services. *End Violence against Women*. Retrieved July 20, 2010 from http://www.equalityhumanrights.com/uploaded_files/research/map_of_gaps1.p

Crawford, A. (1997) *The Local Governance of Crime: Appeals to Community and Partnerships*. Oxford: Clarendon Press.

Curtis-Fawley, S. & Daly, M. (2005). Gendered violence and restorative justice the view of victim advocates. *Violence against Women, 11*(5), 603-638.

Davis, R. C., Brickman, E. R., & Baker, T. (1991). Effects of supportive and unsupportive responses to rape victims: Effects on concurrent victim adjustment. *American Journal of Community Psychology, 19*, 443-451.

DeLahunta, E. A., & Tulsky, A. A. (1996). Personal exposure of faculty and medical students to family violence. *Journal of the American Medical Association*, *275*, 1903-1906.

Department of Health, (2000). *Domestic Violence: A resource manual for health care professionals.* London: Department of Health.

Department of Health, (2001). *Lifestyles Survey: Living in Britain - the 2001 General Household Survey.* London: Department of Health.

Department of Health, (2010). *Taskforce on the health aspects of violence against women and children: Report from the sexual violence against women subgroup.* London: Department of Health.

Department of Justice. (2010). National Institute of Justice. *Department of justice.* Retrieved on September 30, 2010, from, http://www.ncjrs.gov/pdffiles1/nij/210346.pdf

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, *38,* 215-229.

Feist, A., Ashe, J., Lawrence, J., McPhee, D., & Wilson, R. (2007). *Investigating and detecting recorded offences of rape*. Retrieved September 20, 2010, from http://rds.homeoffice.gov.uk/rds/pdfs07/rdsolr1807.pdf

Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore: John Hopkins University Press.

Golembiewski, T., & M, McConkie. (1975). The centrality of interpersonal trust in group process. In C. L. Cooper (Ed.), *Theories of Group Process* (pp. 131- 181). London: Wiley.

Gott M, Galena E, Hinchliff S & Elford H. (2004). Opening a can of worms: GP and practice nurse barriers to talking about sexual health in primary care. *Family Practice*, *21,* 528–536.

Groves, B., Augustyn, M., Lee, D., & Sawires, P. (2004). *Identifying and responding to domestic violence.* Retrieved April 25, 2012 from http://www2.aap.org/pubserv/PSVpreview/pages/Files/Pediatric.pdf

Government Equalities Office. (2010). *The Stern Review Office.* Home Office.

Heise, L., Ellsberg, M., & Gottmoeller, M. (2002). A Global Overview of Gender-Based Violence, *International Journal of Gynaecology and Obstetrics, 78*(1), 5-14.

Heise L,. & Garcia-Moreno C. (2002). Violence by intimate partners. In E. Krug (Ed.) *World report on violence and health* (pp.87–121). Geneva: World Health Organization.

Henwood, K. and Pidgeon, N. (1992). 'Qualitative research and psychological theorizing'. *British Journal of Psychology, 83*, 97-111.

Home Office. (2007). *Cross Government Action Plan on Sexual Violence and Abuse*. Retrieved March 10, 2010, from

http://www.homeoffice.gov.uk/ documents/Sexual-violence-action-plan?view=Binary

Home Office. (2009). *Homicides, Firearm Offences and Intimate Violence 2007/08*. Retrieved July 20, 2010 from http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/hosb0111/hosb0111?view=Binary

Home Office. (2009). *Together We Can End Violence against Women and Girls: A Consultation Paper*. Retrieved April 27, 2010, from http://www.homeoffice.gov.uk/documents/cons2009vaw/vawconsultation.pdf?view=Binary

Home Office. (2009). *Together We Can End Violence Against Women and Girls: a Strategy*. London: Home Office.

Hughes, G. (2007) The Politics of Crime and Community, Basingstoke: Palgrave.

Hunter, D., Perkins, N., Bambra, C., Marks, L., Hopkins, T. & Blackman, T. (2011). Partnership working and implications for governance: issues affecting public health partnerships. *NIHR Service Delivery and Organisation programme*. London: Department of Health.

Jewkes, R., Sen, P. & Garcia-Moreno, C. (2002). Sexual violence. In: Krug EG et al., (Eds.)

*World report on violence and health* (pp. 149–181). Geneva: World Health Organization.

Jordan, J. (2001). Worlds Apart? Women, rape and the police reporting process. *British Journal of Criminology*, *41,* 679-706.

Keel, M. (2005). Sexual assault and mental health in Australia. *ACSSA Newsletter, 6,* 10-22.

Kelly, L., Lovett, J., & Regan, L. (2005). *A gap or a chasm? Attrition in reported rape cases.* Child and women abuse studies unit. London: Home Office.

Kitzinger, J. (1996). Focus Groups. In C. Pope & N. Mays. (Eds.) *Qualitative Research in Health Care* (pp.21-30). London: British Medical Journal Publishing Group.

Konradi, A. (2007). *Taking the Stand: Rape Survivors and the Prosecution of Rapists*. Westport, Connecticut, London: Praeger Publishers Inc.

Koss, M. & Harvey, M. (1991). *The Rape Victim: Clinical and Community Interventions*. London: Sage.

Kramer, R. M. (1999). Trust and distrust in organizations: Emerging perspectives, enduring questions. *Annual Review of Psychology, 50,* 569-598.

Levitt. B. & G. March.(1988). Organizational learning. *Annual Review of Sociology, 14,* 319-340. Palo Alto, CA: Annual Reviews.

Liebling, H., & Baker, B. (2010). *Justice and Health Provision for Survivors of Sexual Violence: a case study of Kitgum, northern Uganda.* Germany: LAP Lambert Academic Publishing AG and Co.

Luborsky, L., Crit, S., Christoph, P., McLellan, A. T. Woody, G., Piper, W., et al. (1986). Do therapists vary much in their success? Findings from four outcome studies. *American Journal of Orthopsychiatry*, *56,* 501-512.

Martin, J. (2003). Mental Health: Rethinking practices with women. In: J.Allan, B. Pease & L. Briskman (Eds.), *Critical Social Work: An Introduction to Theories and Practices* (pp. 155-169). Crows Nest: Allen & Unwin.

Mayer, R. C., Davis, J. & Schoorman, F. (1995). An integrative model of organizational trust. *Academy of Management Review*, *20,* 709-734.

McLeer S. V., & Anwar, R. (1989). A study of battered women presenting in an emergency department. *American Journal of Public Health, 79,* 65-66.

Myhill, A. & Allen, J. (2002). *Rape and the sexual assault of women: the extent and nature of the problem.* Home office: Development and Statistics Directorate.

Office of Public Sector Information. (1998). *Data Protection Act 1998.* London: Stationery Office.

Nelson, D. & Burke, R. (2000). Women executives: health, stress and success. *Academy of management executive, 14*(2), 107-121.

Payne, B. (2007). 'Victim Advocates' perceptions of the role of health care workers in sexual assault cases. *Criminal Justice Policy Review, 18*(1), 81-94.

Payne, S. (2009). *Redefining Justice. Addressing the individual needs of victims and witnesses*. Retrieved September 10, 2010, from http://www.justice.gov.uk/sara-payne-redefining-justice.pdf

Pilchta, S. & Falik, M. (2001). Prevalence of Violence and its Implications. *Women's Health Issues, 11*(3), 244-258.

Povey, D., Coleman, K., Kaiza, P. & Roe, S. (2009). *Homicide, Firearm Offences and Intimate Violence 2007/08*. Home Office Statistical Bulletin. Retrieved June 5, 2011, from, http://www.homeoffice.gov.uk/rds/pdfs09/hosb0209.pdf

Preston, L.D. (2003) 'The sexual assault nurse examiner and the rape crisis centre advocate: a necessary partnership'. *Topics in Emergency Medicine, 25*(3), 242–7.

Reid, K., Flowers, P., & Larkin, M. (2005). Exploring Lived Experience. *The Psychologist, 18*(1), 20-23.

Rele, K. & Wylie, K. (2007). Management of psychosexual and relationship problems in general mental health services by psychiatry trainees. *International Journal of Clinical Practice, 61*, 1701 -1704.

Rennison, C. M. (2002). *Rape and Sexual Assault: Reporting to Police and Medical Attention – 1992-2000*. U.S. Department of Justice. Retrieved July 28, 2010, from http://www.ojp.usd.gov/bjs/pub/pdf/rsarp00.pdf.

Robinson, S. L. (1996). Trust and breach of the psychological contract. *Administrative Science Quarterly*, *41,* 574-599.

Robinson, A., Hudson, K. and Brookman, F (2008) 'Multi-Agency Work on Sexual Violence: Challenges and Prospects Identified From the Implementation of a Sexual Assault Referral Centre (SARC)', *The Howard Journal 47*(4), 411–428.

Rodriguez, M. A., Quiroga S. S., & Bauer H. M. (1996). Breaking the silence: Battered women's perspectives on medical care. *Archived Family Medicine*, *5*, 153-158.

Russo, N and Pirlott, A. (2006). Gender-based violence: concepts, methods, and findings. *Annals of the New York Academy of Science*, *1087,* 178–205.

Smith, J. A. (2003). *Qualitative psychology: A practical guide to research methods*. London: Sage.

Stein, D. M., & Lambert, M. J. (1984). On the relationship between therapist experience and

psychotherapy outcome. *Clinical Psychology Review, 4,* 127-142.

Stern, V. (2010). *The Stern Review.* Home Office: London.

Stone, F. (2004). Deconstructing silos and supporting collaboration. *Employment Relations Today, 31*(1), 11-18.

Taft, A. (2003). Promoting women's mental health: The challenges of intimate/domestic violence against women. *Australian Domestic & Family Violence Clearing House, 8,* 1-24.

Taft, C. (2009). Intimate partner violence against African American women: an examination of the socio-cultural context. *Aggression and Violent Behavior, 14,* 50–58.

Tjaden, P., & Thoennes, N. (2006). *Extent, Nature and Consequences of violence against women: Findings from the National Violence Against Women Survey.* United States: Washington, DC.

Ullman, S. E. (1996). Do social reactions to sexual assault victims vary by support provider? *Violence and Victims, 11,* 143-156.

Ullman, S. E., & Filipas, H. H. (2001). Predictors of PTSD symptoms and severity in sexual assault victims. *Journal of Traumatic Stress, 14,* 369-389.

Ullman, S.E., & Filipas, H.H. (2001). Correlates of formal and informal support seeking in sexual assault victims. *Journal of Interpersonal Violence, 16*, 1028-1047.

Ullman, S. E. & Townsend, S. (2007). Barriers to working with sexual assault. A qualitative study of rape crisis centre workers. *Violence against women, (13)*4, 412-443.

Women's Aid. (2008). *Violence Statistics*. Retrieved September 30, 2010, from www.womensaid.org.uk/domestic-violence-survivorshandbook. asp?section=000100010008000100360002

World Health Organization. (2001). *Transforming health systems: gender and rights in reproductive health. A training curriculum for health programme managers.* Retrieved April 18, 2012 from http://www.who.int/reproductivehealth/publications/gender_rights/RHR_01_29/en/

World Health Organization. (2001). Transforming health systems: gender and rights in reproductive health. A retaining curriculum for health programme managers. Retrieved April 18, 2012 from http://www.who.int/reproductivehealth/publications/gender_rights/

World Health Organization. (2009). *Violence Against Women, Fact sheet No 239*. Retrieved June 10, 2010, from http://www.who.int/mediacentre

World Health Organization. (2010). *Preventing intimate partner and sexual violence against women: taking action and generating evidence.* Retrieved April 25, 2012, from http://whqlibdoc.who.int/publications/2010/9789241564007_eng.pdf

## Chapter 3

Reflective paper

Service Responses for Survivors of Sexual Violence:

A Reflective Account

(Words: 1,979; exclusive of references)

Prepared for submission to

Psychology of Women's Quarterly
(See Appendix G)

**Abstract**

The present paper provides a reflective account of the process of conducting a qualitative research study with professionals who work with survivors of sexual violence. The reflections focus upon the impact of opinions and emotions on sexual violence research. The account considers both personal and epistemological factors which may have impacted on the research process.

## 1. Introduction

The present paper provides a reflective account of the process of conducting a qualitative research study with professionals who work with survivors of sexual violence. For the study, two focus groups were carried out with a variety of staff from the National Health Service (NHS) and a rape crisis centre.

Sexual violence is unquestionably an emotive area within which to work and researching this subject brings with it further complexities when one begins to consider the role of emotions in the process of research. Given the highly emotive subject area of the study, I have chosen to focus the present paper on the impact of emotions on sexual violence research. The account will begin with a brief introduction to reflexivity and how this has been used to guide my reflective process.

## 2. Reflexivity

Finlay (2002) defined reflexivity as “the project of examining how the researcher and inter-subjective elements impinge on, and even transform, research” (p. 210). Willig (2001) extended this definition further by differentiating between *personal* and *epistemological* reflexivity. Personal reflexivity, she suggested, involves “reflecting upon the ways in which our own values, experiences, interests, beliefs, political commitments, wider aims in life and social identities have shaped the research” (p. 11). On the other hand, epistemological reflexivity “requires us to engage with questions such as: How has the research question defined and limited what can be found? How has the design of the study and the method of analysis ‘constructed’ the data and the findings?’ (p. 11). Both personal and epistemological reflexivity will be considered in the present paper.

## 2.1 Personal reflexivity

Elliott, Fisher & Rennie (1999) stated that it is good practice when carrying out qualitative research to "own one's perspective" and for the author to specify their theoretical orientations. They suggested that this increases the transparency of the analysis of data and allows for other, alternative interpretations to be considered. This section will provide further insights into the analytical interpretations utilised in the empirical paper (Bishop and Liebling-Kalifani, 2013), as these may have been influenced by my background, preconceived beliefs, ideas and assumptions.

## 3. Theoretical position and values

I believe my interest in feminist theory shaped the research process. Sexual violence is largely a gendered crime and Greenfield (1997) argued that 91% of survivors of are women, whilst almost 99% of perpetrators are men. In light of these estimates and of the broader ideological dynamics and social consequences of sexual violence, feminists have long argued that sexual violence harms not only survivors, but also women and girls as a group. In line with feminist approaches, I am committed to ensuring that women's experiences of sexual violation are taken seriously, that the harm they suffer is recognised, and that those who inflict that harm are held accountable. The choice of topics for my literature review (Bishop, Liebling-Kalifani and Kucharska, 2013) and empirical study (Bishop and Liebling-Kalifani, 2013) undoubtedly reflect this.

Whilst exploring the background to the empirical study, I discovered that virtually all feminist thinking about sexual violence shared underlying themes. Significant to my study, amongst these is feminists' emphasis on "breaking the silence" around sexual violence. Feminist thought and activism has challenged the myth that sexual violence is rare and exceptional, showing that it is in fact a common experience in the lives of women, children and increasingly men.

Through conducting focus groups as part of the empirical study, I met a variety of professionals who had experienced working with a wide range of survivors of sexual violence. From this, I gained an acute awareness of the fact that sexual violence can happen to anyone. My background reading also suggested that, as a woman, I too am at a continued risk of being subjected to sexual violence based purely on my gender. Needless to say, these are some rather depressing truths to be faced with on a daily basis.

However, working on this research was not the first contact I have had with working with sexual violence. In previous roles, I have worked with women who had experienced sexual abuse and had co-facilitated a domestic abuse group. These experiences taught me that attuning to my emotions was an important element of understanding survivors' experiences of sexual violence. As difficult as these emotions were to attune with, they were also imperative to be mindful of.

To facilitate attunement, I kept notes to document the emotional process of the research as well as other important contextual issues regarding the research process. This process enabled me to recognise the impact that the research was having on me emotionally and thus to take steps reflect during data analysis and in supervision sessions, as well as ensuring breaks from the work. As well as enabling me to process through writing my feelings, it also assisted me with the process of developing codes and categories from my interviews.

Throughout the research process, I found a tendency to want to distance myself from the research at times, and indeed distance myself from related topics when I was not working. I considered this emotional distancing to be normal, created by socialisation, whereby we are all expected to be in control of our emotions for the most part and to avoid things which make us feel too emotionally distressed. I am aware however, of the strong opinions that I hold on the topic of sexual violence, and as such it was not possible for me to distance myself from

these; as they form part of my identity. It should therefore be highlighted, that in this study, there was the risk that I would examine the evidence in a biased manner. On the other hand however, my position as a woman, interested and sensitive to the subject area, external to the services where the research was carried out and utilising my skills as a trainee clinical psychologist appeared to assist participants in being able to open up to me and tell me their experiences.

Nevertheless, strong opinions on any subject matter are likely to be laden with emotion. Conventional scientific opinion towards objectivity would imply that subjectivity and emotions could hinder valid scientific work and should therefore be excluded from the research process. With this in mind, I reflect back to one of the findings of my literature review, where I examined a survivor's account of restorative justice. She asked, "How can anyone understand what it is like to be raped, unless they have been raped?". Drawing upon this I asked myself, how can anyone research sexual violence unless they can take into consideration as part of the research, the complex range of emotions and opinions which it will inevitably tap in to? In this way, emotional responses and consequent opinions are natural part of such sensitive inquiry because it cannot be removed so therefore must be considered in its own right.

Philosophers exert the impact of such factors and "humanness" on research (Habermas, 1984). Examples of this can also be seen in the work of social scientists (for example, Campbell, 1987). In this way, the idea that researcher's values and feelings influence their work is relevant if we are to truly understand participants' experiences. In any case, since we cannot rid ourselves of our values and emotion response it is therefore necessary that we reflect on them astutely.

## 4. Epistemological reflexivity

One of the factors which influenced this study was the use of only women participants. Although this was not intentional, only women participants volunteered to take part. There is an increasing recognition of the prevalence of sexual violence against men, which is a valid and yet under-researched area. However, there are consistent estimates of a higher incidence of sexual violence against women (Greenfield, 1997) and the desire for survivors to have access to women professionals has been highlighted (Chowdury-Hawkins, Maclean and Welch, 2008). Therefore, there was increased opportunity to gain access to professionals who happened to be women within the relatively short time scale allocated to the study.

Interestingly, in the vast majority of documented history women were considered to be the property of men; with their value as property measured by their sexual purity. In line with this, sexual violence has been regarded as a property crime against a woman's husband or father (Burgess-Jackson, 1996, pp. 44-49). In this way a woman who had been raped was less valuable as property, and penalties therefore involved the payment of fines or compensation to her husband or father (Burgess-Jackson 1996, p. 68). Significantly, the marital rape exemption law was only abolished in the United Kingdom little over twenty years ago which is clearly a relatively recent residue of the view that women are the property of a man and therefore likely to still play a role in today's societal responses to sexual violence. Given this entrenched historical and cultural legacy, the sample of only women participants may well be justified in the wider historical context.

### 4.1 Epistemological Position

Willig (2001) stated that part of the epistemological reflexivity process involves a consideration of how the method of analysis affects the data and outcomes of the study. For the empirical study, I used a thematic analysis approach (based on Braun and Clarke, 2006).

This epistemological position may have influenced the stages of the research process. For example, during the focus groups I emphasised to the participants that, although I had some prepared questions as a guide, I was keen for them to offer their own thoughts and ideas. This is consistent with qualitative approaches, where participants are positioned as the experts on their own thoughts, feelings and commitments (Reid, Flowers and Larkin, 2005). Effort was made to establish rapport with participants before interviews and focus groups by email and telephone correspondence in order to try to assist participants in feeling comfortable and able to express themselves within focus group sessions. These factors may well have influenced the data that I collected.

**5. Concluding comments**

I found the process of conducting the empirical study (Bishop and Liebling-Kalifani, 2013) to be a challenging, yet rewarding process. The process was emotive at times; and engagement with these emotions led me to develop greater insight into the experience of sexual violence for survivors and service responses to this. For these reasons, I felt committed to fully engage with the data and produce a study that reflected the narrative of those who participated as closely as possible. I intend to feedback the results of the study to participants and also to publish the research findings to allow participant’s experiences to be shared in order that services in the future may be able to respond to survivors more effectively.

What I found most striking from conducting the research were the findings from the literature review (Bishop et al., 2013) regarding the lack of justice for survivors and the lack of evaluation of restorative justice (RJ) practices. This was compounded by the empirical paper (Bishop and Liebling-Kalifani, 2013) where some participants' described experiences of survivors’ harrowing ordeals with the criminal justice system. In anecdotal conversations with survivors of sexual violence who I met through the rape crisis centre, I was asked what my thesis consisted of and consequently I described what RJ was. All survivors were

extremely interested in the RJ concept, and told me that based on their negative experiences of the criminal justice system they would have preferred an RJ response to their disclosure. I found this frustrating as I knew from my background reading (Restorative Justice Council, 2012) that survivors of sexual violence may indeed be able to access RJ. I feel that RJ in cases of sexual violence could potentially be a highly valuable resource for survivors, which is not currently routinely offered. Given the opportunity, I would be very interested to take forward research in this area.

**References**

Bishop, S., & Liebling-Kalifani, H. (2013). Service Responses to Survivors of Sexual Violence. *Unpublished.*

Bishop, S., Liebling-Kalifani, & H., Kucharska, J. (2013). The use of Restorative Justice in Response to Sexual Violence. *Unpublished.*

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Burgess-Jackson, K. (1996). *Rape: A philosophical investigation*. Brookfield: Dartmouth Publishing.

Campbell, D. T. (1987). Evolutionary epistemology. In Radnitzky, G., Bartley, W., Popper, K (Eds.), *Evolutionary epistemology, rationality, and the sociology of knowledge* (pp. 47–89). Open Court.

Chowdhury-Hawkins, R., McLean, I., Winterholler, M. & Welch, J. (2008). Preferred choice of gender of staff providing care to victims of sexual assault in Sexual Assault Referral Centres (SARCs). *Journal of Forensic and Legal Medicine 15*(6), 363-367.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, *38,* 215-229.

Finlay, L. (2002). Negotiating the swamp: the opportunity and challenge of reflexivity in research practice. *Qualitative Research*, *2*, 209-230.

Greenfield, L. (1997). *Sex Offenses and Offenders: An Analysis of Data on Rape and Sexual Assault.* Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.

Habermas, J. (1984). *The Theory of Communicative Action, Vol. 1: Reason and the Rationalization of Society*. ( T. McCarthy Trans). Boston, MA: Beacon Press.

Reid, K., Flowers, P., & Larkin, M. (2005). Exploring lived experience. *The Psychologist*, *18,* 20-23.

Restorative Justice Council. (2012). *What is restorative justice?* Retrieved April 5, 2012 from http://www.restorativejustice.org.uk

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Buckingham: Open University Press.

# Appendices

# Appendix A

## Ethical Consent

**National Research Ethics Service**
**NRES Committee West Midlands - Coventry & Warwickshire**
Prospect House
Fishing Line Road
Enfield
Redditch
B97 6EW
Telephone: 01527 582532
Facsimile: 01527 582540

**Date:** 12 July 2011

Miss Sarah M Bishop
Trainee Clinical Psychologist
Coventry and Warwick Partnership Trust
79 Avenue Road
Kings Heath
Birmingham
B14 7TG

Dear Miss Bishop

**Study title:** **Responding Effectively to Women Survivors of Sexual Violence: A Comparative Examination of Responses by Health Service Workers and Specialist Sexual Violence Workers to inform Good Practice**
**REC reference:** **11/WM/0138**

Thank you for your email of 12 July 2011, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

**Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

**Ethical review of research sites**

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

**Conditions of the favourable opinion**

The favourable opinion is subject to the following conditions being met prior to the start of the study.

the start of the study at the site concerned.

*Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.*

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

*Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of approvals from host organisations*

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

**Approved documents**

The final list of documents reviewed and approved by the Committee is as follows:

| Document | Version | Date |
|---|---|---|
| Advertisement Staff | 2.0 | 21 June 2011 |
| Covering Letter | | 14 April 2011 |
| Evidence of insurance or indemnity | | 01 July 2010 |
| Interview Schedules/Topic Guides | 1.0 | 14 April 2011 |
| Investigator CV | | |
| Letter from Sponsor | | 14 April 2011 |
| Summary CV for supervisor | | |
| Email from Sarah Bishop | | 12 July 2011 |
| Advertisement Women | 2.0 | 21 June 2011 |
| Participant Consent Form | 2.0 | 21 June 2011 |
| Participant Information Sheet: Health Staff | 4.0 | 12 July 2011 |
| Participant Information Sheet: Women Survivors | 4.0 | 12 July 2011 |
| Participant Information Sheet: Specialist Services Staff | 4.0 | 12 July 2011 |
| Protocol | 1.0 | 14 April 2011 |
| REC application | IRAS 3.1 | 11 April 2011 |

**Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

**After ethical review**

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

| **11/WM/0138** | **Please quote this number on all correspondence** |
|---|---|

With the Committee's best wishes for the success of this project

Yours sincerely

**Dr Helen Brittain**
**Chair**

Email: Rosa.Downing@westmidlands.nhs.uk

Enclosures: "After ethical review – guidance for researchers" SL-AR2

Copy to: Kelly Spencer
Coventry & Warwickshire Mental Health Partnership Trust
University Hospital Coventry and Warwick
4th Floor Rotunda [ADA40017]
CV2 2DX

Priory Street, Coventry CV1 5FB
Telephone 024 7688 8328
Fax 024 7688 8702

**Programme Director**
**Doctorate Course in Clinical Psychology**
Dr Eve Knight
BSc Clin.Psy.D. CPsychol

**TO WHOM IT MAY CONCERN** RRU/Ethics/Sponsorlet

September 2011

Dear Sir/Madam

**Researcher's name:** **Miss Sarah M Bishop**
**Project Title:** **Responding Effectively to Women Survivors of Sexual Violence: A Comparative Examination of Responses by Health Service Workers and Specialist Sexual Violence Workers to inform Good Practice**

The above named student has successfully completed the Coventry University Ethical Approval process for her project to proceed.

I should like to confirm that Coventry University is happy to act as the sole sponsor for this student and attach details of our Public Liability Insurance documentation.

With kind regards

Yours faithfully

**Professor Ian Marshall**
**Deputy Vice-Chancellor, Academic**

Enc

Coventry and Warwickshire NHS
Partnership Trust

West Midlands (South) Comprehensive Local Research Network
Fourth Floor, West Wing (ACF40002)
University Hospitals Coventry & Warwickshire NHS Trust
University Hospital
Clifford Bridge Road
Coventry
CV2 2DX

18th August 2011

Sarah Bishop
Trainee Clinical Psychologist
Coventry and Warwickshire Partnership Trust
79 Avenue Road
Kings Heath
Birmingham
B14 7TG

Dear Sarah

**Project Title: Responding Effectively to Women Survivors of Sexual Violence: A comparative Examination of Responses by Health Service Workers and Specialist Sexual Violence Workers to inform Good Practice**
**R&D Ref: PAR060611**
**REC Ref: 11/WM/0138**

I am pleased to inform you that the R&D review of the above project is complete, and the project has been formally approved to be undertaken at Coventry and Warwickshire Partnership NHS Trust. Your research activity is now covered by NHS indemnity as set out in HSG (96) 48, and your trial has been entered onto the Trust's database.

The following documents were reviewed:

| Document | Version | Date |
|---|---|---|
| NHS R&D Application Form | 70012/218508/14/110 | 27/05/11 |
| NHS Site Specific Information Form | 70012/207175/6/33/87601/210988 | 27/05/11 |
| REC Favourable Opinion Letter | - | 12/07/11 |
| Protocol | 1.0 | 14/04/11 |
| Participant Information Sheet: Health Staff | 4.0 | 12/07/11 |
| Participant Information Sheet: Women Survivors | 4.0 | 12/07/11 |
| Participant Information Sheet: Specialist Service Staff | 4.0 | 12/07/11 |
| Participant Consent Form | 2.0 | 21/06/11 |
| Advertisement Women | 2.0 | 21/06/11 |
| Advertisement Staff | 2.0 | 21/06/11 |
| Interview Schedules | 1.0 | 14/04/11 |

| PI/CI investigator CV | - | - |
|---|---|---|
| Evidence of Insurance or Indemnity | - | - |
| Letter from Sponsor | - | 14/04/11 |
| | | |

Your responsibilities are set out in the attached agreement, which must be signed and returned to the R&D Office. You should keep a copy for your records.

All research must be managed in accordance with the requirements of the Department of Health's Research Governance Framework (RGF) and to ICH-GCP standards. In order to ensure that research is carried out to these standards, the Trust employs the services of an external monitoring organisation to provide assurance. Your study may be randomly selected for audit at any time, and you must co-operate with the auditors.

The duration of Trust approval extends to the date specified in the R&D application form. Action may be taken to suspend Trust approval if the research is not run in accordance with RGF or ICH-GCP standards, or following recommendations from the auditors. Research must commence within two years of the REC approval date and within six months of NHS Permission.

I wish you well with your project. Please do not hesitate to contact me should you need any guidance or assistance.

Yours sincerely

**Manjit Kaur**
**R&D Facilitator**

**Cc:** Sponsor Ian Marshall, Coventry University

## Appendix B

## Study Advertisement Poster

THE UNIVERSITY OF WARWICK

Coventry University

Coventry and Warwickshire NHS Partnership Trust

# Primary Care NHS Staff

# &

# Specialist Sexual Violence Service Staff

# Are required for a study on:

## *Service Responses*

## *to Survivors of*

## *Sexual Violence.*

As part of my doctoral degree in Clinical Psychology I am carrying out a study to look women's experiences of services following disclosure of sexual violence.

I hope that through this study we can improve our understanding of women's experiences of services following disclosure, specifically in helping to identify examples of good practice and areas in which development is needed. I hope that this will improve the help and support that is offered to women during this time.

If you choose to take part you will participate in a focus group and you will be asked questions on your views of services for women who have survived sexual violence.

If you are interested in taking part in the study or have a few questions you wish to ask before you opt-in, please feel free to contact me either by telephone on:

**07931 463 861**, or by email on **bishops5@coventry.ac.uk**

Thank you,

Sarah Bishop

Trainee Clinical Psychologist

Coventry & Warwick Universities.

## Appendix C

## Interview Schedule

**<u>Focus Group Interview Schedule Outline</u>**

**Overall research Questions**

What are the experiences of professionals, survivors and voluntary services in providing support for survivors of sexual violence?

What are the factors that enhance and restrict this collaboration?

What are the current experiences of these services and the support provided to survivors?

What are participant's views about how these could be improved?

**Additional questions to aid discussion for focus groups:**

What are the factors that motivate staff to working with this client group?

How do providers support survivors of sexual violence?

What are the services provided?

Do they experience difficulties in this role?

What are their expectations of liaison between different agencies in supporting survivors?

Do they feel their services provide effective and sensitive responses to survivors?

What are the implications of this for training?

## Appendix D

## Study Information Sheet

Coventry and Warwickshire NHS
Partnership Trust

**Service Responses to**
**Survivors of Sexual Violence**

Sarah Bishop
Trainee Clinical Psychologist
Coventry and Warwick Doctoral Course
in Clinical Psychology
James Starley Building
Priory Street
Coventry
Email: bishops5@coventry.ac.uk
Tel: 07931 463 861

**Participant Information Sheet**

As part of my doctoral degree in Clinical Psychology I am carrying out a study to look women's experiences of services following disclosure of sexual violence.

I hope that through this study we can improve our understanding of the experiences of women following disclosure, specifically in helping to identify examples of good practice and areas in which development is needed. I hope that this will improve the help and support that is offered to women during this time.

Who can take part?

Primary care NHS staff and voluntary sectors staff who have worked with survivors of sexual violence.

What will the study involve?

If you choose to participate in the study, you will take part in a focus group which will be facilitated by Sarah Bishop at a local Coventry and Warwickshire partnership Trust site. The focus group will involve Sarah asking you some questions about your views on services for women survivors of sexual violence.

The focus group will last approximately between one, and one and a half hours.

What will I have to do?

You will take part in a focus group along with other members of staff. I will ask the group questions about their views on services for women survivors of sexual violence. If you would like to take part in the study please contact me by telephone on 07931 463 861 or email on

bishops5@coventry.ac.uk. I will take your contact details and then contact you to arrange a date and time for the focus group.

Will the information I provide be confidential?

Each focus group will be recorded using a digital audio recorder and then typed up and saved in a password protected Word document. All identifying information will be removed from the transcripts, and the tape recording will be erased after 4 weeks.

Direct quotes from the interviews will be used in the write up of this study. However, all quotes will be anonymised so that it is not possible to identify you from the quotation.

What we talk about in the interview is confidential. However, if you talk about something that makes me concerned about a potential risk to yourself or others, I have a duty to disclose this information to a third party, for example the supervisors of the research. If this occurs, I will make every effort to discuss this with you before sharing any information.

Do I have to take part?

There is no obligation for you to take part in the current study. Your professional role as a will not be affected if you decide not to participate in the study.

What if I have further questions?

If you are interested in taking part in the study but have a few questions you wish to ask before you opt-in, please feel free to contact me either by telephone on 07931 463 861, or by email on bishops5@coventry.ac.uk

What if I have any concerns or a complaint about the study?

If you would like to express any concerns, or make a complaint about the study please write to me at the above address, or contact me by email on bishops5@coventry.ac.uk.

The research project has been developed under the supervision of, Dr. Helen Liebling-Kalifani and Dr. Ruth Jones who both have specialist interest in women's services. If you have any concerns you can email either of my supervisors on hsx497@coventry.ac.uk or ruth.jones@zen.co.uk.

The study is sponsored and indemnified (in line with Department of Health Research Governance Framework) by Coventry and Warwickshire Partnership Trust. It (will be) reviewed and fully approved by Coventry and Warwick Research Ethics Committee.

## Appendix E

## Consent Form

Coventry and Warwickshire NHS
Partnership Trust

**Title of Study**: Service Responses to Survivors of Sexual Violence

**Researcher:** Sarah Bishop, Trainee Clinical Psychologist, Coventry University, Priory Street, Coventry, CV1 5FB

**Please initial box**

1 I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2 I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐

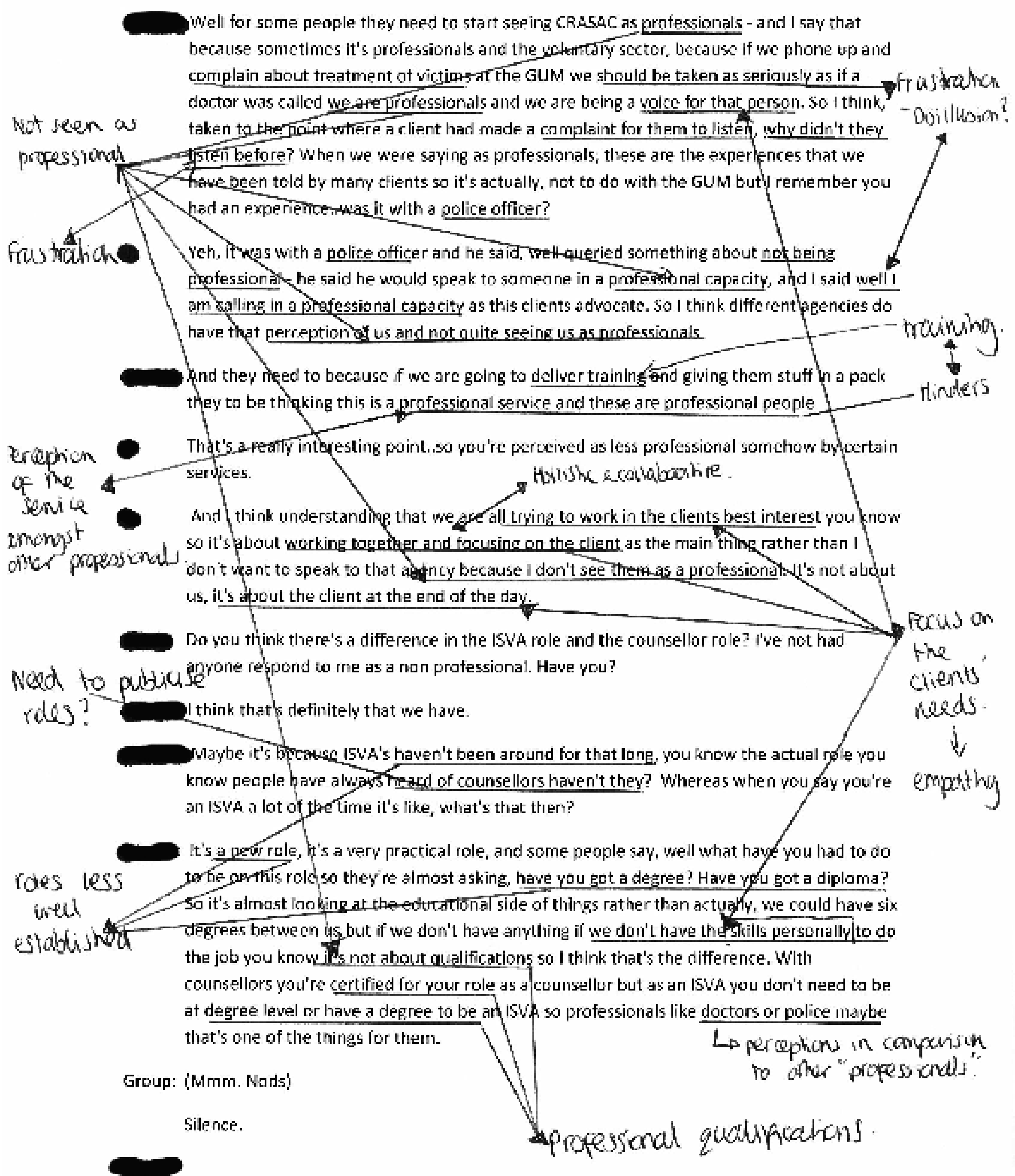
3 I agree to take part in the above study. ☐

4 I agree for my interview to be recorded and transcribed for the research study ☐

| ______________________ | ______________ | ______________________ |
|---|---|---|
| Name of Participant | Date | Signature |
| ______________________ | ______________ | ______________________ |
| Name of person taking consent | Date | Signature |

## Appendix F

## Extract of analysed transcript



Well for some people they need to start seeing CRASAC as professionals - and I say that because sometimes it's professionals and the voluntary sector, because if we phone up and complain about treatment of victims at the GUM we should be taken as seriously as if a doctor was called we are professionals and we are being a voice for that person. So I think, taken to the point where a client had made a complaint for them to listen, why didn't they listen before? When we were saying as professionals, these are the experiences that we have been told by many clients so it's actually, not to do with the GUM but I remember you had an experience, was it with a police officer?

Yeh, it was with a police officer and he said, well queried something about not being professional - he said he would speak to someone in a professional capacity, and I said well I am calling in a professional capacity as this clients advocate. So I think different agencies do have that perception of us and not quite seeing us as professionals.

And they need to because if we are going to deliver training and giving them stuff in a pack they to be thinking this is a professional service and these are professional people

That's a really interesting point..so you're perceived as less professional somehow by certain services.

And I think understanding that we are all trying to work in the clients best interest you know so it's about working together and focusing on the client as the main thing rather than I don't want to speak to that agency because I don't see them as a professional. It's not about us, it's about the client at the end of the day.

Do you think there's a difference in the ISVA role and the counsellor role? I've not had anyone respond to me as a non professional. Have you?

I think that's definitely that we have.

Maybe it's because ISVA's haven't been around for that long, you know the actual role you know people have always heard of counsellors haven't they? Whereas when you say you're an ISVA a lot of the time it's like, what's that then?

It's a new role, it's a very practical role, and some people say, well what have you had to do to be on this role so they're almost asking, have you got a degree? Have you got a diploma? So it's almost looking at the educational side of things rather than actually, we could have six degrees between us but if we don't have anything if we don't have the skills personally to do the job you know it's not about qualifications so I think that's the difference. With counsellors you're certified for your role as a counsellor but as an ISVA you don't need to be at degree level or have a degree to be an ISVA so professionals like doctors or police maybe that's one of the things for them.

Group: (Mmm. Nods)

Silence.

## Appendix G

## Submission Guidelines: Psychology of Women's Quarterly

**Submission Guidelines:**

**Psychology of Women's quarterly**

Follow the general style guidelines set forth in the Publication Manual of the American Psychological Association (6th edition). The entire manuscript - including abstract, quotations, notes, references, figure captions, and tables - must be typed double-spaced. Manuscript pages must be numbered consecutively. The use of sexist or ethnically biased language is unacceptable. Except under unusual circumstances, authors are expected to make available upon request all previously unpublished questionnaires or scales used in an article. The Editor may find it necessary to return a manuscript for reworking or retyping that does not conform to requirements.

*Title and Acknowledgements (page 1).* To facilitate masked review, all indication of authorship must be limited to this page (other pages must show the short title plus page number at the top right). Include on the title page (a) full article title, (b) names and affiliations of all authors, (c) acknowledgments, and (d) mailing and email addresses and telephone and fax numbers of the individual serving as the point of contact.

*Abstract and Keywords (page 2).* Abstract should not exceed 200 words. After the abstract, list appropriate keywords for the manuscript, preferably using terms from the Thesaurus of Psychological Terms.

*Text (page 3).* Use a five-character paragraph indent. Do not use desktop publishing features, such as right margin justification or underline. Only bold and italics may be used. Use a 12-point typeface.

*References.* References cited in text must appear in the reference list, and entries in the reference list must be cited in the text. Follow the examples in the 6th edition of the APA manual for specific guidelines.

*Notes.* Footnotes are not permitted in the text. If necessary, endnotes may be used. Number consecutively throughout text and list on a separate page preceding the following section.