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The health, mental health and well-being benefits of Rape Crisis Counselling,

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Abstract

There is very little research on interventions to alleviate the distress experienced following rape. This action research project developed and piloted the 'Taking Back Control' tool that measured the impact of Rape Crisis counselling over time. Five Rape Crisis Centres in the North of England agreed to pilot the tool, which was administered by the client's counsellor, either on week one or two, and then repeated every six weeks until the end of counselling. 87 clients completed at least two questionnaires. This allowed us to measure change from their first compared with their last data collection point. The most change was made in relation to the statement 'I feel empowered and in control of my life', where 61% strongly/disagreed at the first data collection point compared to 31% at the last data collection point. Large shifts were also seen in relation to 'I have 'flashbacks' about what happened' and 'I have panic attacks'. Overall, some degree of positive change was seen for all measures. This research, despite some limitations, begins to develop an evidence base for Rape Crisis Centres to demonstrate their benefits and to assess and develop their own practice.

Keywords: Rape Crisis, counselling, health, longitudinal research.

Introduction

One woman was in mental health services for fifteen years and no one ever asked her. She had not shared the fact she had been abused as a child, or been asked the right kind of questions. She had been heavily medicated, went from one psychologist to another. All these people had been involved and were not even aware of the underlying causes of why they were treating her. (Rape Crisis worker)

I remember having a 16 year old girl come to us. She had been on anti-depressants since she was 10 because of sexual abuse by a family member. No-one in the health service had ever picked up on why, or even asked her questions about why she was depressed. (Rape Crisis worker)

Rape Crisis Centres have provided support to survivors of rape and other forms of sexual violence in England and Wales since the late 1970s. There currently exist around 45 such Centres across England and Wales, with a further 13 in Scotland. Alongside their role in relation to criminal justice, as the above quotes exemplify, they also play an important role in dealing with the 'root cause' of many issues relating to health, mental health and well-being. This role is often overlooked, however. In 2007-8, less than 8% of Rape Crisis funding came from local health authorities (Women's Resource Centre and Rape Crisis 2008), and that health commissioners often overlooked Rape Crisis, seeing them as 'niche' or even

irrelevant to health commissioning (Women's Resource Centre, 2007). In addition, there is a dearth of evidence on the long term impact of rape counselling (Brown et al., 2010).

Continuous funding difficulties led to a marked decline in the number of these Rape Crisis Centres in England and Wales between the early 1990s and late 2000s. These factors, alongside a move towards evidence-led commissioning and greater competition for more limited resources, has resulted in a pressing need to evidence the impact of the interventions they provide. .

This action research project developed and piloted a tool called the 'Taking Back Control' tool that measures the impact of Rape Crisis counselling on health, mental health and well-being over time. After a review of relevant literature, this article describes how the Taking Back Control scale was developed, the procedure used to collect data, and how the data were analysed. The results section describes how women changed from the first and the last point in time that they participated in the research. Limitations of the research are discussed, and the case is made for continuing to develop the evidence base in ways that carve a middle ground between academic standards and Rape Crisis pressures.

The lack of evaluation of community based support services for rape victim survivors has been highlighted both in England and Wales (Brown et al., 2010) and the USA (Campbell and Martin, 2001; Campbell and Wasco, 2005; Lonsway, Archambault and Lisak, 2009). This has begun to shift with a series of studies about advocates in the USA by Rebecca Campbell and Sarah Ullman and their colleagues on responses in the US, and a series of evaluations of Sexual Assault Referral Centres in the UK (Lovett et al, 2004; Robinson, 2009; Schonbucher et al, 2009; Robinson, Hudson and Brookman, 2009; Robinson and Hudson, 2011). However, none of these have tracked longitudinally the outcomes associated with Rape Crisis support.

Campbell and Raja (1999) found that women who had access to a sexual violence advocate experienced less distress than those who did not have this support, especially in cases where the perpetrator was known to the victim. Similarly, Campbell (2006) showed that the presence and interventions of these specialist advocates led to improved outcomes for victims, including reducing the number of negative responses from the police and health professionals, and buffering against the distress caused by the legal process. In England and Wales, the introduction of Independent Sexual Violence Advisors has received scant research attention, with only one evaluation to date which focuses primarily on process rather than impact or outcomes (Robinson, 2009). This is the first study of its type that has been conducted in England and Wales.

A number of reviews have highlighted the lack of longitudinal designs within the violence against women research field (Koss and White, 2008; Campbell et al., 2011). In the USA, the National Research Council (2004) listed this as one of the top priorities for the immediate future for violence against women research. Campbell et al. (2011) argue that the sexual assault field in particular has benefited from a range of cross-sectional research but that studies which use longitudinal methods are rare. They highlight a range of reasons why longitudinal research would be useful, for example in identifying differential risk patterns for victimisation, understanding survivor's well-being following sexual assault, and how and why survivors recover over time. They point out that two key barriers to longitudinal research are: resources (longitudinal research designs are generally expensive and time consuming) and safety and ethical concerns (ensuring participant safety must be the first priority in any violence against women research). In the case of the research being discussed in this paper, safety and ethical concerns ruled out any form of control or

comparison group for example. Resources were less of an issue, partly because the research period coincided with a period of maternity leave for the principal investigator, meaning the follow up period could be extended at a reduced cost.

In an attempt to map existing research and advancing the use of longitudinal methods, Campbell et al. (2011) conducted a systematic review to identify longitudinal studies of sexual assault survivors. They identified 53 articles which related to 32 studies. They found that the most frequent topic to study using longitudinal methods was the mental health sequelae of sexual victimisation (n=13, 41% of the 32 studies were about this – many from the 1970s and early 1980s). Second most frequent were studies to measure the effectiveness of interventions to reduce rape-related symptomology (including substance abuse) (n=8, 25%); followed by sexual revictimisation (n=4, 12.5%); and interventions that seek to prevent re/victimisation (n=4, 12.5%). In addition to these four substantive foci, three studies (9%) used longitudinal methods for measurement development. Campbell et al. (2011) also note that Rape Crisis Centres are an underused resource in terms of participant recruitment.

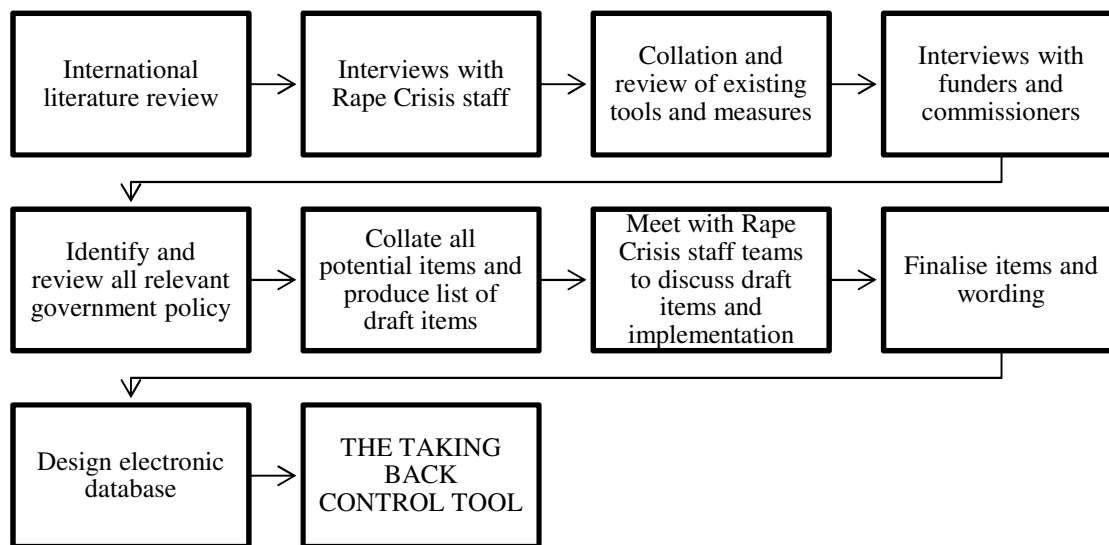
This research aimed to 1) develop and pilot an outcome measurement tool tailored to the work of Rape Crisis Centres 2) encourage the collection of data within Rape Crisis Centres and 3) explore the impact of Rape Crisis counselling on women's health, mental health and well-being.

Research methods

This section describes how the tool was developed, how it was used to collect research data, and how the data were analysed.

Development of the Taking Back Control tool

Figure 1 (below) summarises how the tool was developed.



The international literature review focused on what is currently known about the impact of rape and other forms of sexual violence on health, mental health and well being. It included both traditional academic literature and ‘grey’ literature. Literature on current tools in use, for example, on depression, anxiety and well-being were also reviewed. Interviews were then conducted with the manager/coordinator of each of the five Rape Crisis Centres¹ who we hoped would agree to use the tool². These interviews focused on what the main impacts

¹ Three of the centres were official Rape Crisis Centres in that they were members of Rape Crisis England and Wales. A fourth was a feminist rape service which was not at the time a member but has since joined. The fifth was a generic counselling service with a specialist women-centred rape support project attached to it. For ease of reference we refer to them all as Rape Crisis Centres.

² Two further centres were invited to take part, one declined due to capacity problems and one started to participate but then withdrew following a major environmental incident in the geographical area in which they are based.

were of rape and other forms of sexual violence on health, mental health and well being from their experience. Although we had already examined the international literature on this topic, it was felt also important to ask front line project workers about the impacts, to include a 'bottom-up' approach. Rape Crisis Centre managers/coordinators were also asked about if/how they currently measured the impact of their work in terms of improvements on health, mental health and well-being.

Existing tools and measures identified through the literature review and through the interviews with Rape Crisis Centre managers/coordinators were collated and reviewed. It was found that the existing generic tools and measures (on depression, etc.) were overly detailed and lengthy for use in Rape Crisis Centres. In addition, none of them fully covered the very wide range of impacts identified through the literature review and interviews with Rape Crisis Centre managers/coordinators. Of the five Rape Crisis Centres, two did not collect any outcome data at all, one used a generic statutory healthcare outcome monitoring tool, and one collected only a handful of outcome measures within a longer evaluation of the service overall. Only one Rape Crisis Centre had designed their own health, mental health and well-being outcome monitoring tool, and had been collecting data using it for the previous two years. We found this, and the other tools, a useful starting point for the development of the 'Taking back control' tool.

Three local funders and commissioners were also interviewed. These were an important group to include in the development of the tool, since one of the intended consequences of the tool was to increase the level of Rape Crisis funding through demonstrating the outcomes funders were interested in. Similarly, a review of current government policy was conducted, since it is necessary for Rape Crisis Centres to show how

they fit into these policies (since funding is often attached to them). As well as the Sexual Violence and Abuse Action Plan, more generic policies were reviewed. These were reviewed in order to demonstrate the breadth of the work that is carried out by Rape Crisis Centres and to open up the possibility of alternative, non sexual violence specific, funding streams. The funders, commissioners, and policy priorities did not replace the themes found in the literature review and interviews with Rape Crisis Centre managers/coordinators. Rather, they added a further two perspectives to be taken into consideration³.

The themes that had been pulled out of the literature review, interviews and policies were collated and printed out. This resulted in a list of 63 preliminary measures. These were reviewed initially by ourselves, and 21 of the themes were highlighted as the draft items based on the number of times they were mentioned and the importance accorded to them from the different perspectives (literature, interviews, policy). The full list, with the 21 highlighted draft items, was taken to the five Rape Crisis Centres. At this stage we met with both the manager/coordinator and also the counsellors who would actually be administering the tool. Following these meetings some changes were made to the items we had initially selected and the tool was reduced to 15 measures. Reasons for removal were: being too vague ('I have received some form of justice' and 'I am achieving my personal goals'); being acknowledged as being important but not as likely as the other areas to fit into policy and funding agendas ('I find it difficult to form or sustain an intimate relationship' and 'I have a normal sleeping pattern'); concern not to make negative suggestions ('I feel

³ Indeed, since developing the tool there has been a shift in policy direction associated with a change in government, demonstrating the danger in only collecting current policy related data. At a roundtable event for the Rape Crisis Centres to hear the findings and share their experiences of being involved in the research, many highlighted that their other data collection variables tended to be associated with current policy and associated funder priorities. This runs the risk of contributing to 'mission drift'; something that concerns some Rape Crisis Centres in England and Wales as they attempt to mould, change, and sometimes reinvent their organisations to fit the availability of new funding streams.

dirty, as though I can never be clean' - this impact of rape came through very strongly from counsellors for some but not all women); and counsellors feeling uncomfortable with the measures on drug use ('I use prescribed or over the counter drugs (such as anti-depressants, tranquillisers or sleeping tablets) to help me cope' was removed, but the one on non-prescription drugs was retained and discussed later in this paper) .

Once the items were agreed, the statements to be used were written. These were written as clearly and simplistically as possible. A web based data collection system was designed to manage the data, and the 15 items were entered ready for data to be inputted.

Administration of the 'taking back control' tool

The Taking Back Control tool in its pre-pilot stage consisted of 15 statements (e.g. I use self harm to help me cope with my feelings), which the Rape Crisis client was asked to state how much they agree or disagree with. A standard Likert scale was used with five response categories.

After our meetings with the five Rape Crisis Centres, all agreed to start using the 'taking back control' tool with all new clients. We were pleasantly surprised with this, in particular that the centres already using outcome tools were willing to move over to the new tool. Some of these Rape Crisis Centres had previously been quite reluctant to collect any data at all from their clients, and we were pleased that they wholeheartedly supported the use of the tool and recognised its necessity. The enthusiastic take up is likely to be due to three factors: that the research funder was a regional one that also funded each of the five Rape Crisis Centres; that the principal investigator was well known and respected within

the Rape Crisis movement; and that the timing of the research correlated generally with the start of a new commissioning landscape that prioritised organisations who could evidence and be clear about their outcomes. It is important to note that Rape Crisis Centres have traditionally been extremely cautious in keeping any form of permanent client records due to concerns about them being requested by defence lawyers on 'fishing expeditions' and used in court to the detriment of victim-survivors.

All new clients starting face to face counselling from the five Rape Crisis Centres were invited to take part in the research (i.e. telephone and web-based services would be excluded). Counselling approaches in practice will have varied, given the different backgrounds, training, and Centres that the counsellors worked at; however they all broadly followed a feminist, woman-centred, empowerment model in line with the ethos of the Rape Crisis movement. Depending on the Centre and the individual client, elements of cognitive-behavioural therapy (CBT), goal setting, and rational emotive behavioural therapy (REBT) were used as part of this model. All services were cost-free. Most of the clients identified as female (98%, 85/87). We did not collect individual level demographic details or abuse details at the time; however three of the five Rape Crisis Centres were able to retrospectively give us this data at an aggregate level⁴. The following figures are therefore limited to three Rape Crisis Centres, with a varying base figure due to some additional missing data within these. They are offered as an indication rather than an exact profile of the participants. Out of 54 clients for whom the age was recorded, most were aged between 15-24 (26%, 14/54), 25-34 (28%, 15/54) and 23-44 (20%, 11/54). Smaller proportions were aged between 45-54 (13%, 7/54) and 55 or over (13%, 7/54). One of the Rape Crisis Centres that was not able to supply demographic data provided its services to females aged 13 or

⁴ One did not have time to collate the information and one did not collect the information at the time.

over, therefore it is possible that some clients were aged under 16. The vast majority of sexual violence experienced was historical (defined here as more than one year before starting counselling), accounting for 92% (47/51) of clients. The remainder were recent (within one year: 6%, 3/51) or both (2%, 1/51). The ethnicity of the client was recorded in 40 cases. The vast majority of clients were white (95%, 38/40), with one Asian and one Mixed ethnicity (2.5% each). Discussions and overview of annual figures from the two Rape Crisis Centres that were not able to supply this data suggest their clients are similar to above: mainly/all-female, white, accessing the service more than a year after experiencing sexual violence, and a range of ages.

The tool was designed to be administered by the client's counsellor, either on week one or two, and then repeated every six weeks if appropriate (i.e. unless the client was in distress and was not able to freely consent). It was decided to do it this way rather than using a pre-post intervention design so that clients who do not have a defined and pre-agreed end point to their counselling would be included. In addition, it allowed for Rape Crisis Centres to use it as a 'client management tool' if desired (although problems with the functionality of the web based database meant this option was rarely used). After the client had completed the paper based tool, assisted by the counsellor if necessary, the Rape Crisis Centre logged onto the web based database to enter the client's data. The Rape Crisis Centre could then choose to view individual clients' progress or look at all of their clients on any particular item. The research team could view the data from individual clients, individual Rape Crisis Centres or all five Rape Crisis Centres. It was very important to allow the Rape Crisis Centres to have ownership over their own data and be able to access it whenever they chose to (for example, for funding bids or presentations). During the

research period, clients were given a participant information sheet and asked to sign a consent form. It was made clear that non-participation in the study would not affect their access to counselling in any way. No clients' names or any other individual level data was entered onto the database..

Data analysis

The quantitative data were complicated to analyse because of varying sample sizes at each of the stages of data collection. There were far more clients who completed the initial data collection point (n=260) than there were subsequent points. This paper presents the change responses, so only clients who completed a minimum of two data collection points (n=87).

When the data were analysed and results presented at the roundtable discussion with the Rape Crisis Centres involved in the study it was clear that some of the measures and data did not allow for meaningful conclusions to be drawn. Because of this, three measures were removed from the final version of the tool and are also excluded from the analysis⁵. A fourth measure is included in the analysis but is now an optional measure in the tool: I use non-prescribed drugs to help me cope (counsellors didn't like asking, they thought clients didn't like answering, but there was not agreement about this one so it is left in the results below and can be included as an optional measure).

Ethical considerations

⁵ The three measures that were removed were: 1) The support I receive from this organisation meets my needs (more of a one off question than one to assess change, also difficult to answer when just accessing service for first time); 2) I regularly use mental health services (unclear from quantitative data whether positive or negative); 3) I regularly visit my GP (as above).

Ethical clearance was granted by the Ethics Committee of the School of Applied Social Sciences at Durham University. Since it was the clients' counsellors rather than researchers who were directly administering the tool, it was important that clients knew that a) completing the tool meant they were participating in a research study and that their responses would be shared with the research team and b) that their participation in the research was completely voluntary and that the service they received from the Rape Crisis Centre was in no way linked to their participation in the research. These points, as well as the nature of the research, who the research team were, and what we would do with the information they gave us, was all written on a participant information sheet that was given to clients by their counsellor.

We wanted to give research participants a small token of our thanks for their time and bought a range of small toiletries, e.g. bath bombs, shower gels etc. It was intended that women were offered the opportunity to select one at every time point they participated. However, in practice inconsistencies arose between the Rape Crisis Centres. Some counsellors felt very strongly that women should not receive these and that it interfered with the counsellor/client relationship, while others felt equally strongly that women should be offered the gifts as it showed we valued their participation.

Limitations

The research design had a number of limitations – some of which were deemed necessary for the research to take place. Only two of the five Rape Crisis Centres were used to collecting data from clients. The three Centre's that were more centrally/historically grounded in the Rape Crisis movement did not collect any individual level data and were even reluctant to keep client notes in case they were summoned by the court. It was for

these reasons that the bare minimum of data were requested. We did not ask for any demographical information on the women at the time, meaning that we had to retrospectively ask for this information in aggregate form. Since only three out of the five Rape Crisis Centres were able to do this, we are unable to fully describe our sample. In retrospect, we may have been able to ask for some basic demographical information without it affecting our sample and it is possible we were over-cautious in this respect. Other information that would have been useful would be around the nature of the victimisation, their relationship to the offender, and whether they reported the offence to the police. However, it is possible that asking these type of questions may have put counsellors off being involved in the study and asking their clients if they would like to participate.

In addition, we do not know exactly what proportion of women agreed to participate in the study. Again, this was because of a concern that asking counsellors to keep records of accepts and declines would increase the research burden on counsellors to an unacceptable level. From interviews with the counsellors we know that the vast majority of their clients participated in the first time point of the study (where the sample size was 260), but that clients did not always complete the follow-up stage/s (hence the sample size for the longitudinal analysis was much lower, at 87). The reasons for this were: clients leaving counselling before getting to the follow up stage (e.g. attending less than six sessions); clients completing their initial stage near the end of the research period and therefore not having subsequent data collected/included in the research sample; and counsellors forgetting/being too busy to administer follow-ups. Using the counsellors rather than a researcher to administer the tool hence undoubtedly resulted in variability. In addition, it is

possible that social desirability may have influenced the findings; with clients over-stating (to show ‘progress’) or under-stating (to show continued need for counselling) change.

Results

Table 1 (below) shows, in descending order, the difference reported by clients measured by the number of clients who gave a negative response (i.e. they strongly/agreed with the statement if it was a negative statement or strongly/disagreed if it was a positive statement) on their first compared with their last data collection point.

| Taking Back Control measure (% strongly/agree unless otherwise specified) | First | Last | Difference |
|--|--------------|-------------|-------------------|
| I feel empowered and in control of my life (% strongly/disagree) | 61% | 31% | 30% |
| I have ‘flashbacks’ about what happened. | 84% | 57% | 26% |
| I have panic attacks | 68% | 43% | 25% |
| I use alcohol to help me cope | 28% | 11% | 16% |
| I feel depressed | 72% | 56% | 16% |
| I have thoughts about ending my life. | 39% | 23% | 16% |
| I feel well enough to work or study (% strongly/disagree) | 45% | 29% | 16% |
| I have a fear or phobia that prevents me from doing everyday things | 40% | 29% | 11% |
| I do not feel responsible for what happened to me (% strongly/disagree) ⁶ | 33% | 22% | 11% |
| I over-eat, under-eat, or use food as a means of control | 57% | 47% | 10% |
| I use self harm to help me cope with my feelings | 17% | 7% | 10% |
| I use non-prescribed drugs (such as heroin, cocaine, speed, cannabis) to help me cope. | 6% | 2% | 3% |

This shows that the most change was made in relation to the statement ‘I feel empowered and in control of my life’, where 61% strongly/disagreed at the first data collection point compared to 31% at the last data collection point. Hence, around half of the clients who

⁶ In the amended scale following the pilot this measure is reworded as ‘I feel responsible for what happened to me’.

initially strongly/disagreed no longer did so by the end of the data collection. In addition, more incremental changes could have happened for other clients (e.g. moved from strongly disagree to disagree, or moved from neither agree nor disagree to agree). Large shifts were also seen in relation to 'I have 'flashbacks' about what happened' and 'I have panic attacks'. Overall, some degree of positive change was seen for all measures, although this was small for 'I use non-prescribed drugs ... to help me cope' (which again may be linked to problems with the measure). The change for 'I use self harm to help me cope with my feelings' appears small on first sight (10%), however this is partly due to the small number initially reporting it as a symptom – at the first data collection point this was 15/87 and by the last this was down to just 6/87 – less than half reporting it as a symptom than did originally. The same cannot be said for the other statement with a 10% change: 'I over-eat, under-eat, or use food as a means of control went down from 57% to 47%, a difference of 50/87 to 41/87. The measures with the largest and smallest changes are discussed in more depth in the following discussion section.

Discussion

Some level of perceived control over one's life is an important factor of psychological wellbeing (Frazier et al., 2011). Consequently, traumatic events, especially those which involve a loss of control, can have serious implications for an individual's sense of self and mental health (Frazier et al., 2011). Rape in particular has been shown to threaten many assumptions and beliefs survivors have about themselves and the world around them (Koss, Heise and Russo, 1994). This may be especially pertinent when a woman has been raped by someone known to her (Lawyer et al., 2006). This was demonstrated within our study, with nearly two thirds (61%) of the sample saying they strongly/disagreed with the statement 'I

feel empowered and in control of my life'. Though it is clearly impossible to completely delete the impact of the assault, studies have found that the more perceived control the person has over their present circumstances, the less distress they are likely to feel (Frazier et al., 2011). One particularly important aspect within this notion of present control is perceived control over the recovery process. Walsh and Bruce (2011) found that, among sexual assault survivors, those who had higher levels of perceived control over their recovery process were less depressed and had lower levels of posttraumatic stress. Similarly, Frazier et al. (2011) demonstrated that control was associated with less binge drinking, less feelings of distress about the trauma, and lower levels of general distress. Indeed, in terms of reducing distress, perceived control over the recovery process appears to be even more helpful than the belief that future attacks are unlikely (Frazier, 2003).

It is positive that increasing empowerment and control was where the largest change sat. When we interviewed the Rape Crisis staff about what impact they hoped they were having on women's lives these were the central themes – hence the title of the research tool being 'Taking Back Control':

It's about independence, choice, regaining self confidence and assessing whether they are taking control back over their life. (Rape Crisis worker)

[we hope the service will enable women to] regain strength, self esteem and self confidence. And feel healthier in order to live their lives to the full. (Rape Crisis worker)

The area that had the second largest change was 'I have flashbacks about what happened'. This was the statement that had the largest amount of agreement at time one –

with 84% of clients strongly/agreeing with this. Around a third of those who strongly/agreed with the statement at the first data collection point no longer strongly/agreed at the last data collection point. Tyneside Rape Crisis Centre define flashbacks as:

... temporary states of remembering something painful or traumatic which has been hidden for quite some time in the subconscious mind and during a flashback you may feel as though aspects of the rape or sexual assault are actually happening to you now. The duration of a flashback differs and could last from a few seconds to a few hours. (Tyneside Rape Crisis Centre).

Rape Crisis staff told us that often survivors have flashbacks for many years after a sexual assault:

I don't think people understand that you can be affected even after a long time. Even after 25 years. (Rape Crisis worker)

The image may be visual and can also be accompanied by the feelings, smells and sounds associated with the assault. It's as if that person is right back in the experience, no matter how long ago it had taken place. (Rape Crisis worker)

Flashbacks can occur regardless of how the person is feeling. They can be triggered at any time and can happen anywhere. They can be triggered by anything that serves as a reminder of the sexual violence or just out of the blue. (Rape Crisis worker)

Previous research has consistently documented this relationship between a history of sexual violence and the psychological distress of experiencing flashbacks (Arata 1999; Gold 1994;

Resnick, Acierno and Kilpatrick 1997; Holstrom and Burgess 1978; Hellowell and Brewin, 2004). Research by Campbell (2001) found that women who have been raped re-live the trauma, causing flashbacks, nightmares and thoughts that won't leave. The frequency with which flashbacks occur varies considerably across individuals – some may only experience one flashback, while others experience daily intrusions (Milo, 1997). One study found that, on average, the rate of flashbacks among a group of people who had been raped was 83 per year (Duke et al., 2008).

One of the measures which had a smaller change over time was 'I over-eat, under-eat, or use food as a means of control' (57% strongly/agreed at first compared with 47% at last). Research has consistently highlighted links between sexual violence and eating disorders (see Chen et al., 2010 for overview). Faravelli et al. (2004) compared women who had been raped four to nine months previously with women who had experienced a different life threatening trauma in the previous nine months. It was found that 53% of the women who had been raped had developed an eating disorder, in comparison to 6% of those who experienced a different trauma. Therefore, both this study and previous studies have found eating disorders to be linked to sexual assault, however this study has found that Rape Crisis counselling has less of an impact on this than on some other symptoms. This may mean that eating disorders are more difficult than other symptoms to alleviate, that they need longer, or that different methods of intervention are needed. It may be an area where more training is needed for Rape Crisis counsellors.

A further area where a small percentage change was seen was for 'I use self harm to help me cope with my feelings (change of 17% to 7%)'. Rape Crisis Counsellors felt they had

seen an increase over recent years of clients using self harm, and were sceptical of mainstream responses:

We are seeing more and more cases of women using self harm as a coping mechanism. We know that workers within the NHS have little understanding and often their response is one of impatience. (Rape Crisis worker)

Despite the low percentage change, it is still the case that more than half the people who strongly/agreed with the statement that they used self harm at the start of their counselling no longer did so by the end.

Self-harm was one of the impacts noted by two of the three funders/commissioners that were interviewed. For example, when asked how rape/sexual assault impacts on women's mental health, one responded 'In so many ways: alcohol, drugs, depression, self-harm, feelings of suicide, hopelessness ...'. However, the third simply stated 'I don't personally know.' Although only three funders/commissioners were interviewed and no claims are made to representativeness, this demonstrates just one example of the massive difference in knowledge that exists between funders/commissioners. Although all three interviewees were currently funding/commissioning services in the area for rape victim-survivors, two had a high level of knowledge and awareness of regional service delivery while the third had very little indeed. Finally, the statement 'I use non-prescribed drugs [...] to help me cope' was one that had a low number of participants strongly/agreeing at the start and the end of the process (6% compared to 2%). Some counsellors were of the opinion that this question should be removed from the tool because it would alter the client/counsellor relationship if they were asked to disclose illegal activity to them. The research team felt it was an important question to keep in because it would allow them to access drug and alcohol funding if they were able to demonstrate this was an issue for their

client group. As a compromise, we added a new option of 'do not want to answer' for this and all of the statements. However, and despite the 'do not want to answer' box being rarely used, at the end of the pilot period some counsellors still felt this question should not be included and stopped collecting information on it. This question is now suggested as an optional statement to the Taking Back Control tool.

Conclusions

This research represents the first outcomes study of Rape Crisis counselling in England and Wales, and one of the few times Rape Crisis Centres have participated in academic research that directly involves their clients. A total of 87 clients completed the Taking Back Control tool on at least two occasions, making it possible to look at change over time. The study does have a number of limitations, some of which were deemed necessary at the time in order to recruit. It is possible that we were over-cautious about collecting personal data relating to the client's demographic characteristics and offence type, although it is also possible that the sample size would have been reduced if we had collected this additional data. Gifts were very low in monetary value and offered as small tokens of appreciation rather than as incentives to take part. This was accepted by the ethics committee, but in practice some counsellors refused to use them leading to differences across the research sites. Echoing and adding to the existing calls for more longitudinal research to take place in this area, it is suggested that a discussion should be held between researchers, representatives of ethics committees, rape victim-survivors, and gatekeepers (including counsellors) to discover what incentives/tokens of appreciation/ethical methods of keeping women engaged in sexual assault longitudinal research.

Rape Crisis Centres in England and Wales are under increasing pressure to provide evidence of their outcomes in order to secure future funding. Rape Crisis Scotland has already developed a set of outcomes measures, and Rape Crisis (England and Wales) are developing a set (using the Taking Back Control tool and other outcome measures as a basis). It is hoped that academics and Rape Crisis staff can continue to work together in the future to develop this emerging evidence base and that a path can be navigated through the practicalities of collecting data and the requirements of academic studies. Furthermore, it is hoped that the findings from this study and from future studies can be used and shared throughout the Rape Crisis movement internationally to assess and improve practice internally and demonstrate positive outcomes to external funders and commissioners.

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