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Report of the Special Rapporteur on violence against women, its causes and consequences on her mission to South Africa*

Note by the Secretariat

This report contains the findings and recommendations of the Special Rapporteur on violence against women, its causes and consequences, on her visit to South Africa from 4 to 11 December 2015. The mandate holder examines the gaps and challenges in fulfilling the States obligation to eliminate violence against women, its causes and consequences and recommends measures for preventing and combating violence against women in the country.

* The present report was submitted after the deadline in order to reflect the most recent developments.

Report of the Special Rapporteur on violence against women, its causes and consequences on her mission to South Africa (4 to 11 December 2015)**

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** Circulated in the language of submission only

I. Introduction

1. At the invitation of the Government, the Special Rapporteur on violence against women, its causes and consequences, Ms. Dubravka Šimonović, visited South Africa from 4 to 11 December 2015.

2. During her eight-day visit, the Special Rapporteur met in Pretoria with the Minister in the Presidency responsible for women and high-level officials from her Department, which were in charge of organizing the official programme of the visit. She held two sets of consultations with high-level officials of the following Ministries: labour, social development, home affairs, health, rural development and land reform, education, human settlements, police (including the Deputy Minister), justice and correctional services (including the Minister), home affairs, and the national prosecution authority, including the Sexual Offences and Community Affairs unit. She visited the women section of the Pretoria Central prison (Kgosi Mampuru II) where she listened to testimonies of women detained. She also travelled to Cape Town and East London where she met with a wide range of Province Government officials. In Johannesburg, she exchanged views with both Deputy Presidents of the Constitutional Court and the Supreme Court of Appeal.

3. The Rapporteur also held consultations with the independent constitutional bodies known as belonging to the Chapter 9 Institutions: the Commission for Gender Equality (CGE), the South African Human Rights Commission, the Commission for the Promotion and the Protection of the Rights of Cultural, Religious and Linguistic Communities and the Public Protector.

4. She also visited several shelters in Pretoria, Johannesburg, and Cape Town, which provided her the opportunity to meet with women survivors. Throughout her visit, she also held large consultations with numerous civil society representatives and members from academic institutions. She wishes to acknowledge in particular the role that Masimanyane Women's Support Centre played in facilitating civil society meetings. She also visited the outskirts of both Khayelitsha and Diepsloot townships. Finally, she exchanged views with representatives of some United Nations agencies and programmes in the country.

5. She also would like to thank in particular the Regional Office for Southern Africa of the Office of the High Commissioner for Human Rights, for the assistance extended prior to and during the mission.

6. The Rapporteur expresses her gratitude to the Government for its excellent cooperation, its frank attitude and openness and to the CSOs, academics and other stakeholders for their valuable inputs. She expresses her heartfelt thanks to all the victims of violence who agreed to relate their personal experiences; their testimony was crucial to gain a deeper understanding of the situation of women in South Africa.

II. General context

7. South Africa is still a young democracy deeply influenced by its historical violent past characterised by race, class and gender divide. The violence inherited from the apartheid still resonate profoundly in today's society dominated by deeply entrenched patriarchal norms and attitudes towards the role of women and which makes violence against women and children, especially in rural areas and in informal settlements, a way of life and an accepted social phenomenon. At the core of this violence against women pandemic lie unequal power gender relations, patriarchy, homophobia, sexism and other harmful discriminatory beliefs and practices. Additional triggers of VAW include widespread use of drug and alcohol, high unemployment rate and the continuing

stereotypical portrayal of women in the media. Compounding the problem is the high incidence of HIV[1].

8. The Rapporteur welcomes efforts to improve the overall security situation in the country, including the adoption of the National Development Plan which aims to eliminate poverty, reduce inequality and insecurity by 2030, and which forcibly spells out that "By 2030, people living in South Africa should have no fear of crime. Women, children and those who are vulnerable should feel protected."[2]

9. In a national context in which all the different interlocutors met have repetitively said that in spite of a progressive and inclusive Constitution and laws such as the Domestic Violence Act and the Sexual Offences and Related Matters Act, violence against women and girls is widespread, at a high level and normalised. These stakeholders have all recognised a huge gap between the proclaimed Constitutional principles of gender equality and non discrimination and their practical realization. Section 9 of the Constitution proclaims the rights of all persons to equal protection and benefit of the law, and to freedom from unfair discrimination on the basis of gender, sex, pregnancy and marital status but those rights are not protected in everyday life. In order for an individual woman victim of violence to enjoy in practice the realization of the principle of equality between men and women and the respect of her human rights and fundamental freedoms, the political will expressed in the Constitution as well as in accepted international and regional instruments on women's rights must be supported by a set of comprehensive legislative measures, including the renewed assessment of the elaboration for a Gender Equality Act and/or other laws that efficiently translate those rights into realities, including the possibility to amend the Promotion of Equality and Prevention of Unfair Discrimination Act 2000 (PEPUDA). Their implementation must be supported by effective actions of State actors, who adhere to the State party's due diligence obligations. This would not only protect women and girls, but also prevent and combat violence against women, and provide adequate services to survivors of VAW, punish perpetrators and prevent such violence addressing its root causes and its persistence and tolerance.

III. Manifestations of violence against women, its causes and consequences

10. Data on prevalence and manifestations of VAW reported reveal high level and persistence of different forms of such violence what amounts to systematic women's human rights violations. There is no centralized statistics on incidents and types of violence against women, beyond the mere recording of sexual offences crimes under the Sexual Offenses Act in the South African Police Service (SAPS) released annually. In addition, statistics are in no way conclusive of the real prevalence of VAW as it is an unchallenged fact that there is massive under-reporting of all forms of gender-based violence crimes. In order to shed light on the magnitude of each of the manifestations of VAW encountered, the SR cites, when available, relevant data emanating from recent smaller scale national and international research.

11. The preliminary findings of a 2011 prevalence study in the province of Gauteng conducted by Gender Links and the Medical Research Council found out that more than three quarters of men have perpetrated violence against women in their lifetime and more than half of women have experienced gender-based violence[3]. Particular women's groups,

[1] prevalence rate of 18.9% of Adults aged 15 to 49 prevalence rate,UNAIDS,2014

[2] National Development Plan2030

[3] http://www.mrc.ac.za/gender/gbvthewar.pdf

such as women irregular migrants, trafficked or refugees' women, women belonging to sexual minorities, women living with disabilities, orphans and other vulnerable girls, faced increased risks.

12. Below, the SR analyses some of the most prevalent manifestations of violence that were discussed during her visit, without aiming at being exhaustive of all the different existing forms of VAW in South Africa.

A. Femicides or gender-related killings of women

13. Studies have shown that in some countries between 40 and 70 per cent of female murder victims are killed by an intimate partner[4]." South Africa being among these countries, it makes it one of the countries with the highest rate of femicides. A 2009 national study based on data collected on homicides showed that homicide was declining, that there was a reduction in female homicide, but that such reduction was less among intimate partner femicides while "rape homicides" had proportionately increased.[5] The study concluded that intimate partner violence was the leading cause of death of women homicide victims with 56% of female homicides committed by an intimate partner. As with all forms of intimate-partner violence, intimate-partner femicide is likely to be significantly underreported.

14. The SR reiterates the call she directed to all UN Members States to establish a "femicide" or "gender-relating killings" watch[6]. Through such watch, States should collect and release every year data on the number of such killings, disaggregated by age and sex of the perpetrators, and providing information about the relationship between the perpetrator and the victim/s as well as prosecution and punishment of the former. Most importantly each case should be carefully analysed to identify any failure of protection with a view of improving and developing further preventive measures.

B. Domestic violence

15. Domestic violence is not recorded by the SAPS as a specific crime category and therefore there are no national statistics available. When cases of domestic violence are reported to the police, they are recorded under a range of different categories such as assault, malicious damage to property, pointing a firearm, murder etc.

16. Few studies have been conducted on the prevalence and forms of domestic violence, mostly on intimate partner violence which is said to be the most common form of violence experienced by women. The most recent research in Gauteng found that just under one in five women (18.13%) women reported an incident of violence by an intimate partner while among 1378 men surveyed working in Cape Town municipalities reported perpetrating violence towards their female partners in the past ten years[7]. Patterns of co-occurrence of child abuse with intimate partner violence were increasingly reported.

[4] https://www.unodc.org/documents/congress/background-information/Crime_Statistics/Global_Study_on_Homicide_2011.pdf,page 58

[5] http://www.mrc.ac.za/policybriefs/everyeighthours.pdf

[6] http://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=16796&LangID=E

[7] https://www.issafrica.org/uploads/PolBrief71.pdf

C. Sexual violence, including rape

17. The Medical Research Council has estimated that only one in nine rapes are reported to the police[8], and a 2010 study in Gauteng found that while one in 13 women raped by a non-partner reported the matter to the police, only one in 25 women raped by their partners reported the offence[9].

18. In 2011, 55% of the rape survivors counselled by Rape Crisis Cape Town Trust had been raped by more than one offender. Of these rapes, 25% had been perpetrated by known gangs. In multiple perpetrator rapes, the number of offenders ranged from 2 to 30 in respect of any one victim[10]. Another study offering an analysis of 1 886 rape dockets opened at 70 police stations in Gauteng Province in 2003 found out that the multiple perpetrator rape ('gang rape') constituted 16% of all cases. Most of these incidents started when the victim was outdoors, either alone or accompanied, and occurred in the open or in a public space. In contrast, single perpetrator rape mostly occurs in a home[11].

19. There is a high level of sexual violence against girls in schools perpetrated by both teachers and classmates. In addition, girls suffer sexual violence also on the way to and from school. In 2006, the South African Human Rights Commission (SAHRC) stated that sexual violence against female learners, including violence perpetrated by educators, was one of the most prevalent forms of violence identified through its hearings on violence in schools[12]. A 2014 report that examined the gaps in accountability that permit the continued abuse of learners by educators in the province of Gauteng concluded that there were such gaps throughout the system. These gaps are reportedly due by the lack of implementation of national laws and procedures for disciplining perpetrators and of coordination amongst the Department of Basic Education and the South African Council of Educators which have both been delegated with the duty to launch disciplinary procedures against the perpetrators, This has created a tedious, duplicative and overlapping system. Among the fundamental obstacles to hold teachers accountable are the culture of silence which pervades the school community and the lack of knowledge on reporting mechanisms, including that section 54(1) of the SOA which makes it a crime for anyone who knows about the commission of a sexual offense against a child not to report it[13]. The cost of sexual violence in school is high in particular for girls who often drop out, including because of unwanted pregnancies.

20. Research has shown that sexual violence and other forms of gender-based violence, such as sexual harassment, in mining are rife and not once off phenomena[14]. While the 2002 ban's lift on women in the mining sector coupled with the introduction of a 10% women quota in the Mining Charter are commendable from the point of view of equal working opportunities, women miners constitute a minority group underground and are routinely victims of sexual violence, harassment and abuses, such as male employees

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[8] R Jewkes and N abrahams, The epidemiology of rape and sexual coercion in South africa: an overview, *Social Science and Medicine,* 55:7, 2002, 1231–1244.

[9] M. Machisa et al, The War at home. GBV indicator projects, Gender links,2010

[10] http://rapecrisis.org.za/rape-in-south-africa/#prevalence

[11] https://www.issafrica.org/uploads/CQ41Jewkes.pdf

[12] CALS submission to the SRVAW, available at https://www.wits.ac.za/media/wits-university/faculties-and-schools/commerce-law-and-management/research-entities/cals/documents/Submisison%20Rapporteur%20on%20violence%20against%20women%20CALS%20submission.pdf

[13] CALS "Sexual Violence by Educators in South African Schools: Gaps in accountability",May 2014,p.30ss

[14] Asanda Benya, Women in Mining : A Challenge to Occupational Culture in Mines

expecting sex from female subordinates. In addition to dangers that are inherent in mining irrespectively of sex, women miners experience additional hardships largely unaddressed by mining companies, such as the lack of separate sanitation facilities, insufficient lighting and the confined location where women miners find themselves at time alone with a high number of male co-workers. So far, the response of the mining private sector has been that gender-based violence underground is a criminal justice matter and not an issue for which mining companies take responsibility. However, under both the principle of vicarious liability under the law of *delict* (which establishes the strict liability of one person for the *delict* of another) and the Health and Safety Standards under labour law, successful litigation could trigger the development of legislative provisions binding on multinational corporations to prevent sexual violence underground.

D. Harmful practices

21. Contradictions and tensions between the constitutional rights with respect to cultural rights[15], and the rights that aim to protect women and girls from discrimination and violence were brought to the SR's attention. At the outset, the SR wishes to recall that South Africa has an obligation to ensure that all marriages, including customary marriages are entered into with the free, full and informed consent of both parties and that its legislation is in full compliance with the relevant obligations outlined in article 16 of the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child and other international human rights standards that prohibit harmful practices.

22. The practice of *Ukuthwala,* although recently addressed by the Government was reported to continue in rural areas throughout the country, with higher prevalence in the Easter Cape and KwaZulu-Natal. In the way it is practiced nowadays, *Ukuthwala* often involves the abduction, kidnapping, assault and rape of girls and women to coerce them into child or forced marriage with older men and the payment of *lobola* (bride price) to the girls families. When victims of this harmful practice or their families report *Ukuthwala* to law enforcement officials or traditional leaders, often no action is taken on the wrongful assumption that *Ukuthwala* is a cultural practice and a customary law issue that should be settled between families. The SR welcomes the decision and subsequent appeal decision[16] in the case of *Jezile v S and Others*, where the perpetrator was sentenced to 22 years of imprisonment. During the meeting with the Chapter 9 Institutions, , it was confirmed that culture and tradition cannot justify such practice which clearly violates the constitutional rights to dignity, freedom of choice, security of the person and education. In case of a victim aged between 12 and 16 years old, it constitutes statutory rape.

23. In the above mentioned case, the Court concluded that the facts amounted to a situation in which *ukuthwala* was abused to "justify patently offensive behaviour such as rape, violence and similar criminal conduct under the guise of *ukuthwala*" and that "it cannot be countenanced that the practices associated with the aberrant form *of ukuthwala* could secure protection under our law." In light of recent public outcry, the South African Law Reform Commission (SALRC) was requested to carry out an investigation into the practice of *ukuthwala* to consider its impact on the girl child, the appropriateness and adequacy of the current laws and whether or not the laws uphold the human rights of the girl child[17]. At the time of the visit, the SALRC had published a Revised Discussion Paper

[15] Section 30&31 of the Constitution
[16] http://www.saflii.org/za/cases/ZAWCHC/2015/31.html
[17] http://www.justice.gov.za/salrc/dpapers/dp132-UkuthwalaRevised.pdf

138which positions itself in favour of a draft bill on the prohibition of forced and child marriages.

24. The SR observes that the Constitution outlaws all discriminatory practices through a qualification that stipulates that no person or institution exercising cultural rights may do so in a manner that is inconsistent with any provision in the Bill of Rights[18]. She further observes that, cases of *Ukuthwala* could be prosecuted under different offenses for example as kidnapping and as a statutory rape when the victim is a girl child between 12 and 16, both being crimes but bearing different sanctions. She is of the view that a new consolidated criminal offence and a prosecution consolidated practice would be beneficial as it would not only send a strong message but also clarify existing legislation, including in relation to the definition of child and forced marriage in particular as it relates to age of consent and criminalization of these acts in penal (statute) law.

25. The practice of forced virginity testing was reported to still happen in various situations as a strategy to reduce HIV/AIDS and teenage pregnancy. Recently, a mayor in the province of Kwazulu Natal decided to put in place a scholarship scheme for girls provided they remain virgins. The Children's Act of 2005 prohibits virginity testing of children under the age of 16. For girls above that age, virginity testing can only be performed if the child has given consent, after proper counseling and in a manner prescribed. The SR concurs with concerns raised by the CEDAW committee on this issue[19], questioning, as in the case of the "maiden bursary" referred before whether it is consent or coercion when women and girls can only access scholarships based on them passing virginity tests.

26. The practice of female genital mutilation among migrant and refugee women was also reported to take place but its extent was largely unknown.[20]

E. Violence against women and girls in informal settlements

27. The Rapporteur had the opportunity to observe the situation in some informal settlements. Beside Khayelitsha, she visited the outskirt of Diepsloot, an mixture of formal and informal settlement of approximatively200 000 inhabitants who , for the poorest of them, live in highly congested shacks, without electricity, running water, sewage, rubbish removal, street lights, tar roads, schools and police stations. It is estimated that half of Diepsloot population is unemployed. Due to the high density of these settlements and security concerns, the SR was advised not to enter the settlement. She however received various accounts of cases where young children, even babies, had been raped and in some cases even murdered, often by neighbours or relatives.

28. Perpetrators of such crimes were said to often be unemployed, drugs or alcohol users and most importantly, to have themselves experienced abuses at a young age[21]. Most of these cases go unreported, rape being considered even more acutely a family matter in informal settlements. When cases are reported, police was said not to be able to intervene. Reasons given ranged from the mere impossibility to enter these settlements due to their congestion, lack of staff, Diepsloot for example being policed by less than a dozen of police officers who had taken up function recently in a brand new police station, to lack of

[18] Section 31(2) of the South Africa Constitution

[19] CEDAW/C/ZAF/CO/4,para.22

[20] Discussion with the Minister in the Presidency responsible for women confirmed that FGM is not a general problem but is happening in some cases among migrants and refugees community.

[21] The demographic profile and psychosocial history of a group of convicted perpetrators of the rape of children under the age of three years, Amelia Ann Kleijn,2010

vehicles and volatile security. Victims of VAW are left unprotected and unable to access any services providers within the settlement beyond the only counsellor who runs a Green Door helping abused women and children to report crimes against them to the police and to access healthcare.

29. A study on crimes and abuses has shown that one out of five children report being sexually abused by the age of 17 years old - a likely underestimated proportion.[22] Additionally, when the abusers were asked about the reason for committing such act, the majority answered they did it because of boredom, or in order to have fun, and they widely believed that it was their right to do.

F. Violence against specific groups at risk, including women and girls with disabilities, elderly women and LGTBIs persons

30. Women and children with disabilities are at heightened risk to experience sexual or domestic violence for various reasons, including their low status in communities, their social isolation, their dependence on others and lack of knowledge about their rights. There is little information available about the violence they experience and its extent.

31. Children with disabilities (CWD) are 3 to 4 times more likely to be abused than children without disabilities. In townships in particular, many mothers of such children view such abuse as a tragic inevitability[23]. In a joint submission[24] to the CRPD, the Centre for Applied Legal Studies and Afrika Tikkun illustrated with case examples how sexual abuse of CWD is underreported due to the incapacity of CWD to correctly recall and relay details of such abuse as complainants and witnesses. The few cases reported were said to have led to no conviction. As a result, there is a lack of jurisprudence on sexual abuse cases of CWD, on specific issues faced by complainants and witnesses and sentencing of Perpetrators. Additionally the few CWD who manage to access the judicial system remain intimidated by family members of the accused, together with the fear of the accused being released on bail and returning to their community. As a whole, police, health, social development and justice services are not disability sensitive. In its initial report to the CRPD[25], the Government did acknowledge most of these challenges.

32. Across the country patterns of rape of older women which results at times in death has emerged. The SR welcomes the recent life sentence against the rapist of an elderly woman and notes that such a decision can have a powerful deterrent effect[26].

33. Despite an explicit prohibition of discrimination based on sexual orientation in the Constitution, lesbian women and other sexual minorities are very vulnerable to extreme forms of violence purported at "correcting" their bodies, including the so-called "corrective rape" often accompanied by a particularly heinous murder. This type of extreme violence was reported on the rise, despite the difficulty to detect it since victims are unlikely to spontaneously report their sexual orientation and police do not record this information.

34. The SR welcomes the establishment of a National Task Team on Gender and Sexual Orientation Based Violence formed by government departments, Chapter 9 institutions and

[22] 2015 University of Cape Town OPTIMUS Study

[23] http://www.afrikatikkun.org/page/19/?orderby=date

[24] http://pmg-assets.s3-website-eu-west-1.amazonaws.com/docs/120725afrikapres_0.pdf

[25] CRPD/C/ZAF/1

[26] https://www.npa.gov.za/sites/default/files/media-releases/2016%20April%2012%20-%20Life%20Sentence%20For%20Rapist.pdf

CSOs which designed a National Intervention Strategy for LGBTI issues (2014-2017) with the aim to address so-called "corrective rape" and other forms of violence against LGBTI persons. In addition, a Rapid Response Team was established to attend to the pending cases in the criminal justice system. While there is no specific crime against specific persons or groups, the SR welcomes recent case law which shows that courts have started to address such crimes as hate crimes even in the absence of specific hate crimes legislation. In November 2014, the Johannesburg High Court issued a strong condemnation of the discriminatory attitudes that fuelled such crimes and pronounced a sentence of 30 years imprisonment against the murderer of a young lesbian. The Rapporteur welcomes ongoing discussion in relation to the possibility of drafting legislation on hate crimes.

35. Buying and selling sex are criminalized. There are no data available on the number of people being arrested and prosecuted under the relevant provisions of the SOA but the law was reported to be applied to women in prostitution only. The criminalisation of prostitution has driven women in prostitution underground, increased stigma and discrimination, created obstacles to access services and made them very vulnerable to violence, human rights violations and corruption. There has been evidence of police using the law against women in prostitution to commit abuses. As a result, women in prostitution, who often are ignorant of their rights, do not have access to justice. When they are arrested, they are often denied access to their medication (the HIV/AIDS prevalence is particularly high among prostitutes). There is also the stereotype by police that they cannot be raped. In terms of law reform process, the CGE has issued a position paper[27] laying out the reasons and evidence behind its recommendation that women in prostitution should be decriminalized

IV. Incorporation of the international and regional framework on violence against women

A. International and regional framework

36. South Africa is party to a number of core international human rights treaties, including the Convention on the Elimination of Discrimination against Women ratified without reservations and its Optional Protocol, the Convention on the Rights of the Child and its two Optional Protocols and the Convention on the Rights of Persons with Disabilities. It has not ratified the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families, the International Convention for the Protection of all Persons from Enforced Disappearance and the Optional Protocol to the Convention against Torture. At the regional level, South Africa is, among others, party to the African charter on human and people's rights, the African Charter on the Rights and Welfare of the Child Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.

37. South Africa follows a dualist approach when it comes to the incorporation of international treaties into domestic law, hence requiring a domestic legislative act for such incorporation[28]. Section 39(b) of the Constitution states that when interpreting the Bill of Rights, a court "must consider international law" and "may consider foreign law"[29]. This

[27] http://www.gov.za/sites/www.gov.za/files/Commission%20for%20gender%20equality%20on%20se%20work_a.pdf

[28] www.saflii.org/za/journals/PER/2014/42.pdf

[29] SOUTH AFRICA CONST.ch.2,§12c.

clause has insured that South African jurisprudence develops consistently with emerging international human rights norms.

B. Observations of UN monitoring mechanism

38. In terms of its reporting obligation under CEDAW, at the time of the visit, the draft 5th periodic report was pending approval before parliament and had been published for comments. The SR welcomes the fact that since 2011, South Africa has acted on a number of CEDAW recommendations. She notes however, that on the two issues on which the Committee had asked a follow up within two years, i.e. a clear legislation on gender equality and a unified family code, the Government does not intent to implement these as explained in its follow-up report[30]. As a result, there is no legislation embodying the principle of substantive equality between women and men , or prohibiting and sanctioning direct and indirect discrimination against women in accordance with article 1 and 2 of CEDAW what constitutes a lack of full incorporation of those provisions [31].

39. The SR believes that the Committee's recommendation to consider elaborating a Gender Equality law and to have a unified Family code deserves further discussion. Both would have the potential to establish proper legal framework for the implementation of the constitutional and Convention's principle of gender equality and remove any remaining discrimination against women in matters relating to marriage and family relations, including the practice of polygamy in full compliance with article 16 CEDAW.

40. The Rapporteur notes that despite an early accession to the Optional Protocol to CEDAW in 2005, there are no individual cases which have been submitted under this procedure against South Africa. She further notes an overall insufficient knowledge from all stakeholders in relation to the CEDAW jurisprudence on VAW, and in particular on individual cases and decisions on inquiries on grave or systematic violations of women's rights.

41. Most recently, South Africa was reviewed for the first time and with a 14 years delay by the Human Rights Committee which, after acknowledging the considerable efforts invested, expressed its concerns "that gender-based and domestic violence remains a serious problem in the State party, that the conviction rate for such acts is low and that there is a lack of disaggregated data on the phenomenon. It is also concerned about the persistence of stigma against persons based on their real or perceived sexual or gender orientation, gender identity or bodily diversity, and that such persons are subject to harassment, acts of discrimination and sexual and physical violence"[32].

V. States responses and measures to address violence against women

A. Constitutional, legislative and policy framework

1. Constitutional framework

42. Chapter 2 (sects. 7-39) of the Constitution which is regarded as one the most progressive in the world contains the Bill of Rights. While women are protected by this

[30] CEDAW/C/ZF/CO/4/ADD.1
[31] CEDAW/C/ZF/CO/4,para 14
[32] CCPR/C/ZAF/CO/1,para 20

Bill, including the rights to life, human dignity, freedom and security, including being free from all forms of violence from public or private sources, bodily and psychological integrity, they receive specific protection in section 9, entitled "Equality". Section 9 (3) states that "The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth." All of these human rights must be respected, protected, promoted and fulfilled by the state with respect to the individuals under its jurisdiction. The Constitution being the supreme law, any law that is inconsistent with the Constitution is invalid.

2. Most relevant legislation on VAW

43. The Domestic Violence Act (DVA) of 1998 replaced the Prevention of Family Violence Act and was meant to address high levels of domestic violence by, among other things, broadening the definition of domestic violence and recognising that abuse may take many different forms, including physical, sexual, emotional, psychological, verbal, or economic abuse; as well as intimidation, harassment, stalking, and damage to property. Furthermore, the DVA applies to people in a wide range of "domestic relationships" and includes same – sex relationships as well as extended families. The Act sets out what police must do when they arrive at a domestic violence scene and also provides for victims of domestic violence but also other persons on behalf of the victim to go to court and apply for protection orders. It allows for seizing any arms or dangerous weapons; having a peace officer accompany the complainant to a specified place to retrieve personal property; payments of emergency monetary relief, and restrictions on the respondent's contact with a child. Being gender neutral and insufficiently gender sensitive, the DVA disregards the structural inequality between men and women and focus on women and man equality as victims of domestic violence at the expense of women who are predominantly victims of such violence. Being a civil law, it does not typify domestic violence as a criminal offence.

44. The Criminal Law (Sexual Offences and Related Matters) Amendment Act of 2007 (SOA) criminalizes all non-consensual sexual activity, including marital rape and expands the definition of rape to include all forms of non-consensual sexual penetration. The definition of rape, albeit very short, does not require the use of force and puts consent at the centre of it, which is in line with internationally agreed definition of rape. The act provides various services to the victims of sexual offenses, including free post-exposure prophylaxis for HIV, and the ability to obtain a court order to compel HIV testing of the alleged offender. It created a number of new crimes, particularly with respect to children and people with disabilities. It also created the National Register for Sex Offenders, which records the details of those convicted of sexual offenses against children or people who are mentally disabled, and prevents those listed from working with either group. In 2013, the Constitutional Court struck down sections 15 and 16 of the SOA which made consensual sexual acts between children aged 12 and 15 a crime and which had been applied to prosecute pregnant girls and which exposed children to the criminal system, causing them serious trauma.

45. The PEPUDA seeks to advance equality in public and private life, provides a framework to tackle unfair discrimination, harassment and hate speech and prohibits unfair discrimination on any grounds. It explicitly prohibits VAW, FGM, and the prevention of women from inheriting property, any traditional, customary or religious practice that impairs the dignity of women and undermines equality. It also prohibits policies that limit women's access to land rights, finance or other resources and provides for the establishment of Equality Courts.

46. The Protection from Harassment Act, 2011 provides for the issuing of protection orders against harassment committed outside of a domestic relationship. It defines sexual harassment widely, and even includes electronic harassment.

47. Other relevant legislation includes the Employment Equity Amendment Act, 2013 and the Prevention and Combating of Trafficking in Persons Act, 2013 but their analysis go beyond the scope of the present report.

3. Policy framework

48. A Cabinet-level Inter-Ministerial Committee (IMC), chaired by the Minister of Social Development initiated the South African Integrated Programme of Action for 2013-2018 (PoA) addressing violence against women and children, but also violence against elderly women and lesbian, as well as people with albinism. The SR regrets that the PoA, which had been endorsed by Cabinet was never disseminated at the provincial or district level, does not have the visibility it would deserve and is not the result of a participatory process since CSOs were not consulted. Additionally, no information was available as to the budget for its implementation. The Minister of Social Development reported that the IMC would be rolled out to provincial and local levels and that the PoA was due for review in 2017.

B. Institutional framework: national machinery and independent institutions

49. The SR notes that the Department of Women (DoW) headed by the Minister of Women, established in May 2014 and placed within the presidential cabinet is, as reported by itself, still in a transitional period. Its mission is to accelerate socio-economic transformation and implementation for women's empowerment and participation through oversight, monitoring, evaluation and influencing policy. The SR welcomes the stated intention of the DoW to review, as part of its strategy, the national machinery architecture and assess its effectiveness. She notes that GBV is not part of the mandate of the new DoW but falls within the responsibility of the Department of social development (DSD). The DSD is actually the department responsible for the coordination of national gender-based violence programmes and strategies and with a mandate on victim empowerment programme and on partnerships with CSOs. The DoW has only an operational budget and, facing some financial constraints, had to decide on priorities. While appreciating the DoW leading role on women economic empowerment as a way to reduce their economic vulnerabilities and hence the vulnerability to GBV, there is a lack of clarity on coordination and division of labour between the DoW and DSD on issues of VAW.

50. The Rapporteur was told that the pandemic levels of violence against women could not be the sole responsibility of one government department. An integrated, coordinated, multi-departmental approach is required and in May 2012, the Cabinet-level Inter-Ministerial Committee ICM was established to look at the root causes of violence against women and children as well as a technical committee. It was reported that the IMC is not working efficiently and has only met few times since its inception.

51. The Parliamentary Portfolio Committees exercise oversight functions by requesting government departments to account on measures undertaken in relevant fields, including by requesting a report on implementation of legislation, conducting monitoring visits and holding public hearings. The most relevant Committees are the one on Women and the one on Justice.

52. South Africa has established a number of independent institutions, referred to as "Chapter 9 institutions" since they are constitutionally based in Chapter 9 of the

constitution, in order to secure, each within its own sphere of competence, the respect and fulfillment of human rights to all its citizens. The Rapporteur met with the Commission for Gender Equality, the Human Rights Commission, the Public Protector, the Commission for the Promotion and Protection of the Rights of Cultural, Religious and Linguistic Communities and the Financial and Fiscal Commission. All recognized the need for more cooperation between themselves on different issues related to protection of women's rights and prevention of harmful practices and other forms of VAW.

53. The South African Gender Equality Commission[33] was established in terms of Section 187 of the Constitution in order to promote respect for gender equality and the protection, development and attainment of gender equality. The CGE produced a very important baseline report on measuring progress under CEDAW [34] and providing information on the implementation of the recommendations of the Committee, assess the government's compliance with and implementation of CEDAW and highlight some of the shortcomings of the government's report presented at the CEDAW Committee in 2011. Equally, following the visit of the former SRVAW in 1997, the CGE assessed the government compliance with her recommendations[35]. The SR very much appreciates the CGE's intention to monitor follow up to the recommendations of this report.

C. Some inter-sectoral responses to VAW

54. The Government's strategy to reduce the high level of violence against women is focused on economic development, education and empowerment of women. Government officials have pointed out that the roots of many forms of violence against women lie in poverty in which a majority of the population lives and that education is a vital social vaccine to alleviate poverty and inequalities, and ultimately VAW.

55. The Sexual Offenses Courts were re-established in 2013 by the Department of Justice and Correctional Services. These courts provide specialized victim-support services to reduce the chance of secondary trauma for victims, the case-handling time and improve conviction rates. They have specially trained officials and equipment, a special room for victims to testify, private waiting rooms for adult and child witnesses. At the time of the visit, there were 43th Special Offences Courts. The Rapporteur was informed that these courts have been a game changer: before their establishment there was a 48% conviction rate for sexual offenses cases whereas in 2015, the rate had reached 71%[36]. The Department of Justice informed the Rapporteur that these courts would be rolled out as quickly as possible throughout the country in light of their huge potential. Draft Regulations[37] that should improve their efficiency should soon be adopted aimed to provide for protective measures for victims to be available at designated courts and d focus on the needs of persons with disabilities.

56. The Thuthuzela Care Centres (TCCs) are one-stop, integrated response for victims of sexual violence led at the time of the visit by the National Prosecution Authority's Sexual Offences and Community Affairs Unit (SOCA), in partnership with various donors and non-profit organizations. They are a critical part of the anti-rape strategy, aiming to

[33] http://cge.org.za/

[34] "CEDAW, are we there yet" Measuring South Africa's Progress under the Convention

[35] E/CN.4/1997/47/Add.3

[36] The Rapporteur cautions against the misleading practice of reporting conviction based only on cases that went to trial, practice that she had experienced during her visit from state officials

[37] https://jutalaw.co.za/media/filestore/2015/10/Draft_Regulations_relating_to_Sexual_Offences_Courts_2015.pdf

reduce secondary trauma, increase conviction rates and reduce the length of time taken to finalize cases. They operate out of public hospitals in communities where the incidence of rape is particularly high. They are also linked to sexual offences courts when these exist. They enable rape victims to lodge a case with the police and receive counselling and medical care in one place. They have been hailed as a blueprint for responses to sexual violence. By the end of 2015, 55 TCCs were operational[38]. The quality of care delivered at these centers was, however, said to be uneven and they often lack psycho-sociological services. The Rapporteur notes that most of their funding comes from private donors.

57. The Khuseleka or One-Stop Crisis Centres are one-stop centers offering a continuum of services to victims of all crimes and violence. It was reported that there were actually 8 of these centres in function, operated under the DSD.

58. In December 2011, the Minister of Police announced the reintroduction of the Family Violence, Child Protection and Sexual Offenses Units (FCS Units) which provide specialised police responses to family and sexual violence. There were 176 units nationwide in mid-2015[39]. However, some of these units perform poorly for reasons such as poor management, understaffing, low morale and burnout[40].

59. The Rapporteur regrets the uneven geographic availability and distribution of these inter-sectoral responses to VAW as well as their uneven quality and range of services provided. In particular, most of these centers are not available to women and girls living in informal settlements and rural areas. When victims were able to access and benefit from TTCs, FCLs and sexual offenses courts throughout the justice's chain, convictions rates have significantly improved.

VI. Gaps and challenges

A. Prevention

1. Collection of data and statistics on vaw

60. There are no official data on femicides and other forms of violence against women and massive under-reporting of vaw. The figure of 1 out of 9 cases of rape being reported was accepted by all stakeholders, including state officials. There are also serious flaws with the recording of crimes under the SOA by the SAPS. Also, t The last crime statistics released in September 2015[41] only listed "sexual offenses" and were not disaggregated in terms of types of sexual offenses under the SOA, such as rape or sexual assault. While these statistics showed a decrease from 56 680 in 2014 to 53 615 in 2015, it is difficult to draw any conclusions in relation to specific offenses. It therefore cannot be established that rape has decreased.

61. An additional and serious impediment on data collection is the performance management system of the SAPS which has set the reduction of violent crime by between 4% and 7% as a target, creating a contra effect and disincentive for police to record all violent crimes reported to them[42].

[38] http://shukumisa.org.za/wp-content/uploads/2015/11/Shukumisa_TCC-Report.pdf
[39] http://www.saps.gov.za/newsroom/msspeechdetail.php?nid=4936
[40] Khayelitsha Commission of Inquiry
[41] http://www.saps.gov.za/resource_centre/publications/statistics/crimestats/2015/crime_stats.php
[42] Submission from the Institute for Security Studies (ISS)

62. Domestic violence is not recorded by the police as a specific crime category and therefore there are no statistics available. When cases of domestic violence are reported to the police, they are recorded under a range of different categories such as assault, malicious damage to property, pointing a firearm, murder etc. The DVA does make it a legal requirement for police stations to keep a register of all cases of domestic violence reported. However, the implementation of this requirement across stations is erratic at best and non-existent at worst. A 2014 audit conducted by the Civilian Secretariat for Police (CSP) found that only two of 145 police stations were fully compliant to the Act.[43]

2. Underreporting of cases of VAW

63. There are significant societal and institutional barriers to reporting gender-based violence. Such violence is still very much considered a private matter and victims have to co-exists with perpetrators because of the link to the family or community setting. Victims blame themselves and fear reprisals from the perpetrator that they might know (intimate partner, family member, friend, neighbour, teacher or other community leader) or fear stigmatization from their family, friends or community. They may not have an easy access to a police station or medical facility, lack faith and trust in the police and justice system and fear mistreatment or secondary victimization by the police. This all creates powerful disincentives for victims to report to the police. Cases of police members perpetrating the very same GBV they are mandated to fight play also a strong dissuading factors have also led women victims to distrust the police and even to be afraid of it, causing further underreporting[44].

3. Lack of a national strategic plan on VAW

64. Several interlocutors compared South Africa's experience with HIV and its adoption in 2011 of a National Strategic Plan (NSP) on HIV, STIs and TB as the way forward to gain both political and funding commitment at the highest level. The following features would be pre-requisites for any NSP on GBV: a fully funded plan committing adequate resources, developed through an open, inclusive and consultative process which would belong to all segments of the population and all sectors, with an independent multi-sectoral oversight and accountability mechanism to monitor its implementation. The SR believes that such a NSP would demonstrate the serious commitment towards the elimination of GBV and supports the call for its establishment as the roadmap needed to effectively combat to this pandemic. Such NSP should integrate implementation of commitments based on the international instruments like the CEDAW convention, the DEVAW, the CEDAW General Recommendation on article 19 as well as relevant part of the Beijing Declaration and Platform for Action as well as obligations based on the Constitution, the DVA and other relevant legislation.

B. Protection (services providers)

1. Quality of health care and forensic examination

65. The policy and guidelines for the treatment and care of victims of sexual offenses are key as they guide health providers on the type of health care needed and how to conduct forensic examinations. However, these documents date back from 2003, before the

[43] http://pmg-assets.s3-website-eu-west-1.amazonaws.com/141105research_unit_dva_compliance.pdf

[44] See http://irr.org.za/reports-and-publications/occasional-reports/files/broken-blue-line-2-february-2015.pdf

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introduction of the SOA. They do not reflect the latest developments in the medical treatment and psychological care of victims of sexual crimes.

66. The quality of treatment received in health facilities varies. Some health care workers do not have the appropriate post-rape care knowledge and are inadequately trained to collect forensic evidence. A study found that in 41.5% of cases, the concluding statement related to the gynaecological examination was missing from the form describing the victim's forensic examination[45].

2. Funding of CSO

67. The SR notes that CSOs not only have been working in close cooperation with the Government but have also provided for the majority of services without receiving appropriate compensation for a service from the Government. For example, most post-rape care is provided by CSOs which support victims in the immediate aftermath of rape, assist with adhering to post exposure prophylaxis to prevent HIV infection, counselling and preparation for testifying in court, as well as accompaniment to court[46].

68. Funding of CSOs, including the ones running shelters, is provided by the DSD which covers only a small percentage of the organisation's operational costs. CSOs reported that the Government had been prioritizing prevention over services delivery, and that the DSD funding had been decreasing.

3. Lack of shelters/second-stage housing

69. The DSD reported that there were 88 shelters in total in the country, mostly run by CSOs. Beside a clear insufficient number of shelters, in particular in rural areas and in/around townships and informal settlements, existing shelters struggle with funding and can only rely, in average, on 10% coverage of their operating costs by the DSD. Some important discrepancies exist in the funding allocated between and within provinces as well as in the range and quality of services delivery among shelters. For example, most shelters are not equipped to accommodate mothers with children or with boys older than 7 years or children with special needs or age or women drug users.

70. There is also an acute need for longer-term accommodation for abused women once they leave first stage shelters. Unfortunately, second-stage housing is virtually non-existent, at the exception of a few noteworthy projects such as a pilot programme run by Nonceba Family and Counselling Center in Khayelitsha which had started at the time of the visit. More permanent housing arrangements are also almost inexistent.

C. Prosecution

1. Shortcomings in the criminal justice system's response

71. The SAPS agents are the first responders to GBV. They operate in a difficult context and are confronted with many challenges, including the extreme level of everyday violence and the lack of human resources and equipment. 941 victims friendly rooms have been established in police stations throughout the country. However, information received by the Rapporteur concurs with the findings of the Civilian Secretariat for Police that not all of them are functional or resourced.

[45] https://www.issafrica.org/crimehub/uploads/Shukumisa-health-scorecard.pdf

[46] http://www.shukumisa.org.za/2015/11/16-days-of-discontent-day-7-undervaluing-care-work/

72. In relation to conduct of the police, and while good services does exist within the SAPS, the Rapporteur heard repetitively that women seeking protection had been turned down and told to go back to their abusive partner or communities. Some police members do not believe rape survivors, especially when they are young, and treat them badly. Treatment of groups of women at heightened risk of GBV, including women and girls with disabilities, LGBTI persons, prostitutes, refugees and undocumented migrants has been reported to be even more discriminatory causing secondary victimisation.

73. Other challenges identified with respect to the police actions are the lack of GBV specific training of police, in particular with respect to victims' rights and the procedure to be followed to bring cases forward. Government officials reported that members of the FCS units were receiving basic training on the bill of rights, only 5 days training were devoted to the DVA and the SOA. The poor quality of investigations due to the lack of availability of qualified investigators, including when FCS unit exit, and the insufficient referral of victims to service providers were also raised.

74. At the level of prosecution, the SR was made aware of a number of obstacles. The pressure to deliver convictions allegedly placed on prosecutors was reported to have led some of them to prioritize cases deemed to have more chances to reach a conviction sentence, pushing aside other cases. Difficulties faced by victims whose cases have been repetitively postponed, placing on them an additional emotional and financial burden were also reported.

75. At the level of the judiciary, there are additional obstacles that a victim needs to overcome. Among these, the non-victim friendly conduct of the hearing, the lack of security of the victim who has to face the perpetrator, secondary traumatization but also the use of gender stereotyping by magistrates leading to leniency towards the perpetrator.

2. Specific Gaps in the implementation of the DVA and the SOA

76. State officials have recognized the need to improve police response to domestic violence and in order to do so, have engaged in a thorough review of its implementation. There has been a chronic lack of budgeting for implementation of the DVA since its enactment in 1998 what significantly weakens protection provide by this law and represents a human rights violation by the State.

77. On the other hand, there has been some improvement in the reporting by police of domestic violence. The CSP which provides civilian oversight of the Police Service, is in charge of monitoring police stations' compliance with the DVA. Police non-compliance can have extremely serious consequence, as shown in an emblematic case where the victim, despite having obtained a protection order prohibiting her abusive husband from entering her home was raped by him. The victim successfully brought her case to court which confirmed that the failure to arrest the offender was the factual and legal cause of the rape and that it extended legal liability to police members who had failed to give effect to a protection order[47]. This case is emblematic of the lack of appropriate follow up by police to enforce protection orders which was reported to the Rapporteur throughout her visit.

78. The Rapporteur notes that police called at the scene of an incident are not required to conduct a risk assessment and risk management while this could provide invaluable background information to understand the circumstances, to manage the lethality risk and if necessary to provide coordinated safety and support.

[47] White v Minister of Safety & Security and Others

79. SAPS trainings on domestic violence have significantly increased but seem to have failed so far to address adequately the psycho-sociological impact of VAW on victims. The Rapporteur stressed the need for training programme to be assessed and was pleased to learn about the first completion by police of the Domestic Violence Learning Programme in 2014/2015 which will inform about the quality of the training.

80. In 2013/2014, 255 395 protection orders were applied for through the magistrate courts, but only 88 504 were ultimately made final, which represent 28%[48]. The Rapporteur was apprised of some issues faced by applicants of protection orders. When a victim applies for such order, the court decides whether to grant an interim protection order or to merely issue a notice informing the respondent to appear in court. In many cases, this means that the victim is sent back to a violent home without immediate effective protection. While the DVA encourages issuance of protection order with as little delay as possible, it was reported that the speed at which they are issued varies greatly depending on the courts. Another issue is the false assumption by some police officers that at the time of the serving of the protection order, the applicant has to be present for identifying the respondent, while this is not a requirement under the DVA. Personal views and beliefs of magistrates were reported to come into play negatively towards the granting of protection order, as some view them as tearing families apart. Additionally, magistrates' behaviors are not always appropriate, intimidating applicants and questioning their motives. In case of the breach of a protection order, police officers often are not aware that they can arrest the perpetrator on site and that the breach constitutes in itself a criminal offence under the DVA.

VII. Conclusions and recommendation

81. South Africa has a progressive Constitution, solid legislation such as the DVA and the SOA and policies to deal with gender-based violence. It has also adhered to CEDAW, its OP and regional instruments like the Maputo Protocol. Despite all this there have been gaps in incorporation and/or lack of giving full effect to the principle of substantive gender equality and prohibition of direct and indirect discrimination against women as well as a lack of a holistic and comprehensive legal and policy approach to prevent and combat vaw. Gender-based violence continues to be pervasive and a systematic women' human rights violations.

82. Based on the above findings, and in a spirit of cooperation and dialogue, with the Government, the SR offers the following recommendations:

1. Law and policy reform

(a) Consider renewing efforts to implement the CEDAW recommendations on a Gender Equality Law and on a unified family law which would establish a strong legal framework for the implementation of the constitutional and Convention's principles of gender equality and non discrimination and repeal any remaining discrimination against women in matters relating to marriage and family relations, including the practice of polygamy in full compliance with article 16 CEDAW;

(b) Consider adopting a new consolidated criminal offence to criminalize Utukhwala and a prosecution consolidated practice;

(c) Consider enacting a hate crime legislation which would enable to capture both the hate dimension of crimes and the sexual orientation of LGTBI victims of GBV;

[48] https://www.issafrica.org/crimehub/uploads/Shukumisa-16-Days-fact-sheet-DoJ.pdf

(d) review relevant legislation and regulations in force to decriminalize women in prostitution and take a comprehensive approach to addressing the question of prostitution, including exit programmes for women who wish to leave prostitution

(e) Develop and adopt urgently, in an open, inclusive and consultative process, a National Strategic Plan on GBV with a set of clear strategic priorities and core measurable goals, adequately funded and led by an independent multi-sectoral oversight and accountability mechanism to monitor implementation progress; or alternatively, urgently disseminate and implement at the provincial and district levels the PoA, in partnership with CSOs, widely consult around its upcoming review which should focus on results-oriented measures and allocate sufficient for its implementation.

(f) Provide urgently adequate budgeting for implementation of key measures in relation to implementation of the DVA;

(g) Consider examining the feasibility of regulating the availability of alcohol as a mean to help reduce GBV;

(h) In light of the extreme levels of VAW in informal settlements, such as in Diepsloot, and others alike, consider establishing national inquiries on such violence and the general situation of women and girls in these settlements; also adopt a specific National Action Plan with appropriate recommendations on prevention and elimination of VAW that would take into account the specificities of such informal settlements including safety, housing, education and health needs of women and girls specifically.

2. Investigation, prosecution, support services and protective measures

(a) Continue to increase the number of women police officers

(b) Study the efficiency of protection orders in order to improve them and to make them immediately available to the victim of vaw at risk of new violence. In particular, police should be instructed to conduct risk assessment and risk management to protect victim of immediate treats and to issue interim protection order.

(c) Enforce the DVA requirement to keep a register of all cases of domestic violence reported to the police across all police stations, to make station commanders accountable for the failure to do so and to request police to release detailed crime statistics on domestic violence cases as gathered from the registers;

(d) Operate a shift in SAPS so that it is instructed to encourage reporting of VAW and be assessed on the basis of the quality of services provided to victims and correspondently too remove the element of police performance indicators which penalizes any rises in the reporting of sexual offences;

(e) Improve the training of the police on the response to, management of, and investigation of domestic violence and sexual offences and to ensure that each training is being followed by a monitoring and evaluation process

(f) Ensure that the criminal justice system has the capacity – in human resources, skills, expertise, and funding – to deal efficiently and effectively with GBV, and in order to do so

- make appropriate budget allocation to roll out the victim friendly rooms in police stations, the TTCs, FCLs and Sexual offenses courts in particular in rural areas and informal settlements;

- **ensure the collaborative model of TTCs and sexual offenses court working in tandem which has led to increased conviction rates;**

- **require the NPA to require from prosecutors who abandon prosecution of a case to provide automatically for the reasoning to the complainant;**

(g) With respect to the judiciary:

- **provide mandatory training to, members of the judiciary, including prosecutors and judges, in particular at the magistrate courts level, on the CEDAW Convention and its Optional Protocol, General Recommendations and the Committee jurisprudence on VAW and increase mandatory training on GBV and gender-based stereotypes in general and on key national legislation, in particular the SOA and the DVA and its range of protective measures;**

- **ensure wide dissemination of progressive judgments, including from the Court of Appeal and Constitutional Courts, and jurisprudence from CEDAW;**

(h) In relation to sexual violence in schools, require the DBE and SACE to act jointly in disciplining educators who have perpetrated such acts and to take disciplinary sanctions against teachers or principals who fails to report cases; make the list of sexual offenders teachers available to all public and private schools and design nationwide programme on sexual violence in schools and comprehensive human rights education;

(i) Improve the quality of services provided by police to victims of sexual and domestic violence;

(j) Scale-up delivery and state funding of services for victims, and in particular increase number of social workers who have been trained on GBV and psycho- trauma counseling;

(k) Establish more shelters, in particular in rural areas and informal settlements, including shelters that can accommodate women or their children with disabilities, LGBTI persons, and mothers with sons of 6 years and above.

(l) Implement the recommendations of Chapter12 of the National Development Plan addressing community safety and improving the criminal justice system and report regularly on their implementation status;

(m) Prioritize the needs of VAW survivors in allocating public housing and in access to transitional housing;

(n) Encourage further government and CSOs initiatives like Sonke Gender Justice aimed at engaging men in challenging rigid ideas about masculinity and encourage them to become agents of change;

(o) Increase the use of social media for educational and awareness-raising purposes, through for examples hubs in communities, aimed at both community leaders and the general public, in order to ensure that they understand that all forms of violence against women are unacceptable and at women and girls to enhance knowledge about their human rights.

3. National mechanisms

(a) Strengthen, clarify roles and responsibilities and ensure adequate resources for state institutions to carry out their mandate with respect to gender equality and VAW, in particular the DoW and the DSD;

(b) **Ensure that these state institutions cooperate among themselves and work hands in hands with CSOs;**

(c) **Strengthen the role and efficiency of the ICM so that it can discharge its function of co-ordination of policies and measures to prevent and combat violence against women effectively and ensure that it engage meaningfully with CSOs or alternatively establish an adequate coordinating and monitoring mechanism inclusive of CSOs to effectively prevent and eliminate all forms of violence against women;**

4. **Collection of data and prevention of VAW:**

(a) **Expand the collection of data to all forms of VAW, including femicides, domestic violence and all all types of sexual offenses under the SOA. Data should include details on sex, age, sexual orientation, disability as well as relationship between perpetrator and victim.**

(b) **Encourage the establishment of "femicide watches" in each of the 9 provinces and a "femicide watch" at the national level and analyse each case of femicide in order to identify any failure of protection with a view of improving and developing further preventive measures. The Gender Equality Commission should be entrusted with the compilation of data from the provincial level and be responsible for the national femicide watch.**

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Psychosocial Correlates of PTSD Symptom Severity in Sexual Assault Survivors

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This study's goal was to assess the effects of preassault, assault, and postassault psychosocial factors on current posttraumatic stress disorder (PTSD) symptoms of sexual assault survivors. An ethnically diverse sample of over 600 female sexual assault survivors was recruited from college, community, and mental health agency sources (response rate = 90%). Regression analyses tested the hypothesis that postassault psychosocial variables, including survivors' responses to rape and social reactions from support providers, would be stronger correlates of PTSD symptom severity than preassault or assault characteristics. As expected, few demographic or assault characteristics predicted symptoms, whereas trauma histories, perceived life threat during the assault, postassault characterological self-blame, avoidance coping, and negative social reactions from others were all related to greater PTSD symptom severity. The only protective factor was survivors' perception that they had greater control over their recovery process in the present, which predicted fewer symptoms. Recommendations for intervention and treatment with sexual assault survivors are discussed.

Posttraumatic stress disorder (PTSD) is one of the most common effects of sexual assault with approximately one third of female rape victims being diagnosed at some time following the assault (Kilpatrick, Edmunds, & Seymour, 1992; Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992). However, compared with the symptoms of anxiety and depression, fewer studies of sexual assault victims have looked at correlates of PTSD symptoms. Furthermore, most representative sample studies have not examined a broad range of psychosocial factors that may explain postassault symptoms. This limitation is important because recovery from this trauma may be mitigated or exacerbated by a variety of variables including (a) preassault factors such as history of previous trauma (Koss, Figueredo, & Prince, 2002; Nishith, Mechanic, & Resick, 2000); (b) assault-related factors including objective assault characteristics (Kilpatrick, Saunders, Amick-McMullan, & Best, 1989; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993) and trauma-related outcomes including subjective perceptions of life threat, peritraumatic dissociation, and panic (Griffin, Resick, & Mechanic, 1997; Nixon, Resick, & Griffin, 2004); and (c) postassault experiences such as

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attributions of blame, coping strategies, and social reactions from persons told about the assault (Frazier, 1990, 2003; Ullman, 1996; Ullman & Filipas, 2001). Most research has examined the first two sets of factors, but less work has examined the role of postassault factors in recovery. Yet, these psychosocial factors are potentially more modifiable than survivors' preassault characteristics and experiences or the characteristics of sexual assaults.

Furthermore, recent theoretical reviews have argued that it is critically important to understand the social and ecological contexts of trauma associated with sexual assault (Messman-Moore & Long, 2003; Neville & Heppner, 1999; Ullman, 1999; Wasco, 2002). Such theories are substantiated by empirical evidence. For example, a recent meta-analysis of 14 risk factors for PTSD showed that social support had the strongest effect size (Brewin, Andrews, & Valentine, 2000). This suggests that understanding differences in recovery from sexual assault requires examining a broader set of variable domains than has typically been analyzed. Potentially important factors can be divided into preassault, assault, and postassault domains.

Preassault Factors

Past research suggests that preassault factors may play a role in recovery from sexual assault, although evidence on demographics is inconsistent (Foa & Riggs, 1993; Resick, 1993), with some data suggesting that older age (Frazier et al., 1997) and more education may be related to less severe PTSD symptoms (Ullman & Brecklin, 2002; Ullman & Filipas, 2001). Furthermore, Koss et al. (2002) studied 253 representatively sampled rape survivors from a large university-based sample of predominantly White, educated, employed women in an urban area and found that personological characteristics (e.g., psychological problem history, openness to experience) and violence exposure had more influence on recovery than crime characteristics. Preassault victimization histories may also affect recovery from sexual assault. Nishith et al. (2000) studied a retrospective convenience sample of 117 adult rape victims recruited from police, hospital, and victim service agencies within a month of the rape. They found that child sexual abuse history was related to increased risk of adult sexual and physical victimization, and to greater current PTSD symptoms.

Assault-Related Factors and Outcomes

Studies of both probability and nonprobability samples have found that several assault-related factors and trauma-related outcomes (perceived life threat, more violent assaults, and completed rapes) are consistently associated with more severe PTSD symptoms following sexual assault (Bownes, O'Gorman, & Sayers, 1991; Frazier et al., 1997; Kilpatrick et al., 1989; Resnick et al., 1993; Ullman & Filipas, 2001).

Postassault Factors

Finally, several studies suggest that postassault social cognitions such as attributions of self-blame, basic beliefs about self and others, and perceptions of control are related to the impact of sexual assault (Frazier, 2003; Koss et al., 2002). For example, Koss et al. (2002) found that maladaptive beliefs about self and others and characterological self-blame were related to greater psychological distress. Frazier's (2003) longitudinal study of 171 predominantly stranger rape survivors seen at an emergency room following their assaults showed that both behavioral self-blame and rapist blame were related to higher distress levels, whereas belief that a future assault was unlikely and perceiving one had control over the recovery process were related to less distress. These studies imply that social cognitive factors (e.g., attributions, beliefs, control) are important for recovery. Unfortunately, large-scale studies of diverse samples of survivors have not examined contextual factors like negative social reactions to victims' assault disclosures and avoidance coping that recent studies suggest are associated with poorer recovery. Avoidance coping such as trying to forget about or block out the assault has been associated with poorer recovery in sexual assault survivors (Ullman, 1996; Valentiner, Riggs, Foa, & Gershuny, 1996). Several

cross-sectional studies have shown that negative social reactions to disclosure are related to more severe PTSD symptoms and psychological distress in community (Campbell et al., 1999; Ullman & Filipas, 2001) and help-seeking samples (Davis, Brickman, & Baker, 1991). Finally, recent smaller longitudinal studies have shown that unsupportive reactions and more interpersonal friction with others following assault predict worse PTSD symptoms at follow-up (Andrews, Brewin, & Rose, 2003; Zoellner, Foa, & Brigidi, 1999).

Present Study

The present study builds on past research by examining a broad set of psychosocial factors in addition to demographic and background variables in a large, diverse sample of sexual assault survivors. Four categories of variables were examined. First, demographic variables of race and marital status were hypothesized to be nonsignificant in relation to PTSD symptom severity, whereas older age and more education were expected to be related to less severe PTSD (Frazier et al., 1997; Ullman & Filipas, 2001). Second, preassault variables of trauma history and child sexual abuse were expected to be positively related to PTSD symptom severity. Third, most assault characteristics and trauma-related outcomes (i.e., level of offender violence, victim-offender relationship, degree of survivor distress postassault, and assault severity) were expected to make minimal contributions to symptoms, except for perceived life threat, which was expected to be related to more severe PTSD symptoms. Fourth, most postassault characteristics were expected to be related to more severe PTSD symptoms, including delayed assault disclosure, avoidance coping, characterological and behavioral self-blame, less perceived control over one's current recovery, less current social support from one's social network, and receiving more negative social reactions and fewer positive social reactions from others told about the assault. Overall, avoidance coping and negative social reactions were expected to be the strongest correlates of greater PTSD symptom severity.

METHOD

Participants

The present study analyzed mail survey data from the first wave of a longitudinal study of sexual assault survivors' recovery. Fliers, advertisements, and notices were distributed over a one-year period in the Chicago metropolitan area on college campuses, in the community, and at mental health agencies and rape crisis centers. Women age 18 and older with unwanted sexual experiences since age 14 were recruited for a 45-minute confidential mail survey. In addition to the survey, women were sent study information, a community resource list for women survivors of violence, and a postcard asking if they wished to be recontacted regarding participation in a follow-up survey and/or interview. Women were sent $20 after returning the survey and offered a summary of results. Of those who called and requested a survey, 1,084 women (90%) returned the survey.

Measures

Demographic information assessed included age at the time of the survey (in years), race (White, Black, Hispanic, Asian or Pacific Islander, American Indian or Alaskan Native, Other), household income (six ordinal categories ranging from *$10,000 or less* to *$50,000 or more*), education (four ordinal categories ranging from *less than 12th grade* to *college graduate or beyond*), currently employed (no or yes), current school status (in school or not), marital status (single, married, divorced/separated, widowed, or cohabitating), and parental status (no children or children).

A modified version of the Sexual Experiences Survey (SES; Koss & Gidycz, 1985) was used to identify lifetime prevalence of completed rape, attempted rape, sexual coercion, and unwanted sexual contact. The questions assessed adult sexual victimization from age 14 on, the age criteria used in the *SES*. Following Koss, Gidycz, and Wisniewski (1987), women also answered each *SES* question with respect to whether they had each experience before age 14 to assess child sexual assault. The *SES* has

reported internal consistency reliability of .69 and test-retest reliability at one week apart of 93% (Koss & Gidycz, 1985). Highest severity of sexual victimization was coded continuously according to Koss et al.'s (1987) guidelines. Women reporting multiple experiences on the *SES* were asked to answer assault-related questions about their most serious assault including age at the time of the incident, relationship to the perpetrator (stranger, nonromantic acquaintance, casual or first date, romantic acquaintance, husband, relative), physical injuries (ranging from mild soreness to knife/gunshot wounds), sexual acts (fondling, oral penetration, vaginal penetration), coercive tactics used by the perpetrator (ranging from insistence to weapon use), perceived life threat during assault (no or yes), and degree of upset immediately after assault.

Lifetime histories of traumatic events were assessed with Goodman, Corcoran, Turner, Yuan, and Green's (1998) Stressful Life Events Screening Questionnaire (SLESQ), a brief self-report measure of 10 behaviorally specific items assessing a variety of traumatic events of an interpersonal nature. Because many of these traumatic events are related to psychological distress and PTSD (Resnick et al., 1993; Resnick, Kilpatrick, & Lipovsky, 1991), this measure was scored as the summed number of events experienced by each respondent (excluding adult and child sexual assault, which were already assessed by the SES). Respondents were also asked if they reported the same incident under more than one item. If so, it was counted as one event. Psychometric data are excellent with good test-retest reliability (median $\kappa = .73$), adequate convergent validity (with a lengthier interview) with a median κ of .64, and good discrimination between Criterion A and non-Criterion A events. Prevalence rates for specific events were similar to those reported by Norris (1992) and Kessler, Sonnega, Bromet, Hughes, and Nelson (1995) in two large probability samples.

Respondents were asked about their current social support network using measures of social contact and social resources from the Social Activities Questionnaire of the Rand Health Insurance Experiment (Donald & Ware, 1984). Social contact items included the number of close friends you feel you can confide in (coded continuously as number of confidants), and one question about how well you are getting along with people these days (three ordinal categories). Social resources were assessed by frequency of social contact with informal and formal social network members in the past month (mean of five Likert items about frequency of contact with friends and relatives, and religious service attendance).

Women were asked if they had ever told anyone about the assault (no/yes), the timing of their first disclosure (five ordinal categories ranging from immediately after the assault to more than 1 year postassault), whether they had ever talked with each of several sources about the assault (e.g., friend/relative, mental health professional, clergy, police, rape crisis center, others) and whether each of these sources was helpful.

The Social Reactions Questionnaire (SRQ; Ullman, 2000) was administered to victims who had disclosed their assaults to others. They were asked about how often they received 48 different reactions from other persons told about the assault (five ordinal categories from *never* to *always*). No time frame was specified so that respondents could report on all reactions they received since the assault. The mean number of positive social reactions (tangible aid/information support, emotional support, validation/belief) and the mean number of negative social reactions (taking control of the victim's decisions, blaming the victim, treating the victim differently/stigma, distraction/discouraging talking, egocentric responses) were computed for analyses. A study ($N = 323$) of the psychometric characteristics of the SRQ (Ullman, 2000) using a recruitment strategy similar to that used in the present study showed good test-retest reliability (Pearson r ranged from .68 to .77), construct validity as shown by factor analysis, convergent validity with expected correlations of positive and negative social reactions with other social support and psychological symptom measures, and concurrent validity, assessed by correlating SRQ subscales with corresponding social reactions coded from open-ended data from questions about helpful and unhelpful responses to sexual assault disclosure (Ullman, 2000).

Self-blame attributions were assessed with Frazier's (2003) Rape Attribution Questionnaire (RAQ), a valid

and reliable self-report measure of attributions made by sexual assault victims about why assault occurred. In this study, two 5-point Likert-type scales assessed the two types of self-blame attributions—behavioral self-blame and characterological self-blame—made in the past 30 days. Frazier had obtained reliability data in a sample of female victims entering an emergency room after being sexually assaulted and a sample of sexual assault survivors identified by a random telephone survey. Subscale alpha coefficients ranged from .77 to .89 and test-retest reliability coefficients ranged from .68 to .80 (Frazier, 2002).

Perceived control over recovery from sexual assault was assessed using Frazier's supplemental perceived control items, developed to assess past, present, and future control (Frazier, 2002; Frazier, 2003). In this study, women were asked specifically about their perceptions of control over recovery from their sexual assault experience in the past 30 days. Frazier (2003) reported an alpha of .81 for present control over recovery from assault.

A composite measure of reliance on avoidance coping strategies used in the past 30 days to cope with the assault was computed from six Likert items consisting of behavioral disengagement, denial, and self-distraction subscale items of the Brief COPE, a 28-item self-report scale of coping strategies (Carver, Scheier, & Weintraub, 1989). The COPE has been widely used in studies of stressed populations and has good internal consistency reliability (all subscales' alphas .60 or greater except for one) and test-retest reliability (correlations of .46 to .86).

The Posttraumatic Stress Diagnostic Scale (PDS) was used to assess PTSD symptom severity (see Foa, 1995, for reliability and validity). The PDS is a 17-item brief self-report instrument used to provide a reliable diagnosis of PTSD based on the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (*DSM-IV*; American Psychiatric Association, 1994) criteria and quantification of the severity of PTSD symptoms according to recommendations provided by Foa (1995). This scale was selected because it has been validated with sexual assault victims unlike other available measures (Foa, Cashman, Jaycox, & Perry, 1997). Instructions were modified to ask respondents to rate how often each symptom has bothered them in the past month for their specific sexual assault experience on a 4-point scale from 0 (*not at all*) to 3 (*almost always*). Many women qualified for the PTSD diagnosis in the study (69.7%). Because the average time since the assault was 13.2 years ($SD = 11.0$), this high level of PTSD suggests that there may not be a linear relationship of PTSD and time since assault in our sample. For the analyses, the summed PTSD symptom severity score (0–51) was computed by summing response weights to individual items corresponding to reexperiencing, numbing/avoidance, and arousal criteria symptoms.

Data Analysis

Analyses included all forms of sexual victimization on the *SES*, but excluded women who did not endorse items on the *SES* and those who did not disclose their assaults prior to the survey. This resulted in a sample of 793 cases. Missing data randomly distributed across other variables in the model further reduced the sample, although by using pairwise deletion in the regression we preserved 699 valid cases in the model. This resulted in a ratio of cases to independent variables well over the recommended cutoff of 10 cases per independent variable (Tabachnick & Fidell, 2001), with 36 cases per independent variable. According to Green's (1991) guidelines for having the power of .80 to detect medium-size effects, 202 cases are needed for a regression with 19 independent variables. There are over 3 times as many cases in the regression, suggesting that power is excellent.

Variables were entered into the regression equation in four consecutive blocks to reflect a logical sequence of preassault, assault-related factors and outcomes, and postassault domains. Given our large, heterogeneous sample, demographics were entered in the first block to account for any differences in PTSD symptoms due to differences between women. This was followed by a second block with preassault variables of trauma history and child sexual abuse severity. Block 3 included objective assault characteristics and trauma-related outcomes (e.g., perceived life threat, postassault distress) and Block 4 included postassault experiences of self-blame, coping, control, social reactions,

and current social support. This order of entry of the variable sets reflects the most conservative way to assess the role of postassault factors expected to predict PTSD symptom severity. By entering these factors last, they would have to capture remaining variance not already explained by demographic, trauma history, and assault variables already entered into the model. The dependent variable was the summed total PTSD symptom severity score.

RESULTS

Sample Demographics and Experiences

Most women were currently unmarried (88.7%) and self-identified as an ethnic minority (62.9%). Just under half were African American (46.2%), and over one third were White (37.1%). Women were an average of 32.5 years old ($SD = 11.0$), and 44% had children. Thirty-nine percent had attended some college, one third had completed college or beyond, and one third had a high school degree or less. Half were employed and one third were in school (28.8%). Most women had incomes of $10,000 a year or less (40%) or $10,000 to $30,000 (36%), with one quarter earning over $30,000.

Two thirds of women's adult sexual assaults were completed rapes (71.4%) with the remainder reporting other forms of sexual victimization. In addition, over half had child sexual abuse histories (54.5%), over one fourth of which involved penetration (27.7%). Most women (89.8%) had also experienced either one (16.7%) or two (73.1%) or more additional traumatic events in their lifetimes. In terms of current social support, women had an average of 4.82 confidants ($SD = 4.76$) and over half were getting along with others the same as usual (55.4%), whereas fewer were getting along better than usual (26.8%). Based on a summary measure created from several ordinally scaled items, women's frequency of social contact with friends, family, relatives, and religious services ranged from between once a week and two to three times per month depending on the specific support source.

Women's assaults occurred at an average age of 19.22 years ($SD = 7.92$). Under half of the attacks were by acquaintances (45%), 22.4% by romantic partners or husbands, 20% by strangers, and 12% by relatives. Approximately two thirds of assaults involved some form of physical attack, ended in completed vaginal intercourse (64%), and resulted in minor physical injury (e.g., soreness, bruises, cuts).

A majority of women were very or extremely upset after the assault (76.9%) and told someone about it (80%). One third (33.1%) disclosed immediately after the assault, 29% waited days to weeks after, and over a third (37.3%) told a year or more later. Women told various support sources about the assault, with most telling a friend (84.8%) followed by a romantic partner (65.1%). Almost half had told relatives (47.2%) and mental health professionals (46.6%), whereas 39.3% told parents. Less than one third told doctors, police, clergy, or rape crisis-support sources. About two thirds of women telling each support source said they were helpful, except for police and parents who were helpful in only half or less than half of cases. Means, standard deviations, and internal consistencies of postassault measures of attributions, coping, support/social reactions, and PTSD symptom severity measures are provided in Table 1. Mean substitution was done on all computed variables at

Table 1. Means, Standard Deviations, and Coefficient Alphas for Psychosocial Measures

Measure	*M*	*SD*	Range	α
Social support	3.97	1.17	1.2–7.0	—
Traumatic events	3.04	2.16	0–10	—
Present control	3.76	1.12	5–30	.72
Avoidance coping	2.02	1.07	6–24	.74
Character self-blame	2.59	1.30	5–25	.76
Behavior self-blame	3.33	1.38	5–25	.83
Positive reactions	2.02	0.83	0–4	—
Negative reactions	1.04	0.93	0–4	—
PTSD Symptoms	19.61	12.44	0–51	—

Note. PTSD = Posttraumatic stress disorder. Social support = mean frequency of social contact with others; traumatic events = number of lifetime traumas; present control = sum of perceived control over recovery items; avoidance coping = sum of avoidance coping items; character self-blame = sum of character blame items; behavior self-blame = sum of behavior blame items; positive reactions = average frequency of positive reaction items; negative reactions = average frequency of negative reaction items; PTSD symptoms = summed PTSD symptom severity score.

Table 2. Pearson Correlations of Demographic, Assault-Related Factors and Outcomes, and Postassault Variables

	1	2	3	4	5	6	7	8	9	10	11
1. Age											
2. Disclosure timing	−.01										
3. Social support	.21**	.16**									
4. Traumatic events	.26**	.05	.15**								
5. Child sexual abuse	.10*	.12*	.10**	.29**							
6. Life threat	.25**	−.08*	.05	.28**	.25**						
7. Positive reactions	.02	−.08	−.24**	.06	.03	.19**					
8. Avoidance coping	.10*	.11*	.06	.25**	.22**	.17**	.10*				
9. Present control	.12**	.03	−.07*	.02	−.08**	.01	.24**	−.11**			
10. Character self-blame	−.03	.01	.13**	.12**	.09**	−.03	−.06	.27**	−.23**		
11. Negative reactions	.06	−.09*	−.02	.28**	.26**	.28**	−.02	.32**	−.12*	.24**	
12. PTSD symptoms	.02	.09*	.13**	.31**	.30**	.27**	.07*	.51**	−.19**	.33**	.47**

Note. PTSD = Posttraumatic stress disorder. Age = in years; disclosure timing (five ordinal categories ranging from 1 = *immediately after* to 5 = *more than a year after assault*); social support = mean frequency of social contacts; traumatic events = number of lifetime traumatic events; child sexual abuse severity—0 = *none*, 1 = *contact abuse*, 2 = *coercion*, 3 = *attempted penetration*, 4 = *completed penetration*; life threat—0 = no, 1 = yes; positive social reactions = mean of positive social reactions items; avoidance coping = sum of denial, self-distraction, and behavioral disengagement; present control = mean of six items assessing control over recovery process, 0 = *strongly disagree* to 4 = *strongly agree*; character self-blame = sum of five self-blame items, 0 = *strongly disagree* to 4 = *strongly agree*); Negative reactions = mean of negative social reaction items); PTSD symptoms = sum of PTSD symptoms.
*$p < .05$. **$p < .01$.

ordinal or higher levels of measurement for 20% or fewer missing cases.

Bivariate correlations were calculated for study variables. Time since the assault was not significantly related to current PTSD symptoms in preliminary bivariate analyses. This variable is also usually highly correlated with age, so it was not included in the models. Table 2 presents correlations for variables that were significant in the regression model.

Regression Analysis

Hierarchical blockwise regression analysis was done to determine the relative contributions of demographic, preassault, assault, and postassault factors to PTSD symptom severity. The model had 19 variables in it and was statistically significant, explaining 45% of the variance in PTSD symptom severity scores (see Table 3). As predicted, most demographic variables entered in Step 1 were not predictive of symptoms. Race, education, and marital status were not significant, but older age was related to less PTSD symptom severity. Among preassault variables, both number of lifetime traumatic events and child sexual abuse history were associated with more severe PTSD symptoms. Perceived life threat was related to more severe PTSD symptoms, but victim–offender relationship, assault severity, and offender violence were unrelated to symptoms.

Most postassault variables entered in Step 4 were predictive of PTSD symptom severity. Delayed disclosure was related to more severe PTSD symptoms. Greater levels of characterological self-blame and negative social reactions from others were each related to more severe PTSD symptoms in both models, whereas behavioral self-blame was not significant. Contrary to expectation, positive social reactions to assault disclosure and greater current frequency of social contact with others were both related to more severe symptoms. The only variable predicting fewer PTSD symptoms was present control over recovery.

DISCUSSION

This study assessed a range of domains that may affect PTSD symptom severity in female rape survivors including demographics, trauma histories, assault characteristics, and postassault social cognitive and interpersonal factors. The sample consisted of diverse, urban sexual assault survivors.

Table 3. Correlates of PTSD Symptom Severity in Sexual Assault Victims

Independent variable	β	Adj R^2	R^2 Chg
Block 1: Demographics			
Age	−.12***		
Race	.02		
Marital status	.00		
Educational level	.03		
After Block 1		.04**	.04**
Block 2: Trauma history			
Traumatic events	.12***		
Child sexual abuse	.10**		
After Block 2		.16***	.13***
Block 3: Assault-related factors and outcomes			
Perceived life threat	.11**		
Offender violence	−.03		
Victim–offender relationship	.01		
Postassault upset	.06		
Assault severity	.05		
After Block 3		.20***	.04***
Block 4: Postassault			
Disclosure timing	.06*		
Avoidance coping	.31***		
Present control	−.12***		
Character self-blame	.12**		
Behavior self-blame	.01		
Positive reactions	.08*		
Negative reactions	.25***		
Social support	.09**		
After Block 4		.45***	.25***

Note. Beta coefficients are for the final step of the model with all 19 variables entered into the regression equation. There were 699 valid cases at all steps of the model and in the final composite model presented here.
*$p < .05$. **$p < .01$. ***$p < .001$.

The model tested explained 45% of the variance in PTSD symptoms. The importance of psychosocial factors, such as coping strategies and negative social reactions, in relation to PTSD symptom severity suggests that prediction of symptoms may have been underestimated in previous studies that did not assess these factors.

As expected, few demographic and assault characteristics predicted symptom severity when controlling for trauma history and postassault factors. This is consistent with Campbell et al.'s (1999) findings from a diverse sample of rape survivors in the same urban area as the present study. Only older age was related to less severe PTSD symptoms in this sample, similar to Frazier et al. (1997). Young persons appear to be more vulnerable to severe PTSD symptoms, possibly because they have less-developed coping strategies to respond to stressors. As in past studies of rape victims, cognitive appraisals of life threat at the time of assault were related to more severe PTSD symptoms (Frazier et al., 1997; Kilpatrick et al., 1989; Resnick et al., 1993; Ullman & Filipas, 2001). That assault characteristics such as offender violence, assault severity, and victim-offender relationship were not significant correlates of PTSD symptom severity is likely due to inclusion of more important correlates of PTSD, such as trauma history and child sexual abuse. We found that traumatic event histories and child sexual abuse contributed to sexual assault victims' PTSD symptom severity, suggesting that higher risk of PTSD in rape victims may also be partially attributable to their histories of other traumas (see also Nishith et al., 2000).

Similar to past research (Ullman, 1996), delayed disclosure was related to more severe current PTSD symptoms. This suggests that women may benefit from being able to acknowledge and to talk about their assaults sooner. It may also be that delayed disclosure is associated with other risk factors that relate to more severe PTSD symptoms (e.g., lack of social support). Surprisingly, both general and assault-specific social support was related to more severe PTSD symptoms, making it appear that support somehow leads to PTSD symptoms. However, this may simply reflect that more symptomatic women seek more help. Similar results have been found by other researchers when symptoms and support are measured simultaneously in cross-sectional studies (Dooley, 1985), leading social support researchers to suggest that more symptomatic women seek more support generally, a possibility that cannot be resolved without longitudinal data. It is important that these positive support variables were controlled to ensure a more conservative test of the effects of negative social reactions and other study variables on PTSD symptom severity.

With regard to postassault social cognitions, we found that characterological self-blame was related to more severe PTSD symptoms, but behavioral self-blame was not significant, consistent with Koss et al. (2002). Consistent with

Frazier (2003), we found that present control over one's recovery process was related to less PTSD symptom severity. Importantly, postassault psychosocial factors were strongly related to more severe PTSD symptoms, controlling for demographic, trauma history, and assault-related factors and trauma-related outcomes, and accounted for more variance in symptom severity than any other block of variables. In particular, avoidance coping and negative social reactions to assault disclosures were associated with more PTSD symptom severity. This is consistent with other recent longitudinal and cross-sectional studies of rape victims showing that postassault negative social support (Andrews et al., 2003), negative social reactions (Campbell et al., 1999; Ullman & Filipas, 2001), or interpersonal friction with others (Zoellner et al., 1999) may contribute to women's PTSD symptom severity. This is also consistent with studies showing the negative impact of avoidance coping on women's adjustment to rape (Ullman, 1996; Valentiner et al., 1996).

The results of this study should be considered in light of its strengths and limitations. This sample was diverse in terms of both race and socioeconomic status, which is not typical of many past studies of rape victims. Measures were standardized measures with known validity and reliability, which is an improvement over past research (Ullman, 1996). Importantly, this study examined a broad set of psychosocial factors in addition to demographic and assault-related factors and trauma-related outcomes. Such an analysis allowed for simultaneous assessment of the relative impact of various variables known to relate to PTSD symptoms. The study is limited, however, by its cross-sectional design and nonrepresentative sample, which preclude making generalizations of our findings to representatively sampled rape victims. A significant proportion of women in this study were poor, socially isolated, ethnic minority, urban dwellers, which is likely to be a more stressed portion of this population. There were also limitations presented by the measures that were used. Because this study will ultimately be longitudinal, we assessed some constructs with a past 30-day time frame to be able to assess change in attributions and coping. Although this assessment of current perceptions may be less susceptible to recall bias, it may not capture all of the attributions and coping women engaged in since their assaults, some of which occurred years ago. However, time since the assault was not related to current PTSD symptom severity. If anything, the shorter time frame should serve to attenuate the effects of these variables on symptom severity, making it even more noteworthy that significant effects were found. In contrast, social reactions occurring at any time since their assaults were assessed to capture all of the reactions that women experienced, which is necessary because of the variability in timing of disclosure(s) of assault to others. This carries the limitation of possible recall bias, especially for disclosures occurring long ago. Finally, the study lacked a general measure of psychopathology.

The significance of coping strategies, perceived control over recovery, self-blame, and social reactions for the development of PTSD symptoms suggests that greater focus is needed on these modifiable factors. Future studies of large representative samples are needed to better understand the interrelationships of a variety of social and ecological context factors as they affect individual social cognitive and coping efforts and subsequent recovery from sexual assault. Such knowledge can be used to inform the development of interventions that provide survivors with adaptive coping skills. Further research on the role of social reactions to disclosures can also be used to develop social network interventions to reduce the common negative social reactions of blame, control, and disbelief that contribute to the severity of victims' PTSD symptoms.

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Predictors of PTSD Symptom Severity and Social Reactions in Sexual Assault Victims

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Demographics, assault variables, and postassault responses were analyzed as correlates of PTSD symptom severity in a sample of 323 sexual assault victims. Regression analyses indicated that less education, greater perceived life threat, and receipt of more negative social reactions upon disclosing assault were each related to greater PTSD symptom severity. Ethnic minority victims reported more negative social reactions from others. Victims of more severe sexual victimization reported fewer positive, but more negative reactions from others. Greater extent of disclosure of the assault was related to more positive and fewer negative social reactions. Telling more persons about the assault was related to more negative and positive reactions. Implications of these results for developing contextual theoretical models of rape-related PTSD are discussed.

KEY WORDS: posttraumatic stress; social reactions; sexual assault; disclosure.

Posttraumatic stress disorder (PTSD) is a common consequence of rape experiences with one-third of female rape victims identified in community samples experiencing PTSD at some time after the assault (Kilpatrick, Edmunds, & Seymour, 1992). In longitudinal research assessing rape victims immediately after assault, PTSD characterized 94% of victims within 2 weeks postassault and 47% of victims within 3 months postassault (Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992). A number of studies have examined correlates of the PTSD diagnosis or PTSD symptom severity in sexual assault victims to identify those survivors most likely to develop the disorder after the assault. A study of representatively sampled sexual assault victims by Frazier et al. (1997) showed that over half of

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showed a significant main effect in predicting PTSD symptom severity, with greater PTSD symptom severity in life-threatening assaults ($M = 22.66$ vs. $M = 16.70$ in assaults without life threat), $F(1, 287) = 18.00$, $p < .001$. Injury and victim–offender relationship showed only significant main effects on PTSD symptom severity with more PTSD symptoms associated with injury ($M = 22.58$) than with noninjury ($M = 17.41$), $F(1, 288) = 12.05$, $p = .001$, and more PTSD symptoms for stranger assaults ($M = 23.25$) than for known offender assaults ($M = 18.22$), $F(1, 284) = 7.59$, $p < .01$.

Discussion

This study examined correlates of PTSD symptom severity and both negative and positive social reactions received by female sexual assault victims disclosing their assaults to a range of informal and formal support providers. This is the first study to show that a range of negative social reactions including victim blame, treating the victim differently, distraction, egocentric reactions, and controlling responses are related to greater PTSD symptom severity, using a reliable and valid instrument, the Social Reactions Questionnaire (see Ullman, 2000, for psychometric data). Specifically, being treated differently (e.g., stigmatizing responses) was most predictive of PTSD symptom severity in a multivariate analysis. Being treated differently or stigmatized by others after rape may cause victims to feel as though the incident somehow permanently transformed them. Consequently, if rape victims internalize the idea that they are different or less worthy persons because of their assaults, they may develop greater PTSD symptoms. Stigmatizing responses from others may contribute to violation of positive assumptions about the self among victims that Janoff-Bulman (1992) argues are disrupted by traumatic events. Responses of distraction such as telling survivors to get on with their lives or to stop talking about the assault were also related to more PTSD symptom severity. It is possible that when sexual assault survivors are discouraged from talking about their experiences, they lack an appropriate outlet for expression, and hence, internalize their feelings that are manifested in greater PTSD symptoms. However, this explanation is speculative and further research is needed to understand why specific types of negative reactions predict PTSD symptom severity. In addition, because of the retrospective design, we cannot rule out the possibility that victims who are more symptomatic elicit more negative reactions from others.

Furthermore, less educated victims and those who perceived their lives were in danger at the time of the assault also reported more PTSD symptom severity, consistent with past work (Bownes et al., 1991; Kilpatrick et al., 1989; Ullman & Siegel, 1994). Neither physical injury due to attack nor victim–offender relationship were significant predictors of PTSD symptom severity in this study in contrast

to some past research on rape victims (Bownes et al., 1991; Kilpatrick et al., 1989). This may be due to the largely known offender assaults (83%) in this sample and a less powerful single-item, dichotomous measure of physical injury. These results support and extend past work showing the importance of perceived life threat in the etiology of PTSD symptomatology (Frazier et al., 1997; Kilpatrick et al., 1989; Resnick et al., 1993).

Examination of correlates of positive and negative social reactions showed that greater extent of disclosure, telling more persons, and less severe sexual victimization severity were related to receiving more positive reactions from others. This supports research showing that seeking support and talking about the trauma more extensively with others may be therapeutic for sexual assault victims (Pennebaker, Kiecolt-Glaser, & Glaser, 1988). It is of concern, however, that more severe sexual victimization was related to fewer positive reactions, which was also found in a past study of social reactions to rape victims (Ullman, 1996b). It is possible that because these samples were predominantly known assailant cases it was harder for support providers to either believe or give emotional support (or do both of these) to women disclosing attempted or completed rapes (or both). If this is the case, it is worrisome as these women are at higher risk for psychological problems including PTSD (Kilpatrick et al., 1989). The finding that ethnic minority victims received more negative reactions is also of concern, but perhaps to be expected based on research showing more traditional attitudes toward rape and greater attributions of responsibility to victims in Black and Hispanic men than in White men (Bourque, 1989; Williams & Holmes, 1981). Ethnic minority women also may be likely to face disbelief, blame, and stigmatizing responses from those to whom they disclose, given the racist attitudes shown toward these women by the dominant society (Wyatt, 1992). In a triethnic study of victims seen at a rape crisis center, Lefley, Scott, Llabre, and Hicks (1993) found that psychological distress was greatest in Hispanics, followed by Blacks, and finally Whites. Blacks also perceived more censure from their communities in that study. Research comparing racial groups is needed to improve understanding of recovery from sexual assault in all women.

Exploratory analyses conducted to better understand these race differences showed that Hispanics and mixed race victims, but not Black and Asian women, reported more negative social reactions, specifically more stigmatization and egocentric reactions. These results must be considered quite tentative given the small numbers of women in each race/ethnic group in this study. Such reactions may be more prominent in Hispanic cultures because of their devout Catholic origins. Stigmatization responses may in part be caused by traditional beliefs that women must remain chaste until after marriage. If a woman is raped she is no longer perceived as virginal, and therefore is more likely to be stigmatized and treated differently. George, Winfield, and Blazer (1992) found that sexual assault prevalence was lower among Hispanics than among Whites, and they

Understanding Rape Survivors' Decisions Not to Seek Help from Formal Social Systems

Debra Patterson, Megan Greeson, and Rebecca Campbell

Few rape survivors seek help from formal social systems after their assault. The purpose of this study was to examine factors that prevent survivors from seeking help from the legal, medical, and mental health systems and rape crisis centers. In this study, 29 female rape survivors who did not seek any postassault formal help were interviewed about why they did not reach out to these systems for assistance. Using qualitative methodology, this study found that survivors believed that formal social systems would or could not help or would psychologically harm them. Specifically, survivors thought that systems would not help because survivors themselves believed that they were unworthy of services or that their rape experience did not match stereotypical conceptions of rape. Survivors did not see how the systems could help or protect them from their assailants. Finally, survivors anticipated that systems personnel would cause them further psychological harm by not believing they had been raped or not caring about them. Survivors feared that system assistance would have intensified their painful feelings beyond their coping skills. Therefore, survivors who do not seek help may be attempting to protect themselves from perceived psychological harm. Implications for social work practice are discussed.

KEY WORDS: *health care; help seeking; mental health; rape; sexual assault*

Rape is a pervasive social problem, as national epidemiological data suggest that at least 17 percent of women will be raped in their adult lifetime (Bachar & Koss, 2001). In addition, rape has been linked to multiple negative short- and long-term outcomes, such as psychological distress, repeated sexual victimization, physical health problems, and difficulties in life functioning (Gutner, Rizvi, Monson, & Resick, 2006; Kilpatrick & Acierno, 2003). To alleviate these negative outcomes, rape survivors may seek help from multiple formal social systems, including the legal, medical, and mental health systems and rape crisis centers. For example, within the legal system, law enforcement may address survivors' immediate safety concerns, inform survivors of their rights, and make referrals to other formal social systems (Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001). Hospital emergency departments may provide information about the risk of pregnancy and sexually transmitted diseases (STDs), prophylaxis to prevent pregnancy and STDs, and forensic evidence collection (Ledray, 1996). Mental health centers offer individual counseling and psychotropic medications. Rape crisis centers may provide medical, police and court advocacy, immediate crisis intervention, individual counseling, and support groups (Campbell, Baker, & Mazurek, 1998).

Despite the variety of services available, few rape survivors use services from these formal social systems. Rates of service utilization vary across studies, but it appears that approximately 14 percent to 43 percent of survivors seek assistance from formal social systems, with most studies finding rates around 31 percent (Campbell et al., 2001; Ullman, 1996; Ullman & Filipas, 2001). When survivors do not receive needed services, their health (for example, STDs) and mental health concerns (for example, posttraumatic stress) may remain untreated, which could cause long-term complications.

To date, studies have suggested four key reasons for these low utilization rates: (1) the survivors' psychological response to the rape, (2) the degree of rape severity (for example, force, injury), (3) fear of retaliation by the assailant, and (4) fear of disbelief by system personnel. First, prior research shows that survivors with lower levels of posttraumatic stress or depressive symptoms are less likely to seek help from formal social systems (Lewis et al., 2005; Starzynski, Ullman, Filipas, & Townsend, 2005). In addition, survivors who blamed themselves for causing the rape were less likely to disclose the rape to formal

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social systems (Starzynski et al., 2005). Although studies have shown that survivors with less severe psychological symptomatology are less likely to seek assistance, it is still unclear what prevents these survivors from seeking help.

Second, survivors were less likely to seek help from formal social systems when their victimization did not reflect the stereotypical rape (that is, a rape in which the offender is a stranger who uses a weapon or physical force that results in injury). For example, survivors who were raped by a known offender were less likely to seek help than those raped by a stranger (Campbell et al., 2001; Resnick et al., 2000; Starzynski et al., 2005). Furthermore, survivors were more likely to seek assistance if their rape involved the use of physical force or weapons or resulted in physical injuries (Resnick et al., 2000; Starzynski et al., 2005). These findings suggest the severity of the rape plays an important role in survivors' decision making regarding whether to pursue help from formal social systems. However, it is unclear why rape severity affects survivors' decisions in seeking help.

Third, fear of retaliation by the assailant may affect some survivors' decisions to seek help. Bachman (1998) asked survivors to identify their primary reason for not seeking help, and one in 10 reported that they were fearful their assailants would harm them if they sought help. The legal system provides legal remedies (for example, protection orders) to protect survivors from their assailants, but, still, some survivors are not seeking assistance. Given the availability of legal remedies aimed to protect survivors, it is important to understand why fear of retaliation remains an obstacle to seeking help.

Fourth, concerns about how formal social systems personnel may respond to them may prevent some survivors from seeking help. Logan and colleagues (2005) found that survivors did not seek help because they were worried that formal social systems personnel would not believe them. Prior research has shown that survivors experience mistreatment by formal social systems personnel (Campbell & Raja, 2005). Awareness of rape and mistreatment of survivors has become more public in recent years (Caringella-MacDonald, 1998). Thus, it may be possible that survivors may not seek help because they anticipate poor treatment from formal social systems, such as disbelief or other types of mistreatment.

The extant literature suggests that there are multiple reasons why survivors may not seek help from formal social systems. However, relatively little is known about why these factors prevent survivors from seeking help. The purpose of the current study was to expand research on this topic by using a qualitative methodological approach to explore the underlying reasons why survivors did not contact any formal social systems for assistance. Therefore, in the current study, 29 survivors who never sought postassault assistance from the legal, medical, and mental health systems and rape crisis centers were interviewed about their reasons for not seeking assistance, to further our understanding of the barriers survivors face in accessing formal community resources.

METHOD

Participants

The recruitment protocol for this study was modeled after the techniques of adaptive sampling (Thompson & Seber, 1996; see also, Campbell, Sefl, Wasco, & Ahrens, 2004, for details). The city of Chicago and two contiguous suburbs were divided into regions on the basis of zip codes, and geographic areas representing women of varying races and socioeconomic statuses were targeted for recruitment efforts. In each zip code, the study was advertised through posters, fliers, and in-person presentations to groups of women. The types of settings targeted within each zip code varied but included places where women live, work, or pass through as part of their daily activities, including the following: public transportation, grocery stores, currency exchanges, laundromats, nail and beauty salons, libraries, and churches. The content of the advertisements emphasized that many women have experienced rape or sexual assault, and our research team wanted to interview survivors regardless of whether they sought help from the legal, medical, and mental health systems or rape crisis centers. As a result of our recruitment efforts, 186 adult women contacted the research team to express interest in participating in the study (over an eight-month period). We contacted 157 of these women, of whom 112 (71 percent) were eligible to participate in the study (that is, were at least 18 years old and had been assaulted by a stranger, an acquaintance, a dating partner, or a husband). Completed interviews were conducted with 102 participants (91 percent). In 82 cases (80 percent), it was possible to trace a woman's involvement in the study to a specific zip code location (the remaining 20 percent was obtained through snowball sampling). There were

no significant differences in age, race, marital status, education level, and employment between these participants and the adult female residents of these zip codes, which suggests that the sample in the study is representative of the regions of Chicago from which the participants were recruited. The primary focus of the larger study was to examine rape survivors' experiences with formal social systems. For this study, we focused on the experiences of 29 adult survivors in this sample who did not have contact with any formal help system. Most participants in the larger study had contact with at least one system (legal, medical, mental health, or rape crisis centers), but this subsample represented a distinct group of survivors who had never disclosed the assault to or sought help from formal help systems.

The average age of this subsample of 29 adult rape survivors was 32.48 (SD = 9.66), and most were racial or ethnic minorities: 52 percent African American, 31 percent white, 7 percent Latina, and 10 percent multiracial. Almost one-third (29 percent) were currently married, and 45 percent had children. Most women (83 percent) had a high school education, and 55 percent were employed. There were no significant demographic differences between this subsample of victims with no formal systems contact and the other survivors in the study. Most survivors who chose to not contact any formal social systems were assaulted by someone they knew (acquaintance, date, partner) (83 percent), which was also the case for the rest of the sample; however, there were significantly more cases of nonstranger rape in the no systems contact subsample [$\chi^2(1, N = 102) = 5.24, p < .05$]. Forty-four percent of the survivors who had no contact with formal social systems were not physically injured in the attack, and most did not have a weapon used against them (62 percent). Similarly, most of these survivors were not under the influence of alcohol (62 percent). On average, the rape had occurred 8.23 years prior to participating in the interview (SD = 8.78). There were no significant differences between this subsample and the other survivors in the sample with respect to these assault characteristics.

Procedures

Interviews were conducted in person, with a mean duration of two hours (SD = 49.53 minutes; range = one to four hours). Each participant was given $30, public transportation tokens to reimburse her for transportation expenses, and a packet of community referrals for victims of violence. The tape-recorded interviews were conducted by the faculty principal investigator (PI) and a team of 11 female graduate and undergraduate research assistants who received course credit for their participation in the project (see Campbell et al., 2004, for details regarding interviewer training and supervision). The procedures used in this study were approved by the Michigan State University Institutional Review Board.

Measures

In the interview protocol, survivors were asked if they had any contact with the legal, medical, mental health systems or rape crisis centers for postassault assistance. When a survivor said that she did not have contact with a system, she was asked four follow-up questions: (1) why she decided not to seek assistance from that system; (2) whether there were things that prevented her from seeking assistance from that system; (3) whether anything could have been done that would have made it more likely that she would have turned to that system for help; and (4) looking back, whether she thinks it was a good or bad choice not to seek help from that system and why. The survivors in the focal subsample answered these questions about each of the four systems. The verbatim transcriptions from these questions were the primary data sources for analysis. Supplemental data sources were also consulted, including the audiotapes of the interview, full transcripts, and the PI's field notes from the entire project.

Data Analysis

Data analysis proceeded in two phases. First, two analysts developed open codes (Strauss & Corbin, 1990) that captured key thematic content in the survivors' narratives. In the second phase, we used Erickson's (1986) analytic induction method for data analysis, which is an iterative procedure for developing and testing empirical assertions in qualitative research (see also Ryan & Bernard, 2000). In this approach, an analyst reviews all of the data sources multiple times, with the goal of arriving at a set of assertions that are substantiated based on a thorough understanding of all of the data. The next task is to establish whether each assertion is warranted by going back to the data and assembling confirming and disconfirming evidence. The analyst must look for five types of evidentiary inadequacy: (1) inadequate amount of evidence, (2) inadequate variety in the kinds of evidence, (3) faulty interpretative status of

evidence (that is, doubts about the accuracy of the data due to social desirability bias), (4) inadequate disconfirming evidence (that is, no data were collected that could disconfirm a key assertion), and (5) inadequate discrepant case analysis (that is, no cases exist that are contrary to a key assertion) (Erickson, 1986). Assertions are revised or eliminated on the basis of their evidentiary adequacy until a set of well-warranted assertions remain. For this project, two analysts worked separately through Erickson's method so that the second analyst could provide independent verification of the assertions. Each analyst independently developed a preliminary list of assertions. The first analyst then expanded the list and tested the assertions against the data, refined, and in some instances eliminated them. Once the first analyst had completed what she thought was a well-warranted set of assertions and assembled confirming evidence, the second analyst then cross-checked those assertions against the data. Consensus was reached by the two analysts. Both examined the final list of assertions against the data and found them to be well-supported by the data.

RESULTS

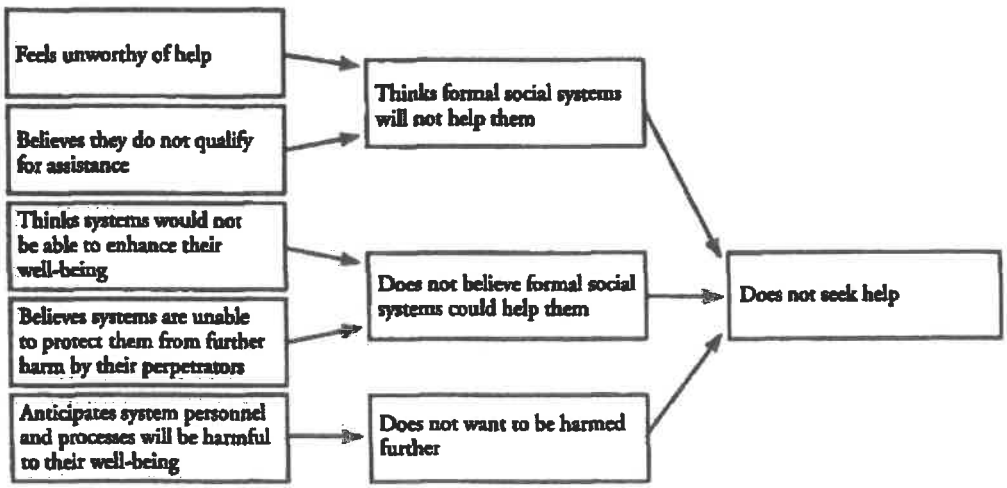
Almost all of the survivors in this study identified multiple reasons that factored into their decision not to seek help (see Figure 1). First, more than three-quarters of the survivors anticipated that these systems would have rejected them personally and their expressed need for help. Some survivors discussed having had feelings of shame and unworthiness, which made them feel that they were unworthy of help. Similarly, some did not think they qualified for assistance. Second, more than three-quarters of the survivors did not believe formal social systems could have helped them. Survivors believed that these systems would not have been able to enhance their well-being or protect them from further harm by their perpetrators. Third, more than three-quarters of the survivors anticipated that formal social systems would have been harmful to their well-being. Survivors described how not seeking help was a form of self-protection against system personnel and processes they had perceived as hurtful. Each of these types of barriers to help seeking was identified by the majority of survivors in this study and should not be considered mutually exclusive groups.

Anticipating Rejection

Feelings of self-blame and shame are commonly experienced by rape survivors (Herman, 1992). For example, survivors reported feeling ashamed and embarrassed about the rape and did not want others to know what happened to them. These feelings prevented survivors from reaching out to formal social systems for help. In addition, survivors in this study frequently blamed themselves for the rape, which prevented them from seeking help, as illustrated by the following survivors:

> Like why...why would I talk to somebody? I was at fault. I blamed myself so heavily and felt so guilty.

Figure 1: Rape Survivors' Reasons for Not Seeking Help from Formal Social Systems



* * *

Why I did not get help, from any of the mental health. Because ... I know ... I was also blame for some of what happened. Not totally, partially.

Survivors who blamed themselves believed that the formal social systems also would blame them. Furthermore, many survivors who blamed themselves thought they did not deserve to receive help from formal social systems. Therefore, survivors may not have sought services available to them to avoid being rejected as unworthy of assistance by system personnel.

In addition, survivors with nonstereotypical rapes (that is, rape in which the offender is known to the survivor and the rape does not involve a weapon) believed that formal social systems would not help them. Similar to most people, survivors frequently had stereotypical views of rape as brutally violent and resulting in severe physical and psychological injuries. Because survivors held these stereotypical views of rape, they did not believe their rape experiences qualified for help. Therefore, survivors did not seek help when their rape experience did not reflect the stereotypical perception of rape. For example, survivors expressed that they would have sought help if their rape had been more physically violent, resulting in visible injuries:

It's like, you had to be really, really messed up. You had to be really like torn, and ripped clothing, and stuff like that. And I didn't really have anything like that.

* * *

Cause I wasn't beaten bad.

Survivors described enduring injuries of soreness and internal pain but believed their injuries were not severe enough to seek medical treatment. Survivors also thought their psychological reactions to the rape were benign compared with their stereotypical perception of rape survivors having "nervous breakdowns":

Some women, it seemed like they're totally devastated, you know. And I don't think it affected me that bad. I tried not to let it affect me like that.

* * *

I don't have any problems sleeping at night or, or feeling...going outside or anything by myself.

Survivors further noted that the rape did not "emotionally scar" them or interfere with their daily functioning and, thus, did not seek help. Survivors explained that the formal social system could not help them or would not respond positively unless their rape experience matched the stereotypical conception of rape. Therefore, survivors may not have sought help from these formal social systems because they anticipated that the system would neglect to help them. In retrospect, many survivors recognized the psychological and physical impact of their rapes. However, they still did not seek assistance, because they thought that formal social systems provided services to only those in crisis or for those who sought help immediately after the assault:

But my impression is that when you're in crisis, the first 24 to 48 hours, particularly, there are services for you. . . . And even for the person like me to feel that you're legitimate to use them; I'm not really quite in crisis cause I'm not bawling...it didn't just happen to me, but mentally, emotionally, I'm a wreck.

These survivors did not view themselves as being in crisis and, therefore, did not believe they qualified for services. Again, survivors anticipated that the system would not help them and did not seek assistance.

System Cannot Help

Although survivors anticipated that system personnel would not provide them services, they also frequently believed that the systems could not help them. Some survivors did not believe they needed the services provided by these formal social systems. These survivors felt confident that their coping skills were strong enough for them to deal with the rape and chose to handle it on their own. In addition, these survivors did not believe formal social systems would enhance their existing coping skills. Furthermore, they were unclear about how the formal social systems could help them. The primary goal of these survivors was to resume normal life, as suggested by the following survivors:

But you have to get yourself together and move on.

* * *

I just didn't want any problems. I didn't wanna talk about it anymore. I just wanted to get myself out of the situation and get it behind.

* * *

I knew how to cope with it, you know. . . . Just go wash up, lay down. . . . You'll be back to normal and go on.

However, they believed assistance from the formal social systems would prolong, not alleviate, painful feelings. Thus, survivors believed the formal social systems would hinder, not foster, their recovery process.

Other survivors believed formal social systems, including law enforcement, could not protect them from further harm by their assailants or the assailants' social networks. Survivors expressed fear that the assailant would kill or brutally harm them if they sought help:

If I could of felt. . . . If someone'd said, "Yeah, you got security."

* * *

I didn't go cause I was scared. . . . They [assailants] already told me what they'd try to do to me. They already told me they were gonna cut my breasts off.

Furthermore, survivors feared that medical and social service systems would contact law enforcement and force them to report the rape. Survivors believed their safety would be jeopardized if they sought help. Thus, survivors believed it was too risky to seek help from any formal social system.

Self-Protection from Hurtful System Personnel and Processes

In addition to believing that system personnel would or could not help them, survivors also expressed concern that system personnel would mistreatment them in a hurtful manner:

They're gonna grill me and make me look like the bad one. . . . I didn't wanna deal with that. I didn't feel like…being dragged through the coals.

* * *

I just felt like… nobody was gonna believe me, you know. And I was gonna have to say, "Well, I was coming from buying drugs." And right then and there, you know, they wouldn't of cared. At least, I didn't feel they would.

* * *

Because it seems like there were a lot of therapists out there, and counselors that really don't care as much.

* * *

I heard before like at the hospital, they make you feel like it's your fault.

Survivors perceived formal social systems personnel as hurtful, often based on their own prior experiences with the systems or based on the experiences of people within their social network. Survivors believed system personnel would harm them by treating them like a criminal instead of a crime victim. Survivors predicted that system personnel would not believe they had been raped or care about them, especially if they had been drinking or using drugs. Overall, survivors believed that seeking assistance from formal social systems meant exposing themselves to additional psychological harm. Survivors worried that they could not cope with this mistreatment and did not want to risk further harm to themselves. Therefore, choosing not to seek help was a self-protective mechanism for survivors.

Survivors also believed that formal social systems require processes that are hurtful, as identified by the following survivors:

I just kinda had some, like apprehensions about going, cause I knew they would probe very intensely . . . they would ask me questions.

* * *

Because it [not seeking help] kept me from going through a lot of unnecessary pain and trouble and display myself all for no good to me.

As illustrated in the quotes, survivors believed the system would require them to disclose the rape in detail and answer numerous, potentially invasive questions. Survivors anticipated this "probing" for information would leave them feeling exposed and vulnerable. Survivors worried this would elicit painful memories and feelings about the rape, which they did not feel ready to experience. Survivors also did not seek medical treatment because they could not bear being touched. These survivors worried that being touched would cause them to become emotionally distraught. On a similar note, survivors believed involvement in one system would require involvement in other systems. For example,

survivors did not seek medical treatment out of concern law enforcement or social services would be contacted:

> And when you're involved in a rape center, you're involved with police. And a whole lot of other people. DCFS, maybe. Court wanna know about your kids. . . . I tell this and I'm gonna have to answer about this and that.

Thus, survivors were concerned about losing control of their privacy. Many survivors also reported being emotionally fragile following their rape. Thus, survivors declined assistance from formal social systems to preserve their mental health from a process that they viewed as psychologically painful.

Additional analyses were conducted to compare the reasons for not seeking help with the demographic characteristics of the participants. However, these analyses did not show any differences among the survivors and their reasons for not seeking help on the basis of demographic characteristics.

DISCUSSION

Formal social systems provide services for the debilitating psychological consequences and physical health problems caused by rape. Yet many survivors do not seek assistance from these systems (Campbell et al., 2001; Ullman, 1996; Ullman & Filipas, 2001). In the current study, survivors who did not seek help from any formal social system after their rape provided a unique perspective by identifying the factors that prevent rape survivors from seeking formal help and discussing why these factors led them to not seek help. This study found that survivors anticipated that the system would or could not help or would psychologically harm them. *Rape* is an act of unwanted sexual penetration committed by use or threat of force, which leaves survivors feeling vulnerable and powerless. Given the nature of the crime, survivors may be inclined to protect themselves from any suspected harm that would exacerbate feelings of vulnerability, powerlessness, or other feelings that might further debilitate their psychological well-being. In all three overarching themes, survivors anticipated that formal social systems could potentially hurt them further. For example, survivors anticipated that the system would not help because their rape experience did not match stereotypical conceptions of rape (that is, violent rape resulting in severe physical injuries). Expanding on prior research, this finding suggests that some survivors may not believe their nonstereotypical rape experiences qualified for help. Furthermore, prior research shows that survivors feel distressed when systems refuse to provide services (Campbell et al., 2001). Taken together, these findings explain that survivors with nonstereotypical rape experiences did not seek services as a mechanism to shield themselves from feeling hurt as a result of this potential rejection.

Survivors also did not have faith that the systems could help them. Survivors expressed confidence in their coping skills to handle their postrape psychological reactions and believed seeking help might intensify painful feelings caused by the rape. Prior research found that survivors with more debilitating psychological symptomatology seek assistance (Starzynski et al., 2005). Building on prior research, this study explains why survivors with less debilitating symptomatology may not seek help, with many survivors explaining they did not see how the system could help. In addition, survivors explained that they feared assistance by the system would have exacerbated their painful feelings to an unmanageable level. Similar to prior research, survivors also feared their assailants would seek revenge if they sought help from any formal social system. Expanding on this finding, survivors elaborated why fear of revenge prevented them from seeking help. Survivors did not think the systems could protect them from their assailant and, thus, believed seeking help would jeopardize their safety. In both cases, this study found that declining to seek help is a way survivors attempt to protect their psychological or physical well-being.

Finally, survivors anticipated formal social systems personnel or their processes would cause them further psychological harm. This anticipated harm included disbelief by formal social system personnel, as suggested by prior research, and other forms of harm, including blame, lack of caring, and interrogation. One of the earlier stages of recovery from rape involves establishing safety by regaining control of one's life and protecting one's self (Lebowitz, Harvey, & Herman, 1993). Avoiding emotional vulnerability can be a strategy for maintaining control and protecting one's psychological well-being (Fine, 1992). Thus, avoidance of help from formal social systems perceived as harmful is a mechanism that survivors use to protect themselves from further psychological pain.

Limitations

Although the current study provides insight on the barriers to survivors seeking help, there are several limitations. First, those individuals who agree to participate in research may be different from the general population of rape survivors. Although this study recruited a diverse sample of rape survivors, the choice to participate was ultimately the survivors'. The barriers to help seeking may be different for those who did and those who did not participate. Second, given the qualitative nature of the study, the findings may not be generalized to the larger population of rape survivors, especially those living in suburban and rural communities. Still, qualitative analysis is particularly useful at providing an in-depth picture of the barriers to help seeking. Third, the retrospective design of the study relies on the memories of participants. It is possible that the participants did not recall other barriers to help seeking. However, it stands to reason that survivors would remember the barriers most salient to them.

Implications for Practice

This study found that survivors do not seek help as a means of self-protection. Understanding this self-protection process suggests that systemic outreach efforts are needed to address the concerns identified by the rape survivors in this study. Prior research has shown that social marketing has been successful in producing changes in the beliefs or behaviors of community members around multiple social problems (Rothschild, Mastin, & Miller, 2006). Social marketing uses communication strategies to encourage people to adopt social ideas or new behaviors around a specific social problem (MacStravic, 2000). Social marketing uses multiple communication strategies, including advertisement through mass media, public relations aimed at building a positive image of the idea and type of behavior recommended, and incentives to make the change useful.

Social marketing as a strategy to increase help seeking among rape survivors is relatively new, but the emerging research shows promise. For example, Boehm and Itzhaky (2004) used social marketing strategies to increase help seeking of child victims of sexual abuse in an ultraorthodox Jewish community in Israel. Victims and their families had concerns about being ostracized if they sought help. The social marketing incorporated religious leaders to promote the message that it was immoral to ostracize victims of sexual violence, which led to increased help seeking among the victims and their families. Konradi and DeBruin (2003) used social marketing to increase usage of a specialized sexual assault medical care facility among college students. The research team created four fliers that addressed obstacles to help seeking unique to that community (for example, concern of confidentiality) and then distributed the fliers systematically throughout the college campus. At the end of the school year, the authors found that the college students were more knowledgeable about the program and its policies (for example, confidentiality) and were more likely to encourage a friend to seek help from the program. In both of these studies, social marketing addressed the concerns of the targeted community (for example, ostracism, confidentiality), which was key to increasing help seeking.

The findings of the current study could be incorporated into a social marketing plan aimed at increasing help seeking among survivors in an urban area. The current study found that survivors of rape do not seek help because they blame themselves for the rape or perceive their rape to be less severe than that of others (for example, believe their rape is less violent than what others experience). As such, social marketing may be a viable mechanism to increase formal help seeking by changing the misperceptions of rape. For example, a social marketing plan could decrease common misperceptions that rape is typically committed by a stranger or results in severe injuries. Survivors may be less likely to blame themselves and, thus, more likely to seek help if they believe their experiences are similar to those of other survivors. Furthermore, social marketing can systematically provide messages, such as "survivors do not cause rape," through mass media venues.

The current study also found that survivors did not seek help when they believed the formal social systems could not help them. Therefore, another aim of social marketing should build a positive image of the services offered by the formal social systems. The findings of the current study would suggest that a social marketing plan should address survivors' concerns about help seeking, such as loss of privacy and fear of services intensifying their emotions to an unmanageable level. Thus, the social marketing should include information regarding confidentiality and common emotions that emerge during the process and strategies to keep these temporary emotions at a manageable level. Overall, the social marketing

message needs to communicate that services are available to all survivors, regardless of the type of rape (for example, acquaintance rape) and severity (for example, degree of violence and injury) thereof. Because survivors viewed help seeking as risky to their well-being, the message also should promote services as beneficial and safe for survivors.

Although social marketing has been found to increase help seeking, survivors will not seek help if they anticipate psychological harm. Survivors in this study anticipated that seeking help would cause them further psychological distress but did not actually seek help from any formal social system. Although the survivors were just anticipating further distress from seeking help, prior research suggests that these survivors may have accurate concerns about help seeking. For example, studies have found that rape survivors often do not receive needed services and are treated by system personnel in ways that they experience as upsetting and victim blaming. Survivors experienced being blamed, were told their cases were not serious enough, and were not believed by system personnel. These negative experiences with formal social systems are associated with higher levels of posttraumatic stress symptoms (Campbell & Raja, 2005; Campbell et al., 2001). Therefore, it is important to improve the systems' response so survivors are not revictimized (for example, blamed) when seeking help from formal social systems.

Social workers are often housed in these formal social systems (for example, police departments, hospitals, mental health agencies, rape crisis centers), providing opportunity for social workers to play an important role in improving survivors' experiences with formal social systems. In addition, many communities are forming multidisciplinary coordinated response initiatives to improve formal social systems' responses to rape survivors (Littel, 2001). Prior research has found that communities with higher coordinated responses were more successful in providing higher quality care consistent with survivors' needs (Campbell & Ahrens, 1998). Furthermore, these community initiatives are associated with law enforcement's improved treatment of rape survivors (Zweig & Burt, 2006). Ethical principles charge social workers with the responsibility of pursuing social change, particularly with and on behalf of vulnerable and oppressed individuals, leaving social workers with the task of preventing systemic harm to survivors (NASW, 2000). Therefore, the presence of social workers in these coordinated responses may have an important role in improving the treatment of rape survivors. Social workers can contribute to these initiatives by advocating for and training on survivor-centered empowerment approaches to working with survivors. However, the unique contributions of social workers in these community-coordinated responses have not been examined. Therefore, future research should explore whether and how social workers contribute to the improved response toward victims of rape within these multidisciplinary initiatives. HSW

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