# “I needed to know that I wasn’t crazy”

## Exploring the experiences of women who sought support for their mental health after sexual violence

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# Executive Summary

We are pleased to present this in-depth report which seeks to present the multi-faceted and often complex experiences 395 women had when seeking support for their mental health following sexual violence committed against them.

Our research found that women had many different triggers to seeking support for their mental health, but that their experiences of doing so ranged from excellent to incredibly harmful. What is clear from this report is that the response of the individual professional who receives the disclosure of sexual violence, and the request for mental health support, has a profound impact on the woman for many years to come.

From exploring the responses of women in this study, psychiatric diagnosis after disclosing sexual violence was common – and even when women directly stated that they did not feel they were mentally ill, but did feel that they were traumatised by the sexual violence they were subjected to, they were still likely to be diagnosed with depressive disorders, anxiety disorders and personality disorders.

Despite this, there is clearly a complex and nuanced relationship with diagnosis after sexual violence, as some women in the study felt that their diagnosis validated them and made them feel in control. Even when they didn't fully believe that they were mentally disordered, and they were able to identify that their suffering and distress arose from the sexual violence, they knew that without the psychiatric diagnosis and medication, they were likely to be refused services or further support due to the medical gatekeeping which exists in our services. Women spoke openly about accepting diagnoses and medication they did not agree with in order to get the help they really wanted: therapy.

Women discussed their experiences of being triggered and struggling profoundly with their trauma and mental health when their children reached the same age they were when they were sexually abused or raped. However, many women in this sample spoke of spending years thinking there was something wrong with them, as they had never connected their 'mental health issues' with their sexual traumas. For some women, the connection between how they thought and felt – and the earlier sexual traumas, was revelatory.

This report finds that women seeking help for their mental health following sexual violence were presented with numerous barriers, stigma, assumptions, stereotypes and an increasingly underfunded and over-medicalised view of their trauma.

Dr Jessica Taylor

**Director of VictimFocus**

## Terminology

The term ‘sexual violence’ will be used interchangeably throughout this report to discuss sexual assault, rape, and sexual offences.

The terms 'victim' and 'survivor' are only used by the authors where they are used by women themselves, or by cited/referenced original authors about their own work. However, we understand many will not align with these terms. It is frequently argued that women and girls do not identify with the term ‘victim’ or ‘survivor’ and prefer not to be defined by the crimes committed against them (Taylor, 2020).

Additionally, the term 'experienced abuse' is only applied where already referred to in the literature or in the qualitative data verbatim, as this term does not adequately describe the action of the perpetrator to choose to subject their victim to harm. At VictimFocus, we feel it is important to use the phrase ‘subjected to abuse' where possible, as this keeps the action where it should be, with the perpetrator.

The phrase ‘psychiatric diagnosis’ will be used as a shorthand for the current classification scheme of functional diagnoses in the DSM-V and ICD 11. This report will only use the term ‘disorder’ for a mental health diagnosis when referred to in the literature, or where a woman used that term herself. The term 'child' or ‘girl’ refers to all young people or young females under 18.

We would also like to take the opportunity to discuss the use of the term ‘crazy’ in the title of the report. Whilst neither of the authors or the organisation endorse the use of this term, many women used this word whilst sharing their experiences with us, and they described a feeling of ‘going crazy’ or being ‘seen as crazy’. It was so significant that it appeared hundreds of times in the data, and women discussed a feeling of needing to know they were not ‘losing it’, ‘going crazy’, or ‘going insane’. We did not want to censor or amend the language of the women who kindly took part in this study.

# Introduction

This report explores the experiences of women who sought support for their mental health after being subjected to rape and abuse. Sexual assault and rape can result in significant distress and trauma, adversely impacting emotional wellbeing and physical health. Within the literature, there is an association between being subjected to sexual violence and being diagnosed with various mental health outcomes, including anxiety, depression, post-traumatic stress, eating and sleep disorders, personality disorders and suicidal behaviours.

Being subjected to sexual violence is also associated with a broad range of lifetime psychiatric disorders regardless of the survivor's age when the abuse occurred (Chen et al., 2010). Concerns about psychiatric diagnosis have stemmed from applying a medical classification to the thoughts, feelings, and behaviours of women and girls subjected to sexual violence, implied as ‘symptoms’ of a ‘mental illness’ or a ‘psychiatric disease.’

Sexual violence is a broad term that describes any physical or psychological violence carried out through sexual means. It can include sexual abuse, sexual assault, rape, incest (intrafamilial sexual abuse, sibling sexual abuse), and childhood sexual abuse, including sexual harassment, stalking, indecent exposure, degrading sexual imagery, voyeurism, trafficking and sexual exploitation. Sexual violence is, perpetrated almost exclusively by men against women. When discussing male violence perpetrated against women and girls, we must refrain from referring to the term VAWG or ‘violence against women and girls’ where possible, as this erases the perpetrator of the offence by not mentioning them. Some activists and grassroots organisations prefer to use the term MVAWG ‘male violence against women and girls’ or simply, ‘male violence’.

According to the Crime Survey for England and Wales (CSEW) year ending March 2020 an estimated 2.9% of women (618,000) aged 16 to 74 years experienced sexual assault (including attempts) in the last year (ONS, 2021). In the same year, a total of 162,936 sexual offences were recorded by the police in England and Wales. Of the women who were victims of rape or assault by penetration (including attempts) since the age of 16 years, the crime survey, year ending March 2017 and the year ending March 2020 combined estimated 63% reported mental or emotional problems, and 10% reported they had attempted suicide as a result (ONS, 2021). The National Society for the Prevention of Cruelty to Children (NSPCC) estimate that 1 in 20 children in the UK have been sexually abused (NSPCC, 2021). Academia and public research have consistently shown that many women and girls are subjected to sexual violence in their lifetime, often more than once (Taylor and Shrive, 2020). However, it is difficult to determine the full extent of sexual assault in the population as prevalence statistics are likely to be underestimated, often due to methods of collecting data, underreporting, and the normalisation of male violence.

A range of short and long-term psychological and physical consequences and emotional impacts are associated with sexual assault and rape. During the assault, it is common to experience natural physical responses such as dissociation or an intense fear of death. Extensive research has shown that common psychological and emotional impacts after sexual assault can include fear, anxiety, low self-esteem, depression, stress, flashbacks, relationship and intimacy difficulties, and self-harm (Campbell et al. 2009).

Physical health effects may occur from forced or non-forced penetration (e.g. sexual coercion), resulting in bruising and bleeding. Other health risks include sexually transmitted disease, gynaecological problems, painful intercourse, sexual dysfunction and pregnancy (Jina et al., 2013). The trauma of sexual violence can cause long-term stress and may present as physical pain such as headaches, fainting, and chronic abdominal pain (Sigurdardottir and Halldorsdottir, 2021). The high prevalence of male sexual violence committed against women and girls is particularly concerning, given the significant psychological consequences for survivors (Campbell, Dworkin, and Cabral, 2009).

There are several interventions available for victims and survivors of sexual assault. These include general and specialised types of psychotherapy (Cowan, Ashai, and Gentile, 2020) and psychotherapeutic treatments, such as anti-anxiety medicines and anti-psychotics (Khadr et al., 2018; Taylor, 2022). The widely used medical model treats mental disorders as physical diseases that warrant a diagnosis, whereby medication is used in treatment. In psychiatry, diagnoses rely on the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) and the International Classification of Diseases: Classification of Mental and Behavioural Disorders (ICD-11). The standard classification in the DSM-V or ICD-11 provides an evaluation for the diagnostic criteria to assess an individual's pattern of physical symptoms for a medical diagnosis (see DSM-V for full clinical definition and criteria; American Psychiatric Association Task Force on DSM-V, 2013).

The general assumption about how most drugs work in most situations in mental health is that they work by targeting and reversing the biological processes that produce symptoms. For example, antidepressants were thought to work by targeting the underlying neurotransmitter and serotonergic mechanisms that produce the symptoms of depression, altering the behaviour, thinking processes, and emotions of anyone who takes them. This has recently been shown to be incorrect in a large umbrella review of the evidence which found that there is no evidenced link between depression and 'brain chemical imbalances', specifically, serotonin (Moncrieff et al., 2022). Antipsychotics are currently thought to work by targeting the biochemical mechanisms that produce psychotic symptoms, however, this is also frequently contested in academic literature. The medical model of mental health often pathologises coping mechanisms and trauma responses, and women are diagnosed with illnesses, disorders, and psychoses instead of being supported with their experiences of trauma (Taylor, 2022).

Violence against women and girls is prevalent worldwide yet historically has been ignored and accepted. García-Moreno et al. (2015) discuss how violence within the home is often a private affair; child sexual abuse persists as a silent shame for the child victim, and rape is frequently a stigma for the victim rather than the perpetrator. It is common for women and girls to be diagnosed with one or more psychiatric disorders and prescribed psychiatric medication when seeking mental health support after sexual abuse and rape (Taylor, 2022).

For example, post-traumatic stress disorder (PTSD) is a psychiatric diagnosis for the psychological symptoms following a traumatic event. A review by Campbell, Dworkin and

Cabral (2009) found the clinical diagnosis of PTSD is often applied when acknowledging the significance of harm caused to victims of sexual assault. In recent years, there has been a fundamental and significant paradigm shift in our understandings of women and girls' reactions to the traumatic events of sexual abuse and rape and the impact trauma has on their mental health (Sweeney et al., 2018).

Despite a significant concern about the prevalence of male sexual violence against women and girls, limited research asks women subjected to sexual abuse or rape about their experience of the support they sought or prescribed for their mental health after sexual violence. While a common understanding exists of encouraging women and girls to report sexual violence to the police and to seek emotional support for their well-being and mental health, many do not. When they do, it is common for women and girls to be diagnosed with a mental health disorder. This report aims to centre women's voices by using aspects of their narratives to explore their thoughts and feelings about being diagnosed or treated for mental health issues and whether this helped or harmed them.

# Literature Review

This search aimed to review the literature surrounding the relevant knowledge of the mental health outcomes for women after rape and abuse, primarily from the social science literature. Extensive research relates to the nature and consequences of mental health outcomes after sexual abuse in adulthood, although limited research relates to childhood. Longitudinal and cohort studies typically identify vulnerabilities and risks across lifetime risks (Chen et al., 2010). Studies concerned with the initial responses include victims in the acute period post-assault and those with chronic symptoms (Ahrens et al., 2007).

Qualitative studies often identify subjective experiences, views, and meanings within a specific time frame and the effectiveness of interventions in treating the mental health consequences of sexual assault. Concerning the effects experienced by victims/survivors, research often focuses on victim/survivor's health symptoms and the treatment targets of post-traumatic stress disorder (PTSD), depression, and anxiety (Baker, Campbell and Straatman, 2012).

Although there is recent attention in the academic literature and public research on the trauma responses of women and girls after sexual violence, there is little discussion of their experiences of the mental health support offered or received.

## The Mental Health Consequences of Sexual Violence

Psychological and physical consequences of sexual assault and rape represent significant and ongoing harm, distress and trauma that may trigger or exacerbate existing mental health issues (Oram, 2017; Campbell et al., 2009).

The health consequences of sexual violence can be categorised as immediate effects directly occurring from the incident to medium or long-term mental health consequences arising after the sexual violation. The impact of trauma from sexual assault can depend on many

factors, including the nature, intensity and duration of the assault or rape, the victim's relationship with the perpetrator and how family, friends and others respond to the victim (Ahrens et al., 2007).
Sexual assault may impact how the victim/survivor interacts with those closest to them. For example, interpersonal relationships, including an intimate partner, close friends, acquaintances, co-workers, and others who make up an individual's social connections, may be adversely affected. There may be difficulties with trust, communication, intimacy and enjoyment of social activities (Dworkin et al., 2017).

Sexual violence causes persistent suffering for women and girls. The immediate and long-term psychological consequences may include feelings of shame, guilt, shock, denial, fear, anxiety, panic, confusion, social isolation or withdrawal, and being calm or subdued. Dworkin et al. (2017) state that women who are sexually violated are at a substantially increased risk of attempting or completing suicide. Prescription medication and other illegal drugs are related to coping mechanisms or a way to escape from reality by self-medicating the trauma symptoms (e.g., nightmares and flashbacks) (Sturza and Campbell, 2005). Ullman et al. (2005) state sexual assault is associated with an increased dependence on alcohol, for example.

Sigurdardottir and Halldorsdottir (2021) point out common consequences of sexual violence for children and adolescents include a feeling of threat and humiliation, secrecy, guilt, disconnection of body and soul, fear and insecurity, self-image issues, self-accusation, feeling responsible for the crime and various physical and mental health problems (e.g., suicidal thoughts). Bebbington et al. (2011) state sexual abuse in childhood is related to psychotic disorders or symptoms in adult women. In adulthood, Sigurdardottir and Halldorsdottir (2021) state the consequences of sexual violence are multifaceted and varied. Adults may experience vaginal problems, recurrent urinary tract infections, widespread and chronic pain, sleeping problems, chronic back problems, fibromyalgia, eating disorders, social anxiety, chronic depression, and chronic fatigue.

Common diagnosed mental health conditions or disorders after a sexual assault include depression, Borderline Personality Disorder (BPD), psychosis and, most commonly, post-traumatic stress disorder (PTSD) (Campbell 2009; Dworkin et al., 2009; Taylor, 2022; Oram et al., 2017). Read and Moncrieff (2021) have pointed out that the dominant view within mental health research and services is that feeling depressed is a type of medical illness partially caused by various biological deficits which are somehow corrected by physical interventions. Mental health practitioners use the diagnostic categories for the classification of mental health disorders in the DSM-V or ICD-11 to describe symptom clusters which aim to clarify causal relationships, prognoses, and treatments. Psychiatric diagnosis is, therefore, a clinical judgement based on observation and interpretation of behaviour and self-report, consequently subject to bias and variation. Depression is thought to be a psychological response to overwhelming stress and often overlaps with physical problems such as chronic pain and cardiovascular disease (Slavich and Irwin, 2014). For common problems such as depression and anxiety, a general practitioner (GP) is able to diagnose an individual after one or two appointments. A GP may diagnose clinical depression when episodes of low mood persist for several weeks, and patients may be offered a combination of antidepressants and therapy (NHS, 2019). For less common problems the GP will refer the person to a mental health specialist such as a psychiatrist, who may see the individual over a longer period before making a diagnosis (MIND, 2022).

Within the literature, depressive symptoms, social anxiety and chronic fatigue are a few of the many cited consequences of adult or child sexual victimisation (Sigurdardottir and Halldorsdottir, 2021). Women and girls exposed to sexual violence have high rates of diagnosis of mood and anxiety disorders (e.g. Neilson et al., 2017). Hedtke et al. (2008) found that women with a history of sexual violence are more likely to have PTSD, depression, and substance use problems.

Within the literature, sexual assault predicts BPD diagnosis, clinical presentation and prognosis in women (e.g. de Aquino Ferreira et al., 2018). The diagnosis of BPD is a personality disorder currently classified by the psychiatric classification system (DSM-V) and characterised by persistent instability in emotional regulation, interpersonal relationships, impulse control and self-image (Zimmerman, 2013). The diagnosis of BPD is applied predominantly to women and, in particular, to survivors of childhood sexual abuse (Shaw and Procor, 2005). A review by de Aquino Ferreira et al. (2018) demonstrates the impact of childhood sexual abuse and adulthood sexual abuse on BPD clinical presentation and prognosis. They found sexual assault victims have higher rates of suicidality, self-mutilation, dissociation, PTSD, psychosocial impairment, identity and attachment disorders, feelings of shame and impaired sexual function. However, Shaw and Proctor (2005) previously argued, the diagnosis of BPD pathologises women's responses to violence and the strategies some women use to survive and resist oppression and abuse.

The National Institute for Health Care Excellence (NICE) describe post-traumatic stress disorder (PTSD) as a potential diagnosis for an adult or child who has experienced or witnessed a traumatic event (NICE, 2020).

PTSD is characterised by re-experiencing intrusive thoughts, emotions or physiological distress through 'flashbacks' or dreams/nightmares. It may include a negative self-perception, avoidance of thoughts or stimuli reminiscent of the event, disassociation and hyperarousal. NICE (2020) states that PTSD should be considered in those repeatedly presenting with unexplained physical symptoms and in people with anxiety disorders, depression and substance abuse. Physical symptoms include headaches, gastrointestinal problems, rheumatic pains, and skin disorders. Children with PTSD may also report headaches and stomach pains. A diagnosis for PTSD may be given when these symptoms persist for more than a few weeks or interrupt day-to-day life (NICE, 2020). Dworkin et al. (2017) state that sexual assault and rape survivors risk developing depressive disorders, personality disorders, and psychosis and are more likely to attempt suicide. Campbell (2009) states that sexual assault and rape survivors are at significantly increased risk of developing (PTSD).

As a psychiatric diagnosis, PTSD implies that the individual suffers from a medical problem, as the "symptoms" are signs of a disorder or disordered behaviours rather than reasonable and rational responses to a lived experience. A medical diagnosis may provide an understanding of a person's problems by drawing on theoretical models to describe bodily function patterns or dysfunction. However, although establishing a diagnosis on biological patterns may be appropriate for physical issues, a psychiatric diagnosis is inherently limited when making sense of emotional and behavioural concerns (Johnstone and Boyle, 2018).

## Disclosure, reporting and help-seeking of women subject to sexual violence

There are many reasons women and girls may disclose they have been subjected to sexual violence. Price et al. (2014) found previous use of mental health services is a strong predictor of women's use of mental health services after sexual assault. Barriers to help-seeking may include a lack of challenges accessing services, awareness about sexual violence and fear of consequences of disclosure. A wide range of false beliefs, stereotypes and rape myths restrict perceptions about what constitutes sexual violence, including who can be a victim and a perpetrator (Baker, Campbell and Straatman, 2012). The help-seeking decisions of victims of sexual assault and rape may also be affected by their perceptions of the criminal justice system's response (Kaukinen and DeMaris, 2005). Littleton and Breitkopf (2006)state feelings of self-blame and adverse reactions received from others are potential predictors of avoidance coping, while supportive responses can assist with recovery and healing. Some women may only recognise they need support when pregnant, giving birth, or having a miscarriage; therefore, screening for sexual trauma in health services can be beneficial. White (2014) points out the importance of offering a framework that obstetric providers may consider when caring for sexual trauma survivors.

Most victims/survivors do not report their sexual assault in the immediate aftermath (Lanthier et al., 2018), and disclosure is usually to friends or family, not services (Lomax and Meyrick, 2020). In the aftermath of sexual assault, victims may hide or minimise behaviours they used to survive the sexual violence out of fear that they will not be believed or blamed for their assault. However, this is often a normal way of responding to life-threatening events and coping with traumatic experiences. When a victim/survivor finally reaches or approaches mental health care, there have often been in significant distress for a long time, and many have already reached a crisis point.

Women and girls may prefer to disclose to informal support providers such as friends, family, or a partner rather than healthcare providers, mental health professionals, or rape crisis workers (Baker, Campbell and Straatman, 2012). Many never disclose their abuse, many take years to seek support, and some never do. Reasons for not disclosing sexual assault include embarrassment, fear of the response from the professional, lack of trust in the mental health professional (Sturza and Campbell, 2005). There may be concern about the treatment available or being diagnosed with a mental health condition that remains on their medical records, possibly affecting their job or even the therapy available during the criminal justice system (Taylor, 2022). In contrast, some women may welcome a diagnosis as it gives them a label that explains their feelings to themselves or access to medication to deal with the emotional impact of the sexual assault.

Mental health care after sexual abuse is often delivered through primary care such as the GP (general practitioner), sexual and reproductive health services, accident and emergency departments, mental health services, and freephone helplines (e.g., rape crisis). Healthcare providers play a central role in assisting women and girls in the aftermath of sexual assault. They act as a gateway, providing referrals to counselling and social and legal services (World Health Organization, 2013). Despite the availability of effective interventions, relatively few women and girls seek formal support services in the acute period (7 days or less) following a sexual assault, with many disclosing weeks, months, or years later, if they do at all (Campbell et al., 2011).

Sexual assault referral centres (SARC) are specialist facilities where people can receive immediate help and support for sexual violence, including access to a forensic medical examination and a crisis worker. They provide services to victims and survivors regardless of whether they choose to report the offence to the police (England, NHS, 2018). There are several ways that women and girls can access a SARC service, including referral by social services, the police, GP or self-referral (England, NHS, 2018).

A GP is often the first point of contact for people concerned about their mental health. While national best practice is for victims of sexual violence to be managed at a SARC, mental health problems are common in primary care, and most are managed solely by the GP. GPs will likely encounter women and girls subjected to sexual violence since sexual violence is so prevalent. While the context of GP discussion differs from specialist psychological therapy, helping patients make sense of their symptoms is in line with a GP's core role (Cape et al., 2010). This involves GPs using their judgement to determine whether signs of abuse are present or if patients should be asked about sexual violence and identify individual health needs (Kennedy and White, 2015). Hughes et al. (2019) point out that health and social care professionals do not routinely enquire about sexual assault, sexual abuse and rape even though a routine enquiry into mental health is embedded into national policy. Furthermore, disclosure training for an incident of sexual assault and rape is may not be adequately covered by a specific training policy, resulting in a GP or surgery staff being unprepared when someone discloses during an appointment.

## Mental Health Interventions after Sexual Violence

The early aftermath following sexual assault is a critical period for determining a survivor's risk or resilience in developing symptoms of post-traumatic stress (Dworkin and Schumacher, 2018). Sexual assault and rape are particularly traumatic events that, in the immediate aftermath, have a significant adverse effect on psychological distress and, for many, lead to ongoing psychopathology and disruptions in psychosocial functioning (Lomax and Meyrick, 2020).

Processing abuse and trauma is a helpful and necessary step to recovery and is the focus in these treatment modalities (Cowan, Ashai & Gentile, 2020). The wide variety of therapy models for victims of sexual assault within the literature are based on psychodynamic, cognitive-behavioural or feminist-informed theoretical frameworks (Regehr et al., 2013). Survivors of sexual assault can benefit from several types of psychotherapy including psychodynamic psychotherapy, TF-CBT, and EMDR (Cowan, Ashai & Gentile, 2020). Cognitive-behavioural therapy (CBT) interventions cover a range of specific approaches, including Exposure Therapy or Prolonged Exposure (ET/PE), Cognitive Processing Therapy (CPT), and Eye Movement De-Sensitization and Reprocessing (EMDR). CBT-based interventions aim to assist individuals in identifying and modifying the dysfunctional beliefs which influence response to stimuli and subsequent physiological and psychological distress.

Such interventions aim to prevent later psychological problems; however, the focus is typically on current symptoms, not past trauma causes. Lomax and Meyrick (2020) have pointed out weak and inconclusive evidence in the literature to support the use of early individual or group trauma-focused CBT (or exposure therapy) interventions.

Dialectical behaviour therapy (DBT) is a talking therapy based on the CBT model, adapted for people who feel emotions intensely. A critical factor in DBT is that suffering arrives from attachment to pain and directly focuses on acquiring emotion regulation skills (Fassbinder et al., 2016). DBT has been shown as an effective treatment for borderline personality disorder. However, although the efficacy and effectiveness of DBT have been evaluated intensively in studies, Fassbinder et al. (2016) identified limited research exists on the specific mechanisms of change in DBT. Decker and Naugle (2008) argue that DBT may be uniquely suited to addressing the multiple affective and interpersonal problems often associated with sexual abuse. However, they suggest it may also be a promising preventative treatment for future sexual victimization. This suggestion of preventing further victimisation places responsibility on the woman or girl for preventing a man from sexually assaulting her.

EMDR is a psychological approach that can be offered to assist the impact of sexual assault trauma. As a form of therapy, it centres on the idea that trauma memories are stored in the body and allow the release of emotional pain. Unlike many other treatments, there is no requirement to talk about distressing and painful memories as it does not focus on changing emotions, thoughts or behaviours. EMDR therapy is seen as a psychotherapeutic response to control the effects of rape and the treatment of PTSD after sexual assault. However, as an early treatment approach, EMDR does not have an absolute therapeutic ambition but aims to reduce the traumatic impact and thereby mobilize the victims' capacity to adapt and avoid the onset of chronic difficulties (Tarquinio et al., 2012).

Pharmacological and non-pharmacological treatments are available for treating depression and anxiety; however, antidepressants are frequently prescribed more than psychological interventions (Cipriani et al., 2018). A review by Public Health England analysis (Taylor et al., 2019) reports that from 2017 to 2018, prescriptions for antidepressants and gabapentinoids had increased, and longer-term prescribing was widespread. This report revealed that 11.5

million adults in England (26% of the adult population) received and dispensed one or more prescriptions for any of the medicines included in the review. Rates of prescribing were higher for women equating to 1.5 times those of men, and the rates generally increased with age. The total of each medication was: antidepressants 7.3 million people (17% of the adult population), opioid pain medicines 5.6 million (13%), gabapentinoids 1.5 million (3%), benzodiazepines 1.4 million (3%) and z-drugs 1.0 million (2%) (Taylor et al., 2019).

Psychiatric medication is marketed as fixing a chemical imbalance by medicating responses to human suffering. Therefore, situating the problem within the victim and not the perpetrator. The public widely accepts the use of varying antidepressants, and prescribing such medication has persisted in mental health care for decades. This acceptance has been justified by the belief that a serotonin deficiency within the brain causes depression (Moncrieff, 2008; Moncreiff et al., 2022). Doctors can prescribe these medications based on NICE guidelines, and justification in the DSM, despite the long list of possible harms arising from the long-term use of some medicines. Moncrieff asserts that a diagnosis can lead to an over-reliance on medication while underplaying its physical and psychological effects. Taylor (2022) found that women who decline medication or therapy can be labelled as treatment-resistant, in denial, and problematic if they require longer-term treatment

With regards to the general use of antidepressants, Taylor et al. (2019) have demonstrated antidepressants (e.g., Benzodiazepines, z-drugs, opioid pain medicines and gabapentinoids) are associated with a risk of dependence and may cause complications for those taking them or attempting to withdraw, particularly if they have taken them for a long time. Some patients may report harmful effects of taking antidepressants or withdrawal symptoms that last for months (Taylor *et al.,* 2019). Eveleigh et al. (2019) explain how individuals using antidepressants without enough knowledge of the possible side effects may be apprehensive about stopping the medication. Therefore, GPs should be aware of the new developments in taper methods and the long-term use of antidepressants, and how their patients' fears, beliefs, and awareness may impact antidepressant use and withdrawal (Eveleigh et al., 2019)

Another approach, electroconvulsive therapy (ECT), along with antidepressants and psychotherapy, is one of the three major treatments for depression and is considered the last resort for depressed patients (NHS, 2019). ECT is a brain stimulation procedure that applies electrical stimulation to produce a series of generalised seizures. Within the literature, ECT is usually resorted to in cases where medication and psychotherapy used to treat severe depression have not responded to other treatments and is also employed for other mental disorders such as bipolar disorder (Read and Moncrieff, 2021). The treatment of ECT has received much controversy recently, partly due to its patient risks and side effects. For example, Li et al. (2020) suggest ECT should be the first-line therapy for depression due to its profound effects in relieving desperation in certain situations. However, Li et al. (2020) appear to have neglected reports in their literature review that recipients endure more memory loss, headaches, muscle aches, and nausea/vomiting.

Over the years, there have been extensive claims and counterclaims for the efficacy of psychiatric medications for mental health treatment. Various researchers (e.g., Sweeney et al., 2016) have demonstrated how providing psychiatric medication after an incident of sexual violence places the woman's mental illness as the treatment focus of the context of sexual abuse. By positioning traumatised victims of violence as mentally ill, traditional models of mental health endorse victim-blaming by pathologising how victims respond to violence. For example, Hengartner and Plöderl (2018) question the validity of antidepressant clinical benefits despite acknowledging that drug treatments effectively help most people with depression. Over the years, psychiatric bodies have increasingly recognised the lack of evidence for serotonin deficiency in depression (eg, Lacasse and Leo, 2005). Recently, a review by Professor Joanna Moncrieff and team (2022), which included all relevant studies investigating the link between serotonin and depression, involving tens of thousands of people, found no support for the evidence that low serotonin levels cause depression. Oram et al. (2022) recently highlighted how psychiatric services could subject survivors of sexual violence to further trauma and prevent healing.

## Trauma-Informed Mental Health Care after Sexual Violence

Recently, there has been considerable public and media attention concerning sexual violence and the association of the potentially stigmatising consequences of diagnoses such as PTSD, BPD and depressive disorder. This has led to an urgent call for a structural and societal shift toward effectively recognising and appropriately responding to women and girls who have been subjected to sexual assault and rape. There has been an increased recognition of the medicalisation of the behaviours and distress of women and girls subjected to sexual assault and how trauma impacts recovery. The development and use of the classification system for psychological distress and behaviour have received much controversy over the years. The issues concerning psychiatric diagnosis stem from applying medical classification and physical disease models to the thoughts, feelings, and behaviours implied as ‘symptoms’, ‘mental illness’ or ‘psychiatric disease’ (Awenat et al., 2013).

The two psychotherapeutic models (medical and social) underpinning the treatment and effects of sexual violence are competing approaches in practice. The current mental health system conceptualises distress and extreme behaviours as symptoms of mental illnesses rather than as coping adaptations to current or past traumas. The medical model pathologises women's responses to violence. It ignores the perpetrators' responsibility by holding the victim accountable for her recovery and focusing on symptom reduction by creating an impairment that dominates their victim status, framing the victim as unwell (Bentall, 2014; Taylor, 2022). Women are assigned as survivors of sexual assault and then diagnosed with PTSD, BPD, anxiety, and depressive disorders and prescribed medications such as anti-anxiety and antidepressants, and reframed as in need of medical treatment.

Trauma-informed approaches in mental healthcare are found in a considerable amount of the literature, underpinning theory and providing an emerging evidence base (Sweeney et al., 2018). Instead of seeing women and girls who have been abused and violated as having mental health issues or psychiatric disorders, a trauma-informed approach to mental health care recognises the effects of trauma as a natural and normal response to extreme circumstances. Instead of seeing trauma responses as abnormal, disproportionate, unjustified and irrational behaviours and feelings, the trauma-informed perspective aims to support those women and girls as being traumatised by the often-repeated acts of violence and treat their trauma as normal, justified, proportionate and rational responses to acts of violence.

Sweeney et al. (2016) explored the effectiveness of trauma-informed approaches. They found reductions in symptoms and improvements in coping skills, physical health, retention in treatment and shorter in-patient stays, including reduced use of seclusion and restraints. Fundamental to trauma-informed practices is 'seeing through a trauma lens' by understanding the connections between experiences and coping strategies and preventing (re) traumatisation (Harris and Falllott, 2001). Johnstone and Boyle (2018) have demonstrated how their 'Power Threat Meaning Framework' is an alternative way of conceptualising trauma and its effects. It offers an alternative way of viewing emotional distress that is not based on psychiatric diagnoses by creating a change in direction: by not asking 'what is wrong with you?' and instead asking 'what happened to you?' (Johnstone and Boyle, 2018).

## Methodology

This study aimed to explore the thoughts and experiences of women who sought support for their mental health after being subjected to rape and abuse. It will also consider their experiences with the professionals they met or referred to at any stage after rape and abuse.

An anonymous survey which combined qualitative and quantitative questions was distributed on social media platforms between 02/04/2019 and 25/04/2019. Users were encouraged to share the study and call for further participants.

Participants were required to be women over 18 years of age residing in the U.K. who had sought mental health support after being subjected to sexual abuse or rape. There were no other participant requirements. Data was not collected on religion or sexual orientation in the present study as it was not required for data analysis as this would be the requesting of surplus data.

All participants were given detailed information about the nature of the study before engaging. There was no deception or misdirection in the study design. Participants were given comprehensive pre-study details about the content of the items and materials and were able to freely choose whether to take part or not. Participants could withdraw at any time and were reminded not to include any identifying information about themselves or others.

## Participants

This study engaged 395 women. Most participants identified as white British. The age range of participants was 18-85 years old; 32 were 18-25, 143 were 26-45, 65 were 46-65, and 1 was aged 66-85. There were no participants aged 85 and over. 241 women stated their age; therefore, the age of 154 women is unknown in this study.

## Method

The survey consisted of twenty-one questions. It began with a detailed explanation of what the questions would ask participants, followed by a definition of sexual violence for information purposes in this study. A consent section was provided, including withdrawal of consent, anonymity and data protection. Participants had the option to skip any question. The survey began with the demographic questions, followed by the questions where participants could respond with free text.

Data from the quantitative responses were analysed using the survey software to provide basic descriptive statistical analysis. Qualitative responses were analysed using manual thematic analysis to create themes for the key findings.

Participants were thanked for their time and provided with signposting for support.

## Ethical considerations

This study was conducted using the principles of the British Psychological Society Code of Human Research Ethics. Participants could choose whether or not to take part based on clear pre-study information. The data was stored and licensed securely. All participants remained anonymous and were discouraged from disclosing personal details, including names, addresses, and any other identifying information relating to themselves or others.

This study had the potential to be traumatic and distressing for participants. It may have attracted women currently being supported or yet to seek support after being subjected to sexual violence. Therefore, the study began with a list of organisations, helplines and services that could support people subjected to sexual violence.

## Key facts: Women seeking support after violence and abuse

1. 74% of women reported sexual violence to their GP and sought support from them. This was the most common professional to disclose to, with the next most common professional being a psychologist at just (47%).
2. There were multiple diverse triggers to women seeking support for their mental health after they were subjected to sexual violence. Help-seeking could occur hours, or years after the incident or period of abuse.
3. Around half of women who took part in the present study had reported the sexual violence they were subjected to, to the police (49%).
4. Some of the most common triggers for seeking mental health support after being subjected to sexual violence were pregnancy, miscarriage, childbirth and being a mum, issues within new relationships and intimacy, poor mental health and emotional wellbeing and reaching what some women termed a 'crisis point' in their trauma.
5. Only 13% of women reported that they felt their healthcare professional had a good understanding of sexual violence and sexual trauma. Many women discussed their disappointment in the lack of empathy and compassion healthcare professionals displayed then they did disclose and seek support.
6. Women expressed a mixture of views and experiences when seeking support for their mental health after sexual violence. For some, the experience was supportive and positive, for others, it was harmful and traumatic.
7. Psychiatric diagnosis of the women seeking support was common, with 79% of women being formally diagnosed with one or more psychiatric disorders after being subjected to sexual violence, and during the course of seeking support for sexual trauma.
8. The most common diagnoses for women to receive whilst seeking support for sexual trauma were depressive disorder (63%), anxiety disorder (53%), PTSD (42%) and BPD/EUPD (24%).
9. Some women found their psychiatric diagnosis helpful and stated that it helped them to categorise and label their 'symptoms'. Some women found their psychiatric diagnosis unhelpful and stigmatising and stated that it was used to reframe them as mentally ill, or problematic.
10. 10% of women were repeatedly offered or suggested to have psychiatric diagnosis but refused to accept or engage in the narrative that they were mentally ill following sexual trauma.

## Key Finding: Help-seeking and Referral process

The first key finding presents the experiences of women who sought help for their mental health after sexual violence and aims to understand the barriers they faced when help-seeking. It also explores their perceptions and experiences of the referral process to mental health services. Understanding the barriers to help-seeking and the referral process, as well as further potential barriers that hinder or prevent women from seeking help from formal mental health services, could present notable considerations for the development of services for sexual violence.

This theme was established by combining three questions from the survey. The first question asked participants how old they were when they were subjected to sexual violence. Participants could select as many statements as they felt applied to their circumstances. There were 520 responses; therefore, many had selected more than one option. Participants also had the opportunity to specify 'other' in a free text box. Comments included coercion, sexual degradation, domestic abuse and abusive relationships. The table below illustrates the reported prevalence of sexual violence against women in the sample.

| **Select any of the statements that you feel apply to your circumstances** | **Total** | **%** |
|---|---|---|
| I was subjected to sexual violence between 18-25 years old | 114 | 49% |
| I was subjected to sexual violence between 10-15 years old | 106 | 45% |
| I was subjected to sexual violence between 16-18 years old | 87 | 37% |
| I was subjected to sexual violence after 25 years old | 76 | 32% |
| I was subjected to sexual violence between 5-10 years old | 73 | 31% |
| I was subjected to sexual violence before 5 years old | 36 | 15% |
| I was still being subjected to sexual violence from childhood when I became an adult (18 years old) | 22 | 9% |
| I am currently being subjected to sexual violence by someone in my life | 1 | 0% |
| Other responses | 5 | 2% |

The majority of sexual violence was committed against women in the sample whilst they were children (58%). 302 individual women selected sexual violence before the age of 18 (76% of the overall sample). However, the most common single response was sexual violence between 18-25 years old. Noticeably, there were also 22 women in the sample who reported being subjected to sexual violence as an adult, which had started and continued from their childhood (6%).

The next question asked participants if they had reported their experiences to the police, which received 233 responses. Participants had the opportunity to specify 'other' in a free text box. Comments included 'reported to police, and I decided not to take further, 'reported by others because I was too young at the time', and 'currently under investigation'. All 'other' comments discussed situations where the woman did not get a positive criminal justice outcome.

The table shows that out of 233 women, 118 did not report. Of the 115 who did report, 12 perpetrators were successfully convicted, giving a successful prosecution rate of 5% of the total, or 10% of those who reported to police.

| **Have you ever reported your experiences to the police?** | **Total** | **%** |
|---|---|---|
| No, I never reported it to the police | 118 | 51% |
| I reported some sexual violence I was subjected to but not others | 22 | 9% |
| Yes, but it was not taken any further | 21 | 9% |
| Yes, it was investigated but the person was not charged | 20 | 9% |
| Yes, the case went to court, and the person pleaded guilty or was found guilty | 12 | 5% |
| Yes, and the person was initially charged, but the charges were dropped, and it didn't get to court | 7 | 3% |
| Yes, and the case went to court but the person was not found guilty | 7 | 3% |
| Other responses | 26 | 11% |

In the final question relating to this finding, examining the help-seeking and referral process, participants stated which professionals they had met or referred to for support for their mental health after sexual violence. There were 761 responses to this question; therefore, many selected more than one option.

| **Professional met/referred to** | **Total** | **%** |
|---|---|---|
| My GP | 168 | 74% |
| Psychologist | 106 | 47% |
| Psychiatrist | 83 | 37% |
| Community mental health team | 76 | 33% |
| Mental health charity | 67 | 30% |
| Crisis team | 52 | 23% |
| Community psychiatric nurse (CPN) | 47 | 21% |
| My local Accident and Emergency (A&E) department | 42 | 19% |
| Police force | 32 | 14% |
| My practice nurse | 16 | 7% |
| My Midwife | 7 | 3% |
| Other | 65 | 29% |

The most common source of support was the GP (74%). Psychologists, psychiatrists, community mental health teams and mental health charities were also common sources of support when women disclosed sexual violence, suggesting that these professionals will commonly support women who have been sexually abused, raped, exploited or assaulted.

Other responses included psychotherapists, self-referrals to private counsellors, University and school-based counsellors, Sexual Assault Referral Centers (SARC), Women's Aid, sexual health clinics, Victim Support and rape and sexual abuse helplines. These responses illustrate how women can access a diverse range of support.

## Key Finding: Triggers to seeking support

This section describes the trigger points that led women to seek support for their mental health after being subjected to sexual violence. A trigger is something that may set off memories and transport a person back to the violence they had been subjected to.

This key finding is important because it captures the complexities of seeking support and how women seek support for a variety of reasons, usually when something triggers them to remember or process trauma.

The triggers to seeking support vary amongst the women who responded to this question. The decision for women to seek support for their mental health after sexual violence is influenced by individual, interpersonal, and sociocultural factors. Women expressed experiencing high levels of distress before realising they were triggered, and needed help.

Participants had the opportunity to answer this question with free text. Many participants did not explicitly refer to the length of time they took after the sexual violence had occurred before they sought support. This was often discussed regarding how old they were at the time of reporting or how old they were when they sought support. Many women had not sought any support until months or years later.

**The following five themes emerged from the narratives within this question:**

1) Pregnancy, miscarriage, childbirth and being a mum,

2) Relationships and intimacy,

3) Poor mental health,

4) Reaching crisis point, and

5) Indirect/unrelated triggers.

## Pregnancy, miscarriage, childbirth and being a mum

This category includes the narratives of 14 women who discussed their thoughts and feelings about pregnancy, miscarriage, childbirth, and being a mum as their triggers for seeking support. Some of the women reported feeling ‘overly worried’ and fearful about their child becoming abused, notably when their child reached the same age as they were at the time of their abuse.

The first subtheme in this category is made up of women who referred to reliving their trauma of rape or abuse through flashbacks triggered by thoughts, feelings, and medical procedures associated with pregnancy and birth. They discussed the intrusive re-experiencing of the sexual abuse they were subjected to as a child. The women portrayed the emotional turmoil and discomfort they felt that triggered memories of the abuse they suffered as a child as the reason for realising they needed to seek help. They also referred to being subjected to sexual violence in adulthood, which triggered emotional responses during their pregnancy or childbirth.

> *“It was only after the birth of my daughter that I sought help for rape that had happened 13 years earlier. During physical examinations during labour I experienced flashbacks of rape that I’d pushed to depths of my mind. I was very confused post birth. Constant state of terror and anxiety. I had to seek help in order to be a good mother”.*
>
> *“I then had a miscarriage at 29 which really triggered a lot of things for me - I was prescribed an anti-depressant to help me sleep and later accessed counselling, initially through work and then paid for privately”.*

These two comments are interesting because women discussed that a pregnant woman may have difficulty feeling “*in control*” at various stages during their pregnancy and birth, and the powerlessness of that sexual trauma may resurface in a way that compounds her sense of vulnerability.

This second subtheme reflects the thoughts and experiences of women who described how the effects of being subjected to sexual abuse as a child had impacted their ability to be a parent. These women sought support because the realisation that someone else mattered in their life felt so compelling.

Several women mentioned accessing support when their child had reached the same age as they were at the time of the abuse they had been subjected to. One explained, *“to keep myself safe, I sought counselling through a sexual violence support service aged 34 when my youngest reached the age I was when I was abused”.*

These women discussed concerns about keeping themselves and their children safe and away from the potential harm of others. Protective compulsions to keep their child safe had become deeply embedded in their thoughts and behaviours.

One woman explained that she became *“fanatical”* about her children's safety when they reached the same age as she was at the time of the assault. Another wrote about accessing support at various times of her life, *“1st time when my daughter reached the age I was when I was abused. 2nd after my father died, he was one of my abusers”.*

These comments highlight the complex emotions women experience when they become a parent and have been subjected to sexual abuse as a child and the ongoing reminder many may face. These women faced difficulties as a parent with their mental health, which triggered them to seek support to help themselves and, for some, so they could help their children stay safe.

This theme demonstrates how triggering it can be for women subjected to sexual violence to be parenting children who reach the same age as they were during the abuse. Specifically, this may be due to realising how childlike and innocent they were at that age, or through trying to understand or imagine how anyone could harm a child. Women reported these strong feelings as being what led to them feeling unstable, afraid, obsessive about their child’s safety and becoming protective. Whilst these are all natural and normal responses to being triggered in this way, it was distressing for some women who didn’t understand why they suddenly became so frightened for their children.

## Relationships and intimacy

This theme was made up of 15 participants who wrote about how the impact of being subjected to sexual violence had affected sexual activity, intimate relationships and relationships with family members. The women felt this was the cause of their need to access support for their mental health. Women expressed various emotional impacts of sexual violence on fulfilling sexual intimate relationships and reconnecting with their bodies which triggered them to access support. Sexual abuse had impacted their sexual relationships with partners, which affected negotiating, developing and maintaining sexual intimacy and became a challenge that they felt required some work. For some, it was challenging to have sex with a partner after getting married, and it was only then that the realisation occurred that it was a struggle to be intimate. Some wrote about sex being physically painful.

> *"I went to the GP. 10 years later because I decided to have sex with my boyfriend (first time to have consensual sex) but found I wasn't able to have sex at all. She diagnosed me and referred me to a therapist".*
>
> *"When I realised I might be gay and that I would have to think about sex again in a meaningful way that wasn't about getting drunk and sleeping around with random people with whom I didn't know if I had been safe or given consent and been mistreated by them, physically and emotionally. I was 23-25 before I even considered I might need help for having been groomed at 14".*

These comments are interesting due to the importance of having a sense of safety and building emotional trust in a sexual relationship for all sexuality and first consensual, meaningful sex. It was common in the data for women to experience difficulties, triggers or unexpected problems with sexuality or their sex lives.

Some of the women discussed problems with feeling comfortable with intimacy with their sexual partners after another person had sexually assaulted them. They appeared to place pressure on themselves to engage in sexual activity after being raped or sexually assaulted when they were not ready.

> *"I thought I had a problem with intimacy in the days after the rape (was in shock/had stopped eating) so saw a uni counsellor who was the first person to use the word 'rape'. She made me see a GP. I tried to get help again 3 years later with another uni psychiatrist but he told me I was too complex for their service and suggested I pay a religious charity he knew for support. Got CBT 10 years after event which helped the most but had to go on meds as part of the condition of having CBT".*

Women wrote about family relations and discussed how their relationships with family members had become challenging. They felt people in their family, such as their siblings or parents, did not understand why they behaved the way they did and often felt no one understood them. Several women described their dependency on alcohol and how it became a way to cover up or mask unbearable feelings of distress, making them unable to recognise their need for support.

One woman wrote, "*I was using alcohol to cope with all the abuse from my husband*".

Another wrote, "*I had repressed memories so didn't know anything was wrong til I was 21 as I was dissociated taking drugs and alcohol and stuff*". Similarly, another woman wrote, "*Even when I started to know something was wrong, it took me a long time to seek help".*

The trauma of sexual violence can lead to painful emotional or physical effects, making it difficult to feel normal, even after returning to their daily lives. Misuse of these substances can increase when there are no other means to deal with the effects of the trauma. Despite this, it was clear from women's experiences that not knowing what was wrong was common. Women were struggling with symptoms which seemed to mirror 'mental health problems', but they had not connected this with their experiences of sexual violence and trauma. Many women in the data discussed 'not knowing what was wrong' for years or decades, often feeling as though they were the problem, or they were going crazy, seemingly with no root cause.

## Poor mental health

This theme includes 43 participants who described going through an extreme phase of poor mental health which many interpreted as unrelated to the sexual abuse. Their mental health subsequently affected how they thought, felt, and reacted to other life events and affected the day-to-day functioning of many of these women, making it difficult and impossible to cope with. The intrusive remembering of their trauma resulted in significant distress before considering if they were ready to access support. Some women had sought help many times and felt they were not being listened to or given the proper care and support. It was only when they became adults that they considered themselves ready to access support, and this was because they realised what happened to them as a child had affected their sense of self as an adult.

The women's stories traced the increasingly extreme emotions they had attempted to self-manage over many years. These women believed they could cope with the effects of rape or abuse as an adult before realising that the emotional turmoil and stress became too significant to endure daily. Within this group however, many had never knowingly connected that turmoil and distress to a trauma at all. One woman wrote, *"It was just my time. and I thought I couldn't do this on my own anymore. It was almost 40 years after the abuse ended".*

A concern amongst these women was reoccurring panic attacks. Struggling with intrusive thoughts and fear of the consequences of another panic attack led to further distress in their daily lives. The intense periods of heightened anxiety and frequency became so overwhelming they affected their ability to study, work and interact with others. One woman explained her panic attacks had become so distressing that she had to be "*signed off work for 18 months after the attack*".

> *"I started having panic attacks as a result of remembering the abuse, quite often throughout the day and usually when I was alone. I decided I couldn't cope anymore and I needed help. The panic attacks started 3 years after the violence".*

Several women discussed talking to their GP after recurring panic attacks but did not feel the need to disclose the sexual violence since it had happened quite some time before. Again, they did not feel they were connected, and instead attributed the panic attacks to 'poor mental health' that was separate to the trauma. One wrote how she was 11 years old when the assault "*happened to her*" and had been suffering from extreme anxiety ever since but did not seek help until she was in her 30s. For her, the trigger point was when she had a panic attack on an overcrowded train, and sought help.

## Reaching crisis point

This theme presents how 35 participants described experiencing a breakdown, feeling suicidal and, for some, attempted suicide. Many women wrote about their experiences of reaching a crisis point before accessing support. Help became of urgent need.

However, most noted that this was not a conscious choice but enforced by others. They discussed not being provided with support or seeking help at the time of the abuse because they did not think they needed to or did not know how to get help. The effects of severe emotional distress were an emotional topic within these responses. The women articulated a direct, causal connection between their mental health and the sexual violence they were subjected to, resulting in intense trauma and suffering. By attempting to suppress the consequences of the trauma, they realised this avoidance was the cause of their breakdown, and many women had kept their thoughts and feelings hidden until years later.

However, concerningly, some found that support was unavailable in their area or could not access the support they needed during the rape or abuse. Despite being in crisis and realising they needed urgent support (or being pushed to access urgent intervention by others), support was patchy and inconsistent.

> *"I had repressed it for years then when #MeToo came out, it brought it all out and opened Pandora's Box for me unfortunately, and I had a breakdown. I was raped at 16 and only dealt with it at aged 40."*
>
> *"…I had a breakdown at 31 and saw my GP. They said there was no available support on the NHS and suggested I contacted charity counselling. I rang Rape Crisis and began counselling 6 weeks later"*

Several women believed the only way to escape the overwhelming pain and distress was to end their life. They had contemplated suicide, and some had made several attempts to end their life. Others only made an initial disclosure of the rape or abuse to the police after attempting suicide and then being admitted to the accident and emergency (A&E) department of the hospital. For some women, seeking support was not a logical or free choice. Their outside environment was the driving force behind the conscious action to look at what was happening to them and what they had been subjected to.

> *"I did not 'decide', I was admitted to mental hospital after suicide attempts and it came out. I was 20 on my first admission, 3 years after the first adult rape (which involved police and subsequent social ostracization). It was a voluntary admission, but I would have been sectioned if I had not agreed"*.

Overall, these findings suggest the distress these women felt became something they could no longer hide or lock away.

## Changes in life events

This final theme captured in this key finding was developed from the responses of participants who wrote about various other changes in their life that were unrelated or not directly related to the sexual abuse.

Women felt their unrelated experiences had triggered them to seek support because they had reached a point where their emotions were too much, and they just needed to get some help. These triggers included moving to another town or city, attending university, the death of a friend/family and others who had reached out to support them.

Many of these women described experiencing disturbing flashbacks, panic attacks, hyper-vigilance and high anxiety levels. They faced emotional difficulties and challenges of moving house and changing their environment. For some, this meant new waiting times for support and a mental health diagnosis they disagreed with. When some women attempted to raise concerns about their diagnosis with their GP or therapist, they felt they had been labelled as causing trouble, disruptive, and told they were lying about the abuse.

> *"Moved areas, now under local CMHT, who have diagnosed me as having paranoid personality disorder, they said there is no proof of abuse because I have self-reported. Felt offended to my core".*
>
> *"Had counselling through the SARC and ISVA before trial. I tried to access support straight after but waited 6 months for counselling through the SARC. CMHT also did not offer treatment or support for sexual violence. Have since moved where the CMHT are more supportive and had CAT (Cognitive Analytical Therapy)."*

These responses suggest a difference in the availability of mental health care from the community mental health team, which often depends on where a person lives. Several women wrote about their university's negative and positive effects on their mental health. The most common triggers for these women related to starting university and moving away from home which triggered flashbacks and symptoms they could not deal with. One woman described feeling "*lucky (kind of) to get the immediate support of a mental health advisor at my university*" in the first few days after being assaulted.

Another wrote, "*the trigger point was starting university and falling in love. I wanted to deal with my issues so that I could live a 'normal' life".* Another wrote, "*I next accessed support for my mental health at approx age 21 following leaving university and feeling unable to cope with changes in my life - I was prescribed antidepressants".* This comment suggests a significant amount of time had passed before she was able to access support.

Some women explained that other people in their life had encouraged them to seek support, one woman was persuaded by her boyfriend and his family to seek help, and another was encouraged by her fiancé. One described how the counsellor she saw at Relate helped her understand that what she had been subjected to was a rape.

For others, the trigger point for looking for support was as simple as being asked, "Are you OK?" by a complete stranger, which made women reflect on the fact that they were not OK at all.

Women also found that starting a new job was the trigger for seeking support; this was reflected in how they described going through a significant change in their life. A small number of women described similar experiences due to graduating from university. Although they did not state their age, it was clear that the significant achievement in their life had caused a shift in their emotions, which led them to seek support. One woman explained that when she began working in the Violence Against Women and Girls sector, she "increasingly encountered triggers" and another wrote how she had found feminism as a way to save herself because rape "kept happening" to her.

Some women understood that other traumatic events, such as seeing stories in media about other sexual violence, had made memories of their abuse come to the surface. Some wrote that they realised as adults that sexual abuse occurred as a child.

## Key Finding: Responses and understanding of professionals

This third key finding presents how professionals responded to the women when they disclosed their experiences of being subjected to sexual violence (Q12) and their experiences of their route to care and support for their mental health (Q13). Asking women subjected to sexual violence about their experiences of the professionals they sought support from is crucial to understanding how to provide appropriate and sufficient resources.

This finding includes the responses to three survey questions. In the first question, participants were asked if they felt the professionals, they were referred to had a good understanding of sexual violence and sexual trauma (Q7). The chart below shows that 253 women responded to this question; 121 women felt that some professionals were much better than others; 76 stated no, 29 answered yes, and 12 didn't know.

| **Do you feel the professionals you were referred to had a good understanding of sexual violence and trauma?** | Total | % |
|---|---|---|
| Some better than others | 121 | 53% |
| No | 76 | 33% |
| Yes | 29 | 13% |
| Don't know | 12 | 5% |
| Other | 15 | 7% |

Participants had the opportunity to specify 'other' in a free text box. Responses mainly reflected an 'inadequate response to disclosure' and a 'lack of trust in professionals'.

One participant wrote she had never disclosed the rape to her therapist, *"didn't trust her. She called me a prostitute even though this was my first sex partner and it took me a long time to figure out what I thought she meant*".

A lack of trust was echoed by another woman who wrote, *"When I spoke to my GP about domestic abuse no one ever asked me if I had been sexually abused".*

Another explained, "*Some understanding - although the response felt like it was inappropriate at times, e.g., level of distress displayed by therapist when hearing disclosure and in discussion was discomforting*". These comments start to paint a picture of the difficulties some women face when seeking support.

The next part of this finding about how the professionals responded to the women when they sought support includes responses from the survey question.

**The following two themes emerged from the narratives within this question:**

1) Helpful and understanding approach and,

2) Dismissive and apathetic attitudes.

## Helpful and understanding approach

This theme describes how the women perceived the response from the professionals to be helpful and understanding. Some women wrote about their GP responding appropriately, portraying an empathetic nature and acting quickly by arranging a referral to the local mental health services. These women felt their GP had listened to them. They described how they "*felt*" they had been heard, understood, and believed.

One woman described her GP as "*kind"* as she was not "*pushed*" to go into detail about the sexual assault. She explained how her doctor had diagnosed her with PTSD and then kindly telephoned her every week for four weeks while she waited to be seen by a psychotherapist. There was a sense of relief that the therapy helped her to look at her own belief systems and to move on with her life.

Others wrote the GP they had seen had handled their disclosure and need for support sensitively and supportively. Some women were referred to the SARC, and all of these women were happy with the support provided.

> *"Yes, there were the people who helped me realise what happened was rape. They still reassure me it was because I struggle sometimes with that word as I was in a relationship with my rapist".*

The following quote is significant because it shows how professionals can respond appropriately with compassion and empathy; however, it highlights the complexity of receiving a mental health diagnosis for many women who responded to this question and throughout this study.

> *"Yes, I informed the Psychiatrist who carried out my MH assessment. She was empathetic and said my response was completely normal and understandable from what I had endured. When I was diagnosed with multiple conditions it was a relief to know I wasn't crazy or psychotic which is what the social worker involved in my case had claimed (my children were initially removed from my care because a social worker stated I was psychotic, which was disproved by the Psychiatrists I had to see. I was forced to undergo 3 MHA assessments because the social worker was insistent I was psychotic and each time the assessment cleared me of any psychosis she dismissed the reports and arranged another assessment)"*

In many ways, women felt happy with the diagnosis and support, although the relief of being taken seriously outweighed the realisation they had been given medication and a mental health diagnosis that may then be used against them.

## Dismissive and apathetic attitude from professionals

Women described how they felt silenced by professionals when they disclosed the abuse. Many of the professionals displayed a dismissive and apathetic attitude.

Some women described their sense of self as being undermined by professionals, which affected their self-worth and sense of identity. One woman explained how she told her GP, but her disclosure of sexual violence was met with pure disbelief as if she had been making it up.

Another described her experience with the GP to be awkward and not very helpful. One woman expressed how the level of distress displayed by her therapist as she spoke about the abuse left her feeling shocked and unsupported.

One described how a male detective was keen on gaining a criminal justice outcome, but lacked empathy for what had actually happened to her. Another wrote, "*NHS, did not seem to be too significant when for me it was the MOST significant".*

Several women wrote about being asked awkward and unnecessary questions about their feelings, which made them feel to blame for what happened. Women discussed how they felt that the responsibility was put on them and not on the abusers. In this process, professionals inadvertently blamed women, and maintained the secrecy and shame of sexual abuse by missing crucial opportunities to support women and girls.

Questions asked about the experience of the referral pathway to mental health support. Therefore, in the final question related to this theme, participants were asked what their route to care was like. There were 239 responses to this question.

**Two themes emerged from the narratives within this question:**

1) Long wait to get support and support was not available,

2) Sought own support.

## Long wait to get support and support was not available

This theme includes the majority of respondents who answered this question. They either described experiencing long delays before being provided with mental health support or any support was unavailable. Overall, the women found it challenging when they attempted to access mental health services, and many found the support available did not meet their needs, which left some women fearing for their life. Some had been refused help by the professionals they saw because they had been categorised as not being in "*enough need*" or "*unwell enough*". Some women wrote about being denied support from the GP, because too much time had passed since the assault

> *"Initially GP referred me to rape centre and they weren't interested as it happened years ago. They said they only dealt with recent rape, not historic. Once reported to police I was put in contact with Victim Support and a rape centre".*

Other women explained how they felt when they had not heard back from their GP. This made them feel like they should give up trying to help themselves if no one else cared. What support they received often left them feeling blamed, doubted, and re-victimised.

Almost half of the women who responded to this question discussed their experiences with their GP. They described their GP as providing support in the form of medication for anxiety and pills for sleeping. Many emphasised they had repeat prescriptions for medicines, which for some went on for many years, even decades.

They felt the medical model of mental health lacked recognition of trauma or the provision of trauma therapy, making the abuser invisible by focusing on the women's mental health by diagnosing them with depression, anxiety, PTSD and BPD.

One woman described to her GP that she had gone to A&E during a severe panic attack and was referred by her GP to a mental health support service for CBT. She appeared comforted by the follow-up appointments with her GP while waiting to see a psychologist.

Several women chose to visit their GP because of extreme distress. They described the professionals they were referred to as not having enough experience dealing with mental health symptoms after sexual violence. After being diagnosed with a mental disorder, women also reported a lack of regular check-ups by the GP. They were often left without support once they were diagnosed and medicated.

One woman explained she was not offered talking therapies despite making it clear that she needed to talk to someone. She wrote, "*just sleeping and anxiety pills and they re-fill my prescriptions without speaking to me or asking me to come in and discuss how I'm feeling*".

Although another described feeling "*extremely lucky to initially get a GP*". Some women encountered barriers when accessing support, yet this depended on how long since the sexual violence had occurred. It felt easier to access support if the abuse was more recent than decades previously. This was often because women felt that abuse and trauma that had happened many years ago was not as important, or serious, or that professionals would not take it seriously.

One wrote of how she was offered antidepressants and sleeping tablets which she refused and requested counselling, although she "*ended up on the meds eventually*" because she was suicidal and the counselling had still not been offered.

Women who disclosed the assault to their doctors commonly received prescription medications. Women felt their GP was not interested in supporting them unless they accepted the medication. This response felt distressing and upsetting. These women's narratives characterised their doctors' responses as "cold" and felt their doctors were silencing them by prescribing medication with little or no explanation.

This inadvertently puts the issue entirely or primarily within the individual woman rather than their reported traumas, or current circumstances. It implies something is wrong with the women rather than helping identify what is going on in their lives so there can be an attempt to improve their suffering and circumstances.

A smaller number of women discussed their experiences of attending A&E. One described that her GP had instructed her to attend A&E, and she described how her GP appeared not to know what else to do. Another described how A&E had become a regular part of their help-seeking experience, as there were no other services available.

*"I was in and out of A&E and received no formal support until I accepted the BPD label which allowed me to get treatment in a Therapeutic Community. I never believed the BPD label; but it was the only way to access the support"*.

Frequently in the data, women discussed reluctantly or deliberately accepting a diagnosis in order to gain support, despite not believing they had any form of disorder. Arguably, this is an indicator of a system that does not support women outside of the medical model of mental health, and also demonstrates how much medical gatekeeping there is around access to support services. Many services require a psychiatric diagnosis to be accepted by the patient in order to allow them to access the service.

Several discussed their group therapy experiences; some said it increased their anxiety and were further triggered or traumatised. One described the responses she received from Rape crisis as "*fairly good*". She also felt she did not belong in a group with other women because the abuse she had been subjected to was not as severe or recent as other women. She wrote, *"I wasn't ready to sit in a group with other females who had been raped because my abuser had not penetrated me in the decade of abuse so I did not feel I "belonged" to the same category of victims*".

Others felt that often the sessions did not last long enough due to a lack of funding and thought they had disappeared from the records by not being asked to attend.

*"I was sectioned and then offered Group Therapy. This lasted only six months instead of the eighteen months because of lack of funding. It was due to start again but I never heard from them again. That was two years ago".*

The most common treatments received by women were cognitive behavioural therapy (CBT), several forms of counselling, and medication. Many women described being placed on waiting lists that took anything from 3 to 24 months to be seen by professionals. Often, support in a therapeutic environment was limited to set sessions, usually 6-10 weeks. Referrals were typically by their GP, and they often struggled to get access to therapeutic services.

Others accessed CBT through a local charity. However, some women were told that the service was not qualified or specialist enough to provide adequate support due to the 'severity of symptoms'. One woman felt so distraught by the CBT that she "*asked to be referred to the mental health hospital*" because she believed her "*symptoms were uncontrollable*". However, her GP advised her to do another round of CBT because they felt that her symptoms were not that bad.

Most of these women had waited over a year after the initial assessment for therapy in the mental health services, and some gave up because it was too long, because they felt ignored, or their mental health issues were not perceived to be 'severe enough' to be seen when needed. They felt that the "*route to care was a joke".*

One woman was informed that she needed to attempt suicide a minimum of five times to be able to receive emergency crisis support. Several discussed the difficulties in accessing support from female counsellors as they felt they could not talk to a male therapist. Many explained this reason as simple, since a man had sexually assaulted them, they did not want to talk to a man about it. One woman described how she was automatically given an appointment with a male counsellor and would not have attended if that was her only option. Another wrote, *"I was so desperately unhappy I didn't give a shit who I saw as long as it could happen soon".*

## Sought own support for mental health after sexual violence

This theme includes the responses of women who sought their own support from mental health services after sexual violence. They described making self-referrals to charities or private therapists and being unable to seek help until they become adults.

Many women wrote similar accounts, including long waiting lists via the NHS, and a general lack of trust in their GP in referring them for the right support, or giving them the proper medication. Some women wrote how their GP told them they had to make their referral for support, although they were unsure how to do it.

Many felt this process was time-consuming and challenging. Help in their local area felt limited because most free places only offered CBT.

The self-referral process felt like a long, complicated, time-consuming, costly and draining route.

> *"I struggled to find help in my local area as places and charities were overworked and oversubscribed with people they were working with. I eventually contacted private counselling services and professionals to try to get help, but I ran out of money and had to stop the sessions".*

Another described how she spent nearly all of her savings on private treatment because her sexual trauma symptoms were impacting her life *"so severely"* that she *"just wanted to get 'better' and didn't trust the NHS to help"*

## Key Finding: Diagnosis as harmful and unwanted

The fourth key finding aims to portray how the women felt about being diagnosed with a psychiatric diagnosis when they sought support for their mental health. It is in two sections. The first section discusses the responses indicating how receiving a diagnosis felt harmful and unwanted. The subsequent key finding examines the women's narratives that reflected how the diagnosis or treatment felt the opposite, and that the diagnosis was helpful and wanted.

Only 246 participants indicated they had been diagnosed with a mental health condition when seeking mental health support. As 395 women took part in this study, it is possible that some women (149 women) did not receive a diagnosis or simply preferred not to answer this question.

127 women stated 'yes', 57 selected 'no', 15 'did not know', and 56 had been diagnosed with multiple.

| **When you sought mental health support, were you diagnosed with any mental health conditions?** | **Total** | **%** |
|---|---|---|
| Yes | 127 | 55% |
| No | 57 | 25% |
| I have been diagnosed with multiple mental health conditions | 56 | 24% |
| I don't know | 16 | 7% |

The following question in this theme presents the way women perceived being diagnosed with a psychiatric diagnosis.

Participants were to select any relevant but only select the diagnoses given by a professional or written on their medical records. This question did not explore which professional made the diagnoses or how often they had been seen by the professional(s). There were 544 responses to this question from 183 women; therefore, many women selected more than one option. Participants had the opportunity to specify 'other' in a free text box. Many of these responses included eating disorders (anorexia and bulimia). Others wrote; dependent personality disorder (DPD), avoidant personality disorder (APD) and vaginismus.

| **Diagnoses given to women after disclosing sexual violence** | **Total** | **%** |
|---|---|---|
| Depression | 135 | 63 |
| Anxiety disorder | 115 | 53 |
| Post-traumatic stress disorder (PTSD) | 90 | 42 |
| I have never been formally diagnosed | 36 | 17 |
| Borderline personality disorder (BPD) | 31 | 14 |
| Emotionally unstable personality disorder (EUPD) | 21 | 10 |
| I refused to accept a diagnosis, I didn't agree with it | 21 | 10 |
| Dissociative identity disorders | 15 | 7 |
| Psychosis or 'psychotic episodes’ | 10 | 5 |
| Bipolar disorder | 13 | 4 |
| Obsessive compulsive disorder (OCD) | 8 | 4 |
| Body dysmorphia | 7 | 3 |
| Any other personality disorder not listed here | 7 | 3 |
| Mania or Hypomania | 4 | 2 |
| Schizophrenia | 1 | 0 |
| **Other** | 35 | 16 |

This table demonstrates that it is common for women to be diagnosed with at least one mental health issue after disclosing sexual violence. The most common diagnoses after sexual violence are depression, anxiety, PTSD and various personality disorders. The least common were bipolar disorder, obsessive-compulsive disorder, body dysmorphia, mania or hypomania and schizophrenia. Another interesting finding is that refusal to accept a mental health diagnosis is relatively high, as 21 stated they had no formal diagnosis, equating to roughly 1 in 10 of the women who responded to this question.

The following two survey questions used to describe this theme were aimed at the women who were diagnosed with a mental health condition or disorder after disclosing sexual violence. Participants were asked about the diagnosis, whether they thought it was helpful, and whether they agreed with the diagnosis, which received 164 responses. The following survey question asked participants to reflect on the experience of being diagnosed and if they felt it was right to be diagnosed with a mental health condition which received 149 responses.

Participants had the opportunity to answer these questions with free text. This section considers how their responses to these questions reflect how receiving a mental health diagnosis is harmful and unwanted. It includes those who disagreed or were unsure if the diagnosis was right for them. A strong theme of ‘Not validated’ emerged, which portrays the narratives of nearly half of these women who wrote about how their diagnosis after sexual violence made them feel as though their thoughts, feelings and emotions were not heard. They felt they were not listened to or understood.

## Not validated

After several visits to the GP or therapists, and for some, just one visit, these women became labelled as suffering from mental health issues and intense problems with controlling their emotions, which resulted in a diagnosis of depression, ‘personality disorder’ and ‘borderline personality disorder’.

*"It was complete bullshit! And wrong. And unhelpful".*

*"I knew my diagnosis was wrong but felt powerless to question it".*

Many others echoed these comments, who felt the professionals did not attempt to understand why the women had these feelings, leaving them angry and insulted by the diagnoses. Many described how they could not question the diagnosis and the medication they had been given.

One woman wrote, “*Being told, ‘you have bipolar’ or ‘you have a personality disorder’ as though it is an unquestionable fact”.* Several of these women expressed concern that the real cause of depressive thoughts (sexual trauma) had been overlooked.

Sometimes the women felt that the diagnosis justified their reactions and emotions, but this acceptance of being labelled as ‘mentally ill’ came at the cost of being stigmatised by society.

One wrote, “*That label follows you everywhere. If I go to the GP now with tummy problems, they automatically link it to depression*”.

Another wrote, “*Felt like this was what the doc wanted rather than me. It was like them covering themselves rather than taking care of me*”.

The mental health diagnosis made them feel they were not being listened to. Women expressed how the label had failed to validate their trauma. It was just a way to access treatment and support to cope with the symptoms. These women felt disempowered by the mental health label, and for many, carrying around a mental health diagnosis felt like a burden. Some described the diagnosis as *“useless*”.

The women in the sample often demonstrated that wherever they went, people found out one way or another that they were ‘mentally unwell’ after being raped or abused.

Another important note from the participants' responses is that many of the women considered GPs to view medication as a way to manage a crisis or to treat or reduce the symptoms of their mental illness that had resulted from the trauma of sexual violence or to prevent the disordered behaviour from returning. The medicalized treatment women receive for their trauma, and their diagnoses after being sexually abused therefore disregards the care they need in favour of medication.

These women described how the diagnosis prevented several of them from getting what they called, “*the right help*” and felt like an excuse not to help with real issues, like a “*brush-off”.* The anxiety and depression diagnoses had closed off paths for other interventions. However, they expressed clearly that labels are not helpful for normal reactions. Some felt their GP began to treat them differently once a mental health diagnosis was on their records. Others felt professionals couldn't agree on labels, and saw them as problematic or complex.

One woman wrote how the diagnosis of anxiety was not accurate, and felt that PTSD was a better fit for her. Others described how they knew they were not depressed because they were reacting to a traumatic event. Many wrote that it became obvious that the trauma of rape was the cause of feeling depressed or anxious, but they were diagnosed as having a mental health disorder.

Many women disagreed with being diagnosed with a mental health disorder and felt abandoned by the professionals who should be there to help them. Several had attempted to challenge this decision with the medical professional and felt their emotional experiences had been rejected and ignored.

> *"I thought getting it would help because I could take medication and, in some cases where I felt comfortable, tell people I was anxious and depressed. However, that was over 10 years ago, and I feel as though it has become part of my personality and can be a bit of a cage. It takes a huge effort to remind myself I don't have to be that way, and that feeling happens so very rarely."*

This comment reflects how the label of the disorder can define the identity of the woman. Many of the women in this study felt their personality was not actually disordered, and they were not unstable – but realised that it had become a part of their identity that not only others had accepted, but they had accepted it themselves, too.

Having a diagnosis felt "*even more disempowering, invalidating and belittling*"; another wrote "*I was livid. It felt so disempowering, so blaming".* These women explained that they do not have a disorder, and are simply reacting to trauma, but this was not taken seriously. Conversely, one woman wrote, "*I didn't feel stigmatised by the diagnosis…"* but engaging in the course of EMDR therapy and being perceived as "*cured*" felt very "*problematic"* for her self-understanding. She wrote of feeling that she had been positioned as ill, the EMDR had been positioned as a cure to her illness, and it she had struggled with the professional view of her and the nature of her sexual trauma.

Other women described being "*given a personality disorder & left*" to cope alone after disclosing sexual violence, which felt like an "*excuse not to help with real issues*". For some, being diagnosed with depression and anxiety made them feel ashamed, as it was a way of putting a "*plaster on a bigger problem*".

Other women had been kept awake at night by the constant reminders of what happened to them, and the years of unsuccessful attempts to get the right help. One woman wrote, *"It still keeps me awake at night sometimes thinking about how the professionals let me down so much*".

Most of these women recognised that after the sexual assault or rape, they had experienced "*a normal reaction to an abnormal set of circumstances*", but they had not been able to find any professionals who saw their sexual trauma through that lens. Instead, they were diagnosed as abnormal or disordered, which had caused them further distress.

However, although some felt they were having normal reactions, ultimately, they felt something must have been wrong with them. The diagnosis did not improve their mental health as expected, hindering their recovery by causing feelings of persistent self-blame and societal shame. Women wrote about how they perceived their brains had reacted to events they had been subjected to, and subsequently, they were left to deal with the trauma.

The women saw the diagnosis of PTSD as being told they were abnormal and implied a state of victimhood for others. The mental health label subsequently held these women responsible for the actions of their abuser and they were not validated as women reacting to what they had been subjected to. The label of PTSD defines them as defective and damaged members of society. They did not relate to being "disordered"; they realised they had been "traumatised". One woman wrote, *"labels are for jars, not for people."*

# Key Finding: Diagnosis as helpful and wanted

This second section considers how the responses to receiving a mental health diagnosis reflect being helpful and wanted and includes those who agreed with all or some of their diagnosis. The theme emerged of, ‘It gave me a better understanding of myself’, which consists of the thoughts and feelings of most participants who responded to these questions.

## It gave me a better understanding of myself

Many women wrote how the diagnosis helped them to make sense of the symptoms, took the weight off the self-blame, and made life easier. They felt it was helpful to know what they were dealing with, which gave them something to work with. For these women, getting support for their mental health was highly important because they believed they were damaged or broken.

Women found the confirmation they were not crazy to be beneficial because they felt something was wrong with who they were. For many women, it was useful to have a mental health diagnosis because they reported that they could then understand what they were dealing with.

Many of these women described how they had attempted to guess their diagnosis from a list of symptoms online, and were happy to find they were correct. The knowledge of what the diagnosis included and the typical symptoms became a valuable tool that enabled them to research the symptoms of their diagnoses and understand their problems.

One woman explained she was relieved to have a diagnosis because it explained her symptoms. The diagnosis “*made sense*”. It was *“accurate”*. The diagnosis *“made it easier to explain to others without going into other life events”* for another*, “it seemed to make sense”* because although she reported having depression and anxiety all of her life, *“it just got much worse at that time”* when she was subjected to sexual violence.

Others explained how a mental health diagnosis provided a way out of the persistent memories of rape, sexual assault, and abuse, because it shifted the focus from the trauma, to the belief that they had a mental disorder. They believed the diagnosis was needed because it was a way to move on with their life, gave them knowledge of what to work with, and became a functional tool to improve their life. Some women took years for their feelings and emotions to be recognised. These women had made repeated attempts to access different therapies and try varying medications.

One woman wrote, "*I know I had PTSD afterwards, but it took me years to realise*." However, it also made some women question who themself as if they had *"made it all up"* and was *"as bad"* as they thought the abuse or assault was and even questioned if they had caused the violence.

Although some women felt confused about what a diagnosis meant, they felt relieved to be diagnosed and given antidepressants as they had already searched their symptoms and felt PTSD was an appropriate fit. Receiving support for being 'mentally unwell' was important for some as they were experiencing other pressures such as exams, where they could demonstrate a diagnosis or need to their university examination or assessment boards. The diagnosis helped many of these women come to terms with what they were going through. However, another said that she was not sure how she felt. One wrote that she was unsure but, "*just glad I didn't give up going and finally got antidepressants*." Although it was a label, they had answers which provided something to work with.

Some of the women felt upset about their diagnosis, but also happy to be able to blame their feelings on something else, and not on themselves. In this way, the diagnosis felt separate from their sense of self. For one woman, it felt *"upsetting"* to receive a mental health diagnosis, although she explained *"at the end it was helpful to give it a name and be reassured I was not crazy".*

Others wrote how the issue was in their brain. They felt they had lost touch with reality and had been saved by the medication or therapy. Some women agreed with the diagnosis and expressed relief from the medication. One woman wrote, *"I was diagnosed with bipolar disorder which I do agree with as medication has been effective and there are also occasions where I have lost touch with reality".*

For some women, interventions from the mental health system were part of the repertoire of thoughts against themselves that something was wrong with them. The need to get support was immense because they knew ‘something was wrong with them’. They felt they were faulty or damaged. Some described how they needed to be offered specific support as they would not have known what to look for themselves.

> *“It is a label, but I have an answer, even though I am confused about what the diagnosis means and unsure if it is actually correct, I just accepted the diagnoses, and pretend I am ok, it is a relief to know I am not crazy, the diagnosis explains what is going on for me. Because I felt there was something wrong with me”.*

Another wrote how she was relieved to be told that she had a dissociative identity disorder because she thought she was *“slightly mad, creating a sort of split identity to tolerate the abuse”.*

The referral to mental health services confirms a feeling of madness and distorts perceptions of recovery while deepening the sense of disempowerment and loss of self-esteem.

One wrote, “*I felt believed and it helped me move on. It took the weight off the self-blame and helped me grasp feelings and made sense of so many emotions.”* They explained how it felt right to be diagnosed with a mental health issue because receiving support became possible. This was repetitive, in that women were relieved to be given a diagnosis because it was their only route to professional support in services where the diagnosis was mandatory for referral.

One woman wrote, “*Obviously, it is PTSD, no fucking shit, Sherlock, the PTSD helped me understand my feelings”.* Another woman described being very unwell and a danger to herself and others. One expressed that her suicidal thoughts were not “*normal”.* For many of these women, it was crucial to feel like they were in control and to be able to attempt to regain control of their lives.

## Key Finding: Treatment and Support

The key finding considers the experiences of accessing or being prescribed treatment and support for their mental health (Q10). This finding also considers how the treatment and support helped them feel better (Q16) and how it impacted their life with a diagnosis or without one (Q17).

The first survey question (Q10) in this finding asked participants to indicate what types of support they had accessed or been prescribed for their mental health following sexual violence. They were able to select as many responses as possible that were relevant to them. There were 700 responses to this question. As shown in the table below, most women who responded had accessed or been prescribed more than one service following being subjected to sexual violence. This question did not explore how many referrals women had or how often they sought support.

| Types of support prescribed for women after disclosing sexual violence | # | % |
|---|---|---|
| Counselling | 162 | 71% |
| Medication | 151 | 67% |
| Cognitive Behavioural Therapy (CBT) | 99 | 42% |
| Charity support | 49 | 22% |
| Support groups | 44 | 19% |
| Trauma therapy | 39 | 17% |
| Psychoanalytic therapy | 32 | 14% |
| EMDR | 31 | 14% |
| Mental health support worker | 21 | 9% |
| Never offered support | 18 | 8% |
| DBT | 19 | 8% |
| Other | 38 | 17% |

Counselling (71%) and medication (67%) were the most common forms of support accessed or prescribed to women who had been subjected to sexual violence. Only 17% of women were offered trauma therapy, despite them clearly disclosing a sexual trauma.

Participants had the opportunity to specify 'other' in a free text box. They had received or were Electroconvulsive Therapy (ECT), acceptance commitment therapy (ACT) and cognitive analytical therapy (CAT).

Out of these responses, most answers reflected that support came at a cost. This cost reflects money, time and a risk to their life. Many women sought help through private therapy, charity counsellors, and alternative therapy, such as life coaching.

*'I was initially refused access to M.H. support during the police investigation of my case (I was told to choose either having a criminal case or M.H. support because I couldn't have both). Eventually when the police cases were closed, I was assessed by the CMHT & told my M.H. condition was too severe and my suicide risk too high to be able to access help, and I was discharged from the service without receiving any help.'*

Other responses highlight the lack of funding and availability. One woman wrote, *"Since government cuts there is no longer 1 to 1 counselling available" and* another wrote, *"I had counselling at my GP practice in my 20s. Then paid privately for longer term therapy"*

The next question from the survey included in this theme of the women's experiences of the treatment or support that was accessed or prescribed. Women were asked what treatment they were offered when they were diagnosed with psychiatric disorders, and whether the treatment helped them to feel better.

Participants had the opportunity to answer this question with free text. There were 158 responses to this question, and 237 did not respond; therefore, it is possible that they preferred not to answer this question. Women were recommended many treatments or interventions for their mental health after sexual violence; psychotherapeutic treatment, counselling and therapy, and medication, including being sectioned to a mental health hospital.

**Five key themes emerged from the responses;**

1) No, the treatment did not help,

2) Yes, the treatment did help,

3) It changed how others see me,

4) Feeling broken; and

5) Doesn’t change a thing

## No, the treatment did not help

This theme was comprised of participants who were given treatments, sometimes multiple. The treatment caused numerous side effects which made them feel worse, and most were receiving varying forms of treatments years after they first sought support.

For many women, it appeared common to be given medication and counselling simultaneously. Others said they had never received the counselling or were still on the waiting list, and many said this waiting list was too long.

These women described experiencing a lack of appropriate referral to services to assist their emotional distress. One woman explained she had been refused support from the mental health service for nearly three years until she was placed on a waiting list for tertiary care in a trauma clinic which was expected to be as long as 40 months. The medication felt like a temporary fix to a long-term problem which simply masked the issue and made them feel worse.

One woman described being given a combination of Lamotrigine and Duloxetine, which made her “*feel numb*” and at least once, she felt suicidal. Another wrote*, “I was put on various cocktails of anti-psychotic drugs, antidepressants, a stimulant and Xanax ”*. This woman also described how she was provided with medications that calmed her panic attacks but increased her suicidal ideation and self-harm. She also explained how her medication was “*switched to SSRI*”, which left her feeling *“flat or anxious”.*

A woman described how the counsellors she had seen had made her feel useless, and the pills always made her tired and exhausted. She wrote, *“so it wasn’t helpful and I tried many different ones”.*

Some wrote about how Propranolol had prevented their physical panic attacks (increased heart rate, increased blood pressure, increased respiratory rate) from reoccurring due to its effects on adrenaline, but it didn’t treat or cure their psychological panic or anxiety. Some described the medication as making them feel better temporarily, but they returned to their previous state when they stopped taking them. Further, some women discussed how it felt when they attempted to withdraw from the medication, as they experienced distressing withdrawal and side effects.

The medication came with harmful consequences; for some, the counselling therapy helped, but the medication made one woman, “*feel like a walking zombie”* and she *“couldn't function so I had to come off them”.*

*“At 15/16 I was given pills and told I had to take them. The pills made me pass out in the middle of the night (they gave me severe vertigo) no one had informed me of the side effects and I wasn't receiving any support from my family. I was terrified, thinking I was dying on my bathroom floor. I was really scared my family would find out (I'd been raped within the family) and considered taking the entire packet so that it would be over”.*

These comments are important because they reflect the broader phenomenon that medication and therapy can have a harmful effect. Several women explained the difficulties of accessing CBT for their trauma responses. One woman stated, *“Counselling…CBT…Psychologist…Psychiatrist…It got a bit confusing”.* Another wrote*, “Counselling and CBT - this was not the right approach for trauma - terrible and really unhelpful …and therapists definitely not skilled enough for this”*.

The antipsychotic medications had many downsides for the women in this sample. They mentioned how the effects varied widely. Most women did not feel that antipsychotics made any positive difference to their sexual trauma.

> *"I was put on antidepressants. I don't think they did anything and eventually took myself off them over time. I was given betablockers for the anxiety which I still use occasionally, and diazepam which I only used in emergencies. I didn't like them as they made me sleepy. Only the beta blockers were helpful".*

Others described how her treatment after sexual abuse was focused solely on what medication she should take, and the conversations became about illness, medications and treatments.

> *"I was prescribed Sertraline, initially 50mg and currently 100mg. Most of the conversations around "treatment" have been in terms of medication, and any counselling/talking therapy/online CBT offers are a) very limited and b) have a massive waiting list."*

Another described that she *"got medication and supportive therapy"* but "n*either have helped," because she is "still a patient there 10 years later"* she ended her comment by saying *"Oh, I also got ECT".*

Several women discussed the length of sessions available to be too short, often in terms of not continuing for long enough to get to the problem. Some reflect on the effects that CBT had on their emotions. Initially, CBT was helpful for some, but it soon became clear that the sessions were not enough. One woman wrote, "*I only received partial help with PTSD then I ran out of the allowed time on the NHS"*. Another wrote, *"Over the phone counselling sessions that weren't compatible for me. Did not complete the counselling".*

## Yes, the treatment did help

This theme is made up of the women who felt the prescribed or recommended treatment helped them. They also discussed a combination of therapy such as CBT, EMDR, and Psychotherapy, and medications which included antidepressants, Lithium, Risperidone, Duloxetine, and Fluoxetine. There was a mixed response to treatment and most women were offered various therapies.

Some women felt the trauma therapy helped as it allowed them to move on with their life *"EMDR was the most helpful. It allowed me to move on with my life and not be affected by it anymore. Talking therapy was less helpful".* For some, antidepressants initially helped; however, once the antidepressants were prescribed, some GPs stopped monitoring or supporting the women, and one decided to stop taking the medication as she was not made aware of the side effects or withdrawal effects that may occur. She wrote, *"I quit by myself and side effects of feeling suicidal were definitely not helpful!"*

Conversely, another wrote *"The treatment helped a lot. However, since the CBT stopped I'm struggling again".*

Overall, this theme was much smaller than the contrasting theme of medication and treatment being unhelpful and harmful. More women discussed harm, and they discussed harm in more detail. Some women did report medication and treatment being helpful, but even when they did, it was often caveated with negative side effects or negative experiences. Where some women felt their diagnosis was positive, their medication or lack of therapy was negative. Conversely, where some women felt their diagnosis was harmful or inaccurate, they found some of the treatments or therapies to be helpful. There were no women in the data who reported a wholly positive experience of being diagnosed, and then prescribed therapies or medication.

## The impact of a psychiatric diagnosis following disclosure of sexual violence

To explore this further, women were asked what impact diagnosis of a mental health issue or disorder had on their lives.

Participants had the opportunity to answer this question with free text. There were 168 responses to this question. 227 did not respond; therefore, it can be assumed they preferred not to answer this question. 149 participants wrote about a mental health issue or diagnosis's impact on their life. 14 participants commented on how they thought a diagnosis would have impacted their life had they been given a diagnosis. Only 14 participants wrote about the impact of not having a diagnosis. Overall, these women said it doesn't affect them because they either don't think about it or were too young to realise that it could have made a difference in their life without a diagnosis.

**The following three themes emerged from the responses to this question:**

1) How others see me,

2) Feeling broken,

3) doesn't change anything

## It changed how others see me

This theme incorporated most of the responses to this question. Participants felt the impact of a diagnosis had positive and negative effects on how others see them. Many thought that the diagnosis validated how they felt, which felt like a relief as it helped others understand them and enabled them to understand themselves better to get some normality back in their lives.

Others felt the diagnosis gave a way to explain themselves and make sense of why they felt the way they did about what had happened to them, to process the gravity of the situation and provide room to realise the incident does not define who they are. The label helped to explain why their life was falling apart. The assault was too traumatic to think about or talk about, but the mental health labels provided a way to access support without speaking in detail about the distress and trauma of sexual assault.

> *“I realised it wasn’t all my fault and I wasn’t somehow deficient, but I also felt ashamed and found it hard to tell people, particularly people who had let me down in the past, such as family members. Dealing with it all while adapting to becoming a parent was probably harder than the rape itself.”*

The diagnosis also helped the recovery process because they could access services with mandatory diagnosis referral criteria. Without the diagnosis, these services were not available to them. However, one woman suggested that the PTSD diagnosis meant she was not seen as a whole person, “*Not sure, but I feel the diagnosis of PTSD describes a set of symptoms rather than me as a whole person - if that makes sense*”.

Another wrote that her diagnosis, “*Gave me a framework for my stage of distress and helped me recognise responses and increased self-care - I asked for a diagnosis*”.

By contrast, others felt the diagnosis added to the sense of shame due to the stigma attached to mental health issues. There was a fear of discrimination and not being taken seriously. The diagnosis had a significant impact because of being judged by others, being treated differently, and being discriminated against.

One woman wrote, “*Everyone then looks at you differently and as damaged goods*”. Another stated, “*I am treated differently by medical staff when they see I have diagnosed personality disorder*”.

## Feeling broken

The second theme was established from participants' responses discussing the frustration of taking medication for their trauma and emotional reactions to the abuse that did not work.

Some wrote about how the medication made them feel crazy or as if they had overreacted to the trauma. One woman wrote that medication after sexual violence, "*made me feel faulty to keep getting all these diagnoses*". For some, the diagnosis and the medication after sexual violence became a "*barrier to future employment*".

Others explained they were no longer taken seriously because everything they do is now blamed on the diagnosis, such as BPD. Women felt like they were a burden to others and that friends could not cope with the thoughts and feelings they were experiencing.

One woman described a mixed experience*, "Understood my brain a bit better. It made me feel like a victim with a label. It helped me understand why I couldn't do certain things (sleep, anxiety, panic)"*.

Some described that even after going through a criminal justice process and getting justice, it felt like the pain was never going to be over.

> *"It has pretty much destroyed my life. How the NHS has treated me has ruined me, taken away my strength, my fight, my belief in good, my understanding of what happened and what was and wasn't my fault."*

Another wrote about how she could not heal until she received the right help because she was *"tired of fighting it".* Overall, these participants described how it affected every area of their life.

> *"I think professionals think because I've had justice, I should be a happy little survivor and get over it like it's a magic wand… unfortunately the reality is somewhat different"*

Women also described how the medication gave the impression it would fix their life but came with intense responsibility to remember to take the pills.

One wrote, *“been on medication since early teen years. I feel much worse emotionally when I miss a pill, but I have never succeeded at reducing dosage or weaning off the drugs”.*

The general impression was that the drugs helped women to remain stable and productive. However, many women wrote about feeling weak due to the label of a diagnosis, which then meant they was unfairly judged by others, such as medical professionals or insurers, leaving them fearing for their job security.

For some women, the diagnosis provided some relief, which was expressed as the only pathway available to getting support. One woman explained a double-edged sword effect to diagnosis following sexual violence, *“In many ways a diagnosis has helped, it has allowed me to access more support services within mental health and at university. It has also made me feel though like I'm going to be 'disordered' for the rest of my life, I don't really have much hope of getting better.* This reflects how many of these women described their concerns of never getting back to who they were.

## It doesn’t change anything

A less common, although important theme that emerged from this question reflects how women felt their diagnosis had become something they were able to ignore. For these women, the labels they described did not make a difference in their life. Those with a diagnosis felt as though they had been able to ignore it. It had no impact because it was perceived by the woman as useless, powerless, irrelevant, or not helpful. Some women felt that diagnosis was not necessary, and would add little to their lives.

> *“The diagnosis itself had little impact on me. It allowed me to appropriately label my condition to others without reeling off long lists of behavioural symptoms from the outset, but that was the only major difference.”*

One woman described how she didn't "*feel anything*", and it was just her luck to be diagnosed with a disorder. Another expressed how the mental health diagnosis did not change "*anything*" in her life because she was already suffering; the label just gave her a new name for how she suffered. Therefore, the diagnosis simply shifted the focus from the sexual trauma to a mental disorder.

Others felt the diagnosis was more for validation purposes. However, many women discussed the way that their diagnosis, whether they accepted it or not, was used against them to position them as unstable or in need of medication.

> *"It did not overly bother me as I did not tell anyone. In hindsight getting brain-numbing-dependence-causing medication was regrettable… as I was unable to get off the pills. Also, my medication was used against me in the trial."*

The diagnosis came with shame and a need to hide it from others. As this woman described, "*I've hidden it from most people so that the diagnosis doesn't have an effect*."

In this theme then, women had a wide range of experiences with diagnosis and treatment. It was more likely to have had multiple negative impacts on the woman, but commonly there were also some positive aspects of a psychiatric diagnosis, referral route, or access to treatment.

# Key Finding: Validation and understanding of trauma

This finding describes how participants felt about the professionals they sought support from. Two survey questions were combined in the analysis to create this theme. The first survey question asked participants; ‘Do you feel that the sexual violence you were subjected to was taken seriously and considered when you sought support for your mental health, or when professionals were diagnosing you and treating you for a mental health issue or disorder? (Q18)’

There were 198 responses to the first question, and 197 did not respond; therefore, it is possible they did not seek support, were diagnosed by a professional or preferred not to answer this question.

**The following two themes emerged from the narratives:**

1) My trauma was not taken seriously; and

2) My trauma was taken seriously

## My trauma was not taken seriously

The most common response refers to the trauma from sexual violence not being taken seriously by professionals. This theme is made up of 138 participants. Almost all the women who responded to this question felt their trauma was “*not taken seriously”* when they sought support for their mental health.

These women feared their accounts of their emotional distress resulting from abuse were frequently misunderstood, misconstrued, minimised, and used against them. It was clear from these comments that nothing was done to reassure them their trauma was taken seriously, and one woman said that after she disclosed the sexual violence, “*the world felt so unsafe”*. One wrote, *“They don't have a clue to be frank, sorry, but a degree doesn’t bring you any closer to empathy or emotional/humane intelligence”.*

One woman described how it took seven years to be listened to and given the help she needed so that she could cope with what had happened to her. She appeared relieved to be a "*different person*" since seeking support, yet recognised that her healing could have started sooner if she was taken seriously years earlier. Another described how she did not fit the ideal victim status because she would go out drinking, which resulted in people claiming she was a fantasist. The impact of being called and perceived as a woman who lies about or creates elaborate fantasies and narratives of being subjected to sexual violence was clear, as women discussed this in detail.

These women felt to blame for the abuse because of being told, or feeling, that they had not done enough to protect themselves. One woman described a phone call from her GP in which she disclosed sexual violence, and they told her that did not have time to follow up with her. Another wrote, "*The first few people I spoke to were very belittling. There were many after who took me seriously, but to be honest a lot of damage had already been done*."

At times, they needed support for other situations in their life, but it always came back to the abuse. For some, it felt as though they were shouting down an empty corridor where no one was listening.

> *"I feel like we can shout as loud as we like, but there is simply no volume to the outside world, it's kind of like living in a horror book."*

Another wrote how it was like screaming into a void for two decades because no one cared that she had been subjected to sexual violence. Because her issues had started in her childhood, therapy sessions were always focused on her as a child, rather than the sexual violence she was seeking support for, which happened later. This is an example of where modality of therapy, or the intention of the therapist became the priority, instead of the trauma and needs of the woman.

Many wrote about their GP, and described a lack of skills and consistency in the care provided. They suggested there should be better resources created for GPs so they could understand how to talk about sexual violence with their patients. Whilst some women expressed feeling belittled, other women discussed the frustration of waiting a long time to find the right provider after first mentioning their abuse to the GP.

One woman wrote, *"My GP certainly didn't take it seriously. I felt like my age and gender played a role in him thinking I was a "dumb girl" who was attention seeking".*

## My trauma was taken seriously

The second most common response is made up of the responses of 46 participants. Overall, these responses are relatively conflicted at times. Although they agreed the response was good, many of their comments include difficulties they faced in reaching support. The dilemmatic nature of their responses should be noted. The following quote reflects many of the responses to this theme.

> *"It has been recently, my current GP has always told me that my symptoms are a response to the trauma I have experienced and he goes out of his way to be supportive. Previously I have been told to 'get over it', that I need to go home and think about why I can't cope, (that stayed with me for 20 years, I felt so humiliated) that what happened could have been worse and that I should be thankful for not being killed. These were said by different professionals over the years. As soon as I was told my response was normal, I felt so much better and my healing began."*

These women discussed aspects of the services they found helpful, although they expressed feeling lucky to be able to receive the support. Several sought help from private services because the trauma had manifested into something which became uncontrollable. One woman wrote, *"Talking about my private psychologist - yes absolutely. My assault had* *manifested into a repressed memory and it took a lot of work to retrieve it and work though my feelings. I was then referred to a female therapist in order to speak more openly."*

Although women described how their trauma was taken seriously by the professionals they had seen, many felt like a postcode lottery to be able to get the treatment they needed. If they moved to a different area, there was a difference in what they could access. One woman wrote, "*In my old hometown, the support was completely different, and I received instant support and regular check-ups."*

There was also a recognition that the services did not provide adequate support. They highlighted how if "*you don't fit in the box*", professionals "*didn't have any alternatives available*"; therefore, whilst there is no one-size-fits-all approach, there were only one-size-fits-all services.

Many suggested the need for better resources and more availability of female-only staff. One woman wrote, "*Yes. The NHS was really good with this (I always request female doctors, and I was lucky that the people who ended up treating me were all female - I don't think I would have responded to males at all."*

Some of the women did not recognise the level of distress they felt as some described the professionals taking their trauma more seriously than they do. Researchers then asked the women what they would like to say to professionals working with women who are struggling with their mental health after sexual violence.

There were 200 responses to this question. 195 did not respond; therefore, it can be assumed they preferred not to answer this question.

**The themes that emerged from the narratives within this question are:**

1) Validate me;

2) Training, do the job right; and

3) Language matters

## Validate me

This theme includes responses from 49 women who directly referred to the need for their feelings and experiences of trauma to be validated. They want to be believed and reassured that the abuse was not their fault. They also wrote about their need to be validated whether or not they wanted to report their sexual violence.

Women wanted their emotions, fears, behaviours and desperation to be taken seriously and validated, as they were commonly seen as attention seeking or exaggerating.

One woman wrote, *"Believe them. Listen. If they say something like "I don't want to be here anymore," it's a cry for help. Don't ignore it.".*

The victim or survivor should not be labelled as the *"problem",* and professionals should not be *"judgemental"* of these women's situations. Women asked for acknowledgement of their difficulties in having "*a normal sex life*" after sexual abuse and rape.

For many women in the sample, there was a complete ignorance from professionals of their sexual needs after being subjected to sexual violence, and so there was no interest or compassion when women disclosed sexual difficulties. This was compounded by professionals not being confident or adequately trained to talk about sexual violence, or about pleasure, sex and intimacy.

Many of these women explained how society relied on labels to support women subjected to abuse and that these labels become the only way of knowing what to provide. Instead, they wrote that women should be treated as individuals who suffer the trauma of sexual violence differently from others. They explained how it takes time to trust a professional, and that in order to validate them, the help they need should depend on what each woman asks for as an individual.

## Training, do the job right

This theme includes over half of the women who responded to this question. Over 100 responses described a lack of knowledge amongst service providers about how and where to seek specialist support for the trauma of sexual violence. Many of these women portrayed the lack of time given to them by the professionals they relied upon.

They recognised the influence of the medical model of mental health and the notion that something is wrong with the woman, and consequently, which diagnosis a woman may receive. These women argued that nothing is wrong with a woman who has been sexually abused, sexually assaulted or raped, and that "*being a victim of sexual violence is not an illness*". Women asked that professionals stop treating women as disordered and realise she is reacting normally to her trauma.

> *"Anger is normal. Fear is normal. despair, loss, grief, rage, fury, abandonment, terror, overwhelming sadness, loss of sense of safety, numbness, self-blame, guilt, shame, strength, courage, relief of surviving, wanting to talk, wanting not to, changing your mind, fluctuating moods, tears, no tears, screaming, all normal reactions. Don't like those symptoms? Us neither. That is the ugly reality of sexual violence".*

Many of these women described the importance of professionals *"listening to victims"* to discover the needs of the woman. They wrote that professionals should treat them as *"individuals, not as items from a diagnosis box".* This was a common answer, in which women felt their identities and personalities became defined and classified by long lists of psychiatric symptoms. Due to this reframing of them, all of their behaviours, thoughts, feelings and actions became part of the disorder they had been diagnosed with.

Women also raised that there should be a better recognition that struggling for years or decades after sexual violence does not mean the women are irreparable, and does not suggest they are abnormal. With the proper support, they can and do "recover", especially when professionals ask the right questions and listen to how women respond. One woman wrote, "*Don't be scared to ask about abuse, we already know what we've been though*".

Overall, these women want to be cared for with a trauma-informed approach, not labelled as disordered and medicated. However, we cannot overlook the voices of the women who wanted to be diagnosed with a mental health diagnosis, and felt they needed the medication, too.

## Language matters

This theme is made up of nearly half of the participants who responded to this question. They described how much of the language used by professionals needed to include more compassion and understanding to offer a better response. These women explained that by showing empathy for what they had been through, "*kindness goes a long way*". One woman wrote, "*simply being women and having to live in a world where we don't feel safe, where we always have to be on guard, is exhausting and impacts on our emotional well-being*". Therefore, to not judge a person, "*based upon their experiences of sexual violence*" or "*compare stories of other women*". Women are not just numbers in the mental health system, they are real people with real traumas.

It is an important point, that recurred. Women felt that their traumas and stories were being compared by professionals, as if they were being asked, 'Well, it's been five years, why are you not okay, but other women are okay by now?'

Women suggested that professionals should include the women in the decision-making of their treatment and diagnosis. Notably, questions should not be asked if people do not have the time to listen to the answers women need to give. Often, women wrote that professionals would open a line of questioning, and they would respond with disclosures or details of how they were feeling, only to have the conversation shut down as there was not time, or the professional stated they were not 'specialist enough' to discuss the trauma with them. Additionally, women asked that professionals did not assume everyone's experiences are the same. Commonly in the data, women wrote about their feeling that professionals had a scripted or specific understanding or stereotype of what a woman subjected to sexual violence should look, think and feel like. When they were outside of these parameters, they were seen as abnormal or problematic, or even, too complex.

# Discussion

This extensive report considered the experiences of 395 women who sought help for their mental health after being subjected to sexual violence. The aim of this study was to seek a deeper understanding of the journey that women may travel when disclosing abuse and violence, and asking for support or treatment for their distress.

Before discussing any further, the authors of this report would like to thank all women who took part anonymously. Their insight, honesty, experiences and commitment to taking part was vital to this report – and hopefully, to causing change through increasing the knowledge of professionals who may be hearing disclosures and help-seeking requests from women subjected to sexual violence.

As mental health in the UK is currently theorised and explained using medical model language and narratives, many women seek support for their distress, trauma, or mental health from their GP. Whilst a GP is not trained in taking or responding to disclosures of sexual offences and traumas, they are often the first professional to hear them. In our own dataset, they were the most common professional that a woman spoke to about her sexual trauma, and sought support from.

Due to this route to care, many women experience a medicalised response to their disclosure and help-seeking, including assessments, treatments, medication, and therapy. Their main sources of support are doctors, nurses, psychologists, psychiatrists, and mental health teams/charities. The report therefore presents an in-depth picture into the complexities and experiences of accessing support in the UK.

Help-seeking was found to be triggered by a range of experiences or incidents whereby women came to a realisation that they needed urgent support or care. Women discussed trigger points such as becoming pregnant or becoming a mother, which indicate a change in role. It was common for women to talk about a sudden expectation to be a responsible adult, in charge of caring for a helpless human being – and the way this triggered their own trauma from sexual violence, or a need to finally process what happened to 'be a better mother'. This trigger is particularly important because sexual abuse and male violence is so common that for many women, pregnancy, birth, loss and motherhood may well be a powerful experience that causes them to reflect or reframe their own experiences of being raped or abused.

Other triggers included forming new relationships, experiencing difficulties in their relationships or becoming triggered by intimacy or sexual contact with a consensual partner. Many women in the data discussed their experiences of sexual contact or emotional intimacy as a trigger to realising that they had not been processing their sexual trauma, or that they could not enjoy emotional connection or sexual intercourse, and needed to seek support.

When teamed with the other triggers, which included going to university, reaching milestones in their lives, reaching crisis points with their mental distress, and feeling unable to cope anymore – this finding could have important implications in real world settings. Women are therefore likely to disclose sexual violence to their GP at routine appointments, in which they have only 5-10 minutes to talk to their healthcare provider. They may also disclose sexual violence to a practice nurse, a midwife, a nurse or healthcare assistant on a ward in a hospital, at a walk-in clinic, at a sexual health service, at a mother and baby group, in a gynaecology service/ward, or in a setting there the woman is seeking help with sexual intimacy and relationship advice.

As the triggers for disclosure are so broad, and can occur in so many different settings, the women in this data had disclosed to hundreds of different professionals and services, most of which did not respond well. Only 13% of women stated that they felt the professionals they spoke to, had a good understanding of sexual trauma. In their answers, they discussed professionals who minimised, ignored, didn't understand, accused women of making it up, or reframed what they had disclosed as something else. Some women also reported that the professional they disclosed to seemed shocked, and some were visibly distressed and uncomfortable talking about sexual violence. It is important to note however, that where women did report helpful and supportive professionals at the point of disclosure and help-seeking, this experience was highlighted as a vital point of support. Simply put, receiving an unhelpful or dismissive response when help-seeking after sexual violence caused serious distress, but receiving a helpful and supportive responses when help-seeking caused a noticeable increase in self-belief, wellbeing, and trust in the services. The response from the professional was influential and memorable for women who took part, for better or for worse.

One noticeable finding from the brief questions asked of women at the beginning of the study was that over half of them had reported the sexual violence to the police. This is a curious finding, as in most other historic and contemporary literature, reporting the police is usually less than 11% (Taylor, 2020). Police reporting of sexual violence has in fact been decreasing year on year for over a decade in the UK (CSEW, 2021). It was therefore important to consider why so many women in the sample had reported to the police, at a rate almost five times higher than the national average. This is possibly linked to the sample – in that all women who took part knew they were taking part in a study about seeking help for their mental health following sexual violence.

There are three possible theories for why the police reporting rate was abnormally high. The first is that women who are likely to report to professional services and seek support for sexual violence are also more likely to report to the police. The second is that when women did report sexual violence to professional services, due to safeguarding protocols and reporting guidelines, they were either encouraged or supported to report the sexual violence to the police. The third is an inverse explanation of the second, that when women report to the police, they are then signposted or encouraged to seek support for their mental health and wellbeing after sexual violence. It could be of interest to other researchers to explore whether there is a relationship between the two forms of disclosure, and if one causes the other. However, it is noted that when asking women about their triggers to disclosure, women did not cite police, or reporting to police as a trigger, so it is unlikely to be the latter.

One of the topics that women discussed at length in their answers was psychiatric diagnosis and psychiatric treatment. 79% of women in this sample were diagnosed with one or more mental disorders following their disclosure to a professional that they were struggling to cope following sexual violence. There are fundamental issues to consider here, in whether any of the women should have been diagnosed with a psychiatric mental disorder when they had clearly disclosed one or many sexual traumas to their healthcare provider. NICE guidelines and best practice protocols for psychiatric diagnosis often ask the professional to ascertain that there is no obvious trauma or traumatic event before making a diagnosis of mental illness. However, if the woman has disclosed sexual or domestic abuse during help-seeking, this would be clear evidence of a legitimate and unambiguous trauma which should mean that psychiatric diagnosis should be precluded or delayed.

Arguably, if a woman is reporting that she has been subjected to sexual violence, and experiencing physiological and psychological impacts of this violence, it cannot be possible to accurately diagnose a set of behaviours or thoughts without reference to that violence and trauma.

Due to the current medicalised understanding of sexual trauma, it is common that signs of distress and trauma in humans are viewed through the lens of disorder, and then described as ‘symptoms’ of an ‘illness’. Arguably, this dominant view leads to women being diagnosed and treated as medically ill, instead of naturally responding to severe trauma caused by another person committing sexual offences against them.

Despite the more theoretical considerations of medical model versus trauma-informed care model, women’s voices were paramount in this study. They spoke of mixed and complex experiences of psychiatric diagnosis and treatment, with some women reporting very distressing and harmful effects of being diagnosed and treated as having a mental disorder following sexual violence, and other women reporting validation, support, and joy at being diagnosed as having a mental disorder. The disparity in experiences came down to personal perspective, and personal experiences of how they were treated as individuals.

Furthermore, the way the diagnosis was used to help, or to harm, impacted the answers women gave.

Women spoke frequently of a deep need to know they were not crazy, insane, losing their minds, or losing themselves in their trauma. For some, receiving a psychiatric diagnosis meant a validating label of a recognised 'illness' that could explain why they were experiencing physiological and psychological impacts of their trauma. Despite the women knowing the root of their suffering (the sexual violence they disclosed to the professional), there were still some women who wanted to be told that they had a mental illness or disorder, and to be given medication to make the pain, memories, sadness, distress or anxiety go away.

This experience can also be split into numerous nuanced reasons. For some women, they didn't care whether they actually did have a mental disorder or not, they knew that they needed some kind of sedative medication or psychoactive medication that would make them feel calmer or clearer. The diagnosis was therefore a means to an end, and a label that they didn't particularly need or care about – but they were prepared to take it in order to get therapy or medication. This is an important point, because it is related to the professional and academic gatekeeping that occurs within support services that are built to conform to the medical model of mental health.

Many services in the UK require a recognised mental disorder diagnosis to gain access to therapeutic services. For some, patients are required to take antidepressants whilst on the waiting list, and during the therapy, in order to be considered a good candidate for the service. Refusal to accept a psychiatric diagnosis on file, or refusing to take medication can result in women's cases being closed, or services not being available to them. Therefore, there are women in the community and in the present sample, who knew they were not mentally ill, did not want to take medication, but knew that they must comply with the medical gatekeeping of the service to be supported.

For other women, they held a strong belief that their brain was the source of the distress, and felt that being diagnosed with a mental disorder would mean they could be treated for problems or imbalances in their brain they felt they must have due to feeling so affected by the sexual violence. This lends itself to the generally accepted narrative that trauma can change the brain, and cause changes that then require medical treatment. This is confirmed in the data by how many women knew that the cause of their trauma was the sexual violence, but still felt they had developed a mental disorder that needed treatment.

For some women, validation was key. In a medical model, one of the only ways to legitimise mental distress and trauma is to have it diagnosed as a mental health issue – a medical condition verified by a doctor. The women spoke of struggling with flashbacks, nightmares, sadness, anger, fear, confusion, thoughts of self-harm and even feeling like they had totally lost touch with reality. For these women, the psychiatric diagnosis was a way of understanding and conceptualising the experiences as a medical condition that they could identify with and live with, seek treatment, and support for, and use it to explain to others why they were feeling, thinking, or behaving in a certain way. Psychiatric diagnosis therefore felt like all their experiences suddenly made sense, and they were not 'crazy' or 'insane'.

Interestingly, this common thread of needing to know that they were not 'crazy' or 'insane' was true for the large number of women who conversely found their psychiatric diagnosis and treatment to be unhelpful, unwanted, and even harmful.

Women in the present sample discussed how their psychiatric diagnosis came about. They talked of being pushed to accept a diagnosis, being confused about what a diagnosis meant but accepting it because there was no alternative explanation or service offered, and feeling as though the psychiatric diagnosis was what the doctor wanted, rather than what was in her best interests as someone who had disclosed sexual violence.

Women who felt their diagnosis had harmed them also discussed the way they were 'labelled' and then treated very differently by those around them, including their care providers. They reported that after they were diagnosed with personality disorders or bipolar disorder, they were treated as unreliable, problematic, manipulative or a waste of time when visiting the doctor for other general issues such as feeling unwell, or having problems with their digestion. They described it as being ‘followed everywhere by the label’, and being seen through a lens of being mentally disordered. Women also spoke of how commonly the diagnosis was included on their notes and records, and so every health professional they engaged with seemed to know or ask about their mental disorder; whether it was relevant or not.

This meant that women also reported feeling that the real reason for their distress (being subjected to sexual violence) was never actually addressed again. Some described it as being ‘given the brush off’ or ‘sweeping it under the rug’.

This is important to note here, because there is a clear consequence to women being reframed as suffering from a medical condition, and a psychiatric disorder, instead of being supported and seen as a woman who had been raped, abused, trafficked or assaulted. Those portrayals are arguably very different from one another, and whilst both have negative connotations, women who took part in this study felt that they wanted the real root cause of their distress to be validated and legitimised. This cannot happen if they are diagnosed and then treated as mentally ill, instead of as a victim of serious crime. One woman said that it felt like her sexual trauma was overlooked from the moment she was diagnosed as mentally ill, and even when she had asked for her diagnosis to be PTSD in order to validate her trauma response, this was ignored.

Many women discussed their perspective on PTSD, and for some, they felt that if they had to accept any psychiatric label, they would be most comfortable with ‘PTSD’ due to it clearly naming and referring to a trauma. Despite this, most women were diagnosed with depressive disorders, anxiety disorders and personality disorders, which they felt, ignored the trauma they were subjected to and made the diagnosis about themselves.

PTSD requires further critical thought if applied from a trauma-informed approach to care. Whilst women felt that it was one of the only diagnoses they would readily accept because it validated and named their trauma responses, it also defines their trauma as a disorder. PTSD is classified as a mental disorder in the DSM-V, and therefore still positions their trauma responses as disordered, instead of normal and natural.

When it came to harmful and unhelpful treatment, many women discussed the way that medication had left them feeling heavily sedated, confused, depressed, unwell, disconnected and ignored. They demonstrated a clear awareness that the medication was being used as a 'sticky plaster' for their sexual trauma, and knew that it would not work. Some women reported being switched from medication to medication, which made them very unwell. Other reported having their dosages and medications increased and multiplied until they were on several powerful anti-psychotics, sedatives and antidepressants at the same time – all of which doing nothing for the sexual trauma they had disclosed to their healthcare provider.

Medication was frequently discussed, as so many women in the sample had been prescribed and had taken (or refused to take) a wide range of drugs. Even the women who had found their diagnosis and treatment helpful had complained of adverse side effects and very negative experiences when trying to wean off or stop taking the drugs. For many, they made decisions away from their doctors to remove themselves or to suddenly stop taking medications even when they knew it would make them feel terrible. These decisions were often made because their healthcare provider was not listening to them when they reported side effects or their desire to stop taking the medication and focus on processing the trauma. Instead, they were often encouraged to keep taking the medication, and instead increase the dosage of their medication or try something new. Often, the fact that the medication was 'not working' was used as evidence that the woman did indeed have a mental disorder and therefore needed higher dosages of the medication or a different type.

Women discussed therapy as the ultimate goal for processing their trauma, but this was not without its criticism, either. For some women, therapy had been life-changing, but for others, it was a quick, ineffective, general set of six or eight sessions of CBT or general counselling that would then end abruptly when the woman had run out of sessions or entitlement. Sexual trauma is arguably not going to be resolved within 6 sessions, and so many women found short bursts of therapy to be unhelpful and distressing. They also discussed issues with therapists, which included victim blaming, shaming, offensive questioning and inappropriate comments being made about the sexual trauma they had been subjected to. Some women felt that their therapist did significant harm, too.

It was common for women to describe years of waiting lists, decades of on-and-off therapy and a lack of service provision. For some women, the only high quality and effective support they had received was from a private psychologist, a voluntary women's charity, rape centre or sexual violence service.

Overall, the experiences of the 395 women who took part in this report present a complex and inadequate response to women who seek help for their mental health after being subjected to sexual violence.

## Limitations of this research

The present study was a preliminary exploratory project into the experiences of women who sought support for their mental health after sexual violence. Although this study offers some valuable insights into the experiences, it has several limitations. Firstly, this study was exploratory and interpretative; therefore, the findings from the participants' narratives cannot be applied to a population. It was also beyond this study's scope to examine the role of women's race, nationality or ethnicity and how this related to seeking mental health support after rape and abuse. This is an important limitation as there is already a body of evidence which suggests that racism plays a role in impacting the way women are treated and perceived when they seek help for both mental health and sexual violence. There was also no requirement to collect data on religious beliefs, sexual orientation, geographic location, or relationship status. This was outside of the scope of this project, but could be important in exploring whether these factors also change the experience of help-seeking after sexual violence. Thirdly, this study did not explore the individual mental health outcomes for all types of sexual violence during their lifetime or their experiences relating to the perpetrator's identity, type of offence, or relationship with criminal justice outcomes.

## Future research

As with many exploratory studies such as this, it leaves us with as many questions as answers. There are many different research projects that could be inspired by, or built upon the findings from the present study.

Specifically, it may be of use to undertake longitudinal research into the journeys of women who have been subjected to sexual violence with different psychiatric diagnoses and those without them. It may be useful to track their wellbeing and trauma processing over time, whilst comparing the medical and non-medical input they have access to.

Furthermore, it could be useful to understand why so many women with psychiatric diagnoses on file after sexual violence feel they are perceived and treated differently when attending their healthcare provider for unrelated health issues, and whether women with subsequent psychiatric diagnoses are stigmatised or discriminated against.

# Recommendations

1. When sexual trauma has been disclosed during the help-seeking process, it must be recognised as a root cause of women's suffering and not as an irrelevant detail that becomes hidden by a mental disorder diagnosis.

2. Healthcare professionals must undertake regular in-depth training in receiving and responding to sexual violence disclosures, and supporting women with their sexual trauma.

3. Healthcare professionals must give accurate and neutral information about psychiatric medication and diagnosis. They must give women a free and informed choice about whether they want to accept a diagnosis or a course of medication, and what it could mean for their health, rights, treatment, and any justice processes.

4. There should be non-medical, trauma-informed alternative pathways for mental health support and sexual trauma that do not seek to medicalise or diagnose.

5. Healthcare services of all kinds should investigate and evaluate whether the inclusion of psychiatric diagnosis on health records changes or influences the service received by women attending appointments or disclosing concerns.

6. It must be always considered that mental health diagnosis can be both empowering and disempowering, validating, and invalidating, helpful, and harmful. This is a personal experience and perspective, and so healthcare providers should explore whether it is in the best interests of the woman they are supporting before encouraging psychiatric diagnosis or treatment as a blanket approach.

7. All service providers should consider moving to a trauma-informed framework that aims to normalise and validate trauma responses and coping mechanisms as rational, normal responses to extreme distress rather than a set of symptoms of a mental disorder.

8. Professionals should be trained and supported to understand that many different settings and experiences can trigger help-seeking, trauma processing, and disclosure of sexual violence. This should be extended to university and college staff, employers, health services, social care, psychology, and policing.

9. Commissioners and budget holders must set aside increased funds for trauma-informed approaches to sexual trauma, so specialist statutory and voluntary services can respond to demand and provide high quality, efficient services to women disclosing sexual violence.

10. Women should not be forced to accept or take medication in return for being placed on a therapeutic waiting list. This should always remain a free choice.

11. Women should not be forced to accept or take medication whilst undertaking therapy. This should always remain a free choice.

12. It should be acknowledged and addressed that inappropriate therapy types and short bursts of therapy entitlement (four sessions or six sessions) could be harmful to women who are seeking support for their mental health following sexual trauma. Instead, women should be referred only with their informed consent, and only to a relevant type of therapy that can be offered for a long enough time as to be effective.

# Resources and helplines for women and girls reading this study

If you have been affected by reading this study, or need to seek support, here are some suggestions for support

**Victimfocus resources**

**FREE resource- Caring for yourself after sexual violence**

**Approximately 15 hours of learning at your own pace. In English, Hindi, Portuguese and Russian.**

Website: https://www.victimfocus.org.uk/e-learning-courses

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**NAPAC**: Offers support to adult survivors of all types of childhood abuse, including physical, sexual, emotional abuse, narcissism, and neglect.

https://napac.org.uk/

Phone: 0808 801 0331 (Monday – Thursday from 10 am to 9 pm and Friday from 10 am to–6 pm)

Email: support@napac.org.uk

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**Rape Crisis England and Wales**

Freephone 0808 802 9999

12 noon – 2.30 pm and 7 – 9.30 pm every day of the year

Rape Crisis England & Wales to promote the needs and rights of women and girls who have experienced sexual violence

Website: www.rapecrisis.org.uk

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**NHS**

The NHS website offers information for people who have experienced rape or sexual assault.

Website: www.nhs.uk/live-well/sexual-health/help-after-rape-and-sexual-assault/

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**Galop**: Provides a free, confidential and independent services for all LGBT+ people who have experienced sexual assault, violence or abuse, however, or whenever it happened.

http://www.galop.org.uk/

Online referrals: http://www.galop.org.uk/report/

Email: referrals@galop.org.uk

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