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COLLECTION OF PAPERS

BREAK THE SILENCE: SEXUAL VIOLENCE ITS IMPACTS AND POSSIBLE SOLUTIONS

PROFEM
CENTER FOR VICTIMS OF DOMESTIC AND SEXUAL VIOLENCE, O.P.S.

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Collection of Papers from the Conference Break the Silence: Sexual Violence, Its Impacts and Possible Solutions

The conference was organized on 22nd October 2019 in Prague by proFem - center for victims of domestic and sexual violence, o.p.s. in cooperation with the Ministry of the Interior of the Czech Republic and was supported by the U.S. Embassy in the Czech Republic and from a grant from Iceland, Liechtenstein and Norway under the EEA and Norway Grants 2014-2021.

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proFem is a non-governmental, non-profit organization working to improve the situation of domestic and sexual violence. It provides counselling and other direct support to victims/survivors of domestic and sexual violence, actively participates in prevention and awareness raising and lobbies for more appropriate legislation in this topic. More at www.profem.cz.

Content

Introduction

Dear readers,

We are pleased to present you with this collection of selected papers from the "**Break the Silence: Sexual Violence, Its Impacts, and Possible Solutions**" conference which took place in Prague on 22nd October 2019.

The conference was organized by proFem – Center for Victims of Domestic and Sexual Violence, o. p. s. with the kind support of the Ministry of the Interior of the Czech Republic, the U.S. Embassy in Prague, and the EEA and Norway Grants. The aim of the conference was to cover the topic of sexual violence from a broad interdisciplinary and international perspective with an emphasis on sharing experiences from direct work with victims of sexual violence. The conference was intended to be primarily for experts who come in contact with victims of sexual violence, both children and adults. There were many experts from non-profit organizations, including social service providers, child protection services, other municipal services, the Ministry of Labor and Social Affairs of the Czech Republic, psychologists, psychotherapists, and students of these and other relevant fields.

Sexual violence, its impacts on the lives of victims and survivors, as well as the broader context of the causes of sexual violence – these are all topics that are being explored more and more in the last few years in the Czech Republic; and public and professional awareness of these topics has been successfully increased to a greater or a lesser extent. Sexual violence has also been increasingly understood as a form of gender-based violence as defined by the Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence.

However, it is not enough to educate and raise awareness. Women and girls (the vast majority of sexual violence victims) need to feel safe in their families, relationships, neighborhoods, schools and universities, workplaces, anyplace where they participate in leisure activities, in public spaces in general. Therefore, our goal should be to eradicate sexual violence altogether. Statistics and experiences of helping organizations show that sexual violence remains a widespread issue – according to estimates, every year 7 000 to 20 000 women fall victim to at least one of the forms of sexual violence. Furthermore, both victims and professionals suffer from the imperfections the system of aid has as individual services are fragmented, inconsequential and oftentimes inaccessible. Many professionals from helping organizations, follow-up services, and law enforcement authorities use adequate tools to help victims of violence of this sort; unfortunately, these tend to be exceptions, rather than the rule. Therefore, the aim of the conference was not only to invite Czech experts from the police, legal assistance, social work, and psychotherapy fields and to discuss current state of affairs, challenges, shortcomings, and benefits of these services, but also to gain valuable and significant inspiration from abroad thanks to the participation of speakers from the USA and Norway.

Conference opening remarks were delivered by Jitka Poláková, director of proFem – Center for Victims of Domestic and Sexual Violence, o.p.s., Kateřina Bělohlávková, head of the Security Policy and Crime Prevention Department of the Czech Ministry of the Interior, and Jennifer Bachus, Deputy Chief of Mission at the U.S. Embassy in Prague. The conference moderators were Sylvie Lauder, journalist from Respekt, an independent political weekly newspaper, and Kateřina Šaldová, Deputy Director in Amnesty International Czech Republic. In the first part of the conference dedicated to current pitfalls in detecting and investigating sexually motivated crimes, there were three papers presented by representatives from the Regional Police Directorate in Prague. The first presenter was PhDr. Alexandra Machková, who spoke about child victims of sexually motivated crimes, about different ways trauma can manifest in, and about the specifics of developmental aspects as one of the factors affecting the impact violent experiences have on children, children´s perception of them and their response to them. After that, Mjr. Mgr. Jan Machuta talked about false and intentional accusations and false denials in criminalistic practice. This part of the conference was concluded by mjr. Bc. Milan Ulrich, DiS. who spoke about the specific aspects of investigating and crime proofing in crimes of moral turpitude against children.

The second part of the conference focused on legal assistance for victims and on expert reports in legal cases. Mgr. Veronika Ježková, the head of legal services in proFem, used case-studies from her own practice to illustrate what life is like for victims of sexual violence with the Law on Victims of Crime in place. Mgr. Hana Wernerová presented Persefona – an organization helping victims of domestic and sexual violence – their services and current challenges related to providing the help needed. After that, PhDr. Štěpán Vymětal, PhD. told us how trauma and PTSD can manifest and what impacts they can have, and also about the differences in resilience and vulnerability in different victims and how knowing about these topics is crucial for the work of expert witnesses.

In the third part of the conference, there were two papers from foreign speakers, namely Lisa Arntzen, M.A., from The Norwegian Centre for Violence and Traumatic Stress Studies, and Jennifer Landhuis, M.S., the Director of the Stalking Prevention, Awareness, and Resource Center (SPARC). Both speakers presented the ways systems of help for sexual violence victims work in their respective countries, and about effective tools in direct care.

In the final, fourth, part, we focused on social services and psychotherapy. PhDr. Dana Pokorná informed us about the system of social and healthcare services for victims of sexual violence in the Czech Republic. Mgr. Petr Odstrčil talked about psychotherapy for traumatized individuals and doc. PhDr. Marek Preiss, PhD. told us about transgenerational trauma[1].

We hope the participants of this conference have gained valuable information, inspirations, and insights and that they will work towards evolving further and increasing their

[1] Not all papers from all speakers were, due to our resources, translated and therefore some of them are only available in Czech language on our website: www.profem.cz.

competence in the field of helping victims of sexual violence. In this regard, we believe the suggestions we put together based on the conference papers could be of use. You can find them on the last pages of this collection. They have been distributed to respective institutions.

We thank you for your interest in this topic. We firmly believe that together we can help to improve the situation for victims of sexual violence in the Czech Republic.

On behalf of the proFem team
Eva Michálková

Current Pitfalls in Investigating Sexually Motivated Crimes

PhDr. Alexandra Machková

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About the Author

PhDr. Alexandra Machková works at the Regional Police Directorate in Prague. She has a degree in Psychology from Charles University, and she has obtained a post-graduate certification in Clinical Psychology. She finished a five-year self-experience psychotherapy training at Prague PCA Institute for Person-Centered Psychotherapy and Counseling, and other training such as Systemic and Couple´s Therapy training, Art Therapy, Bodywork Therapy, and a fundamentals course on Focusing. She worked in Dětské krizové centrum (Child Crisis Centre) for 14 years. She specializes in diagnosing and therapy of trauma, crises, and CSA (childhood sexual abuse) and CAN (childhood abuse and neglect) victims (both children and adults affected by sexual abuse or other forms of abuse). She is a member of the Czech-Moravian Psychological Society.

Summary

This paper is about the specifics of investigating sexually motivated crimes against children, particularly about the pitfalls associated with helping professionals and law-enforcement not being well-informed. It is important to understand the specifics of trauma processing in children, the impacts and effects trauma can have, how such crimes psychologically affect the child – having the child development stages in mind. This paper examines the specifics of sexual violence against children and – by using case studies – it illustrates how important it is for experts to be educated on this topic. Ignorance can lead to serious and unforgivable errors in treating the child victim and in conducting the investigation.

Introduction

In practice, concerning working with child victims of crimes we can often see granting of assistance is being protracted, experts are sometimes not being knowledgeable enough regarding the essence of the problem of sexual abuse (its causes, risk factors, progress) and the effects it has on victims. Lack of knowledge about the topic, lack of preparation and

insight into the mind of a child going through such experience, leads to serious and unforgivable errors in treating the victim, e.g. not being understanding, kind, tactful, and supportive. These issues oftentimes overlap with the atmosphere in their upbringing environment. By being insensitive and unskilled in the way we treat child victims we amplify the negative effects trauma will have on their future lives. There are numerous myths and stereotypes present, unfortunately, not only does the public fall prey to them but also the experts.

Another issue we are faced with in the Czech Republic is a lack of centers prepared to help victims of sexual abuse. This issue concerns both child and adult victims. In the Czech Republic, there are only two organizations for children at risk - Child Crisis Centre (Dětské krizové centrum) specialized in CAN syndrome (child abuse and neglect syndrome), and Locika specialized in helping children affected by domestic violence. It was intended to build a center for child victims with a multidisciplinary team of professionals – police officers, psychologists, lawyers, social workers. However, the Municipality of the Capital City of Prague did not support the proposal due to prioritizing interventions in different areas (more precisely fighting drug abuse).

What Does a Child Victim Look Like?

Generally speaking, there is no single way to recognize what a “perfect” victim looks like. There are many different factors influencing how a victim looks and behaves. So, it is all the more necessary to understand the specifics of how to work with child victims. Oftentimes, sexual abuse begins early in their childhood, most frequently when the victim is about 3 or 4 years old. Quite often the sexual abuse happens to be intrafamilial – within the family circle. The perpetrator is someone related to the child or someone very close to them and the child is emotionally attached to them. Generally, girls suffer from intrafamilial abuse more frequently than boys, even though boys also do. Boys suffer from extrafamilial sexual abuse more often than girls, and it usually begins later in their life (in middle childhood stage), when they spend more time outside of the family. Accusations concerning very young boys are quite often calculated decisions of parents made during their divorce or breakup. Therefore, contrary to popular belief, it does not affect solely prepubescent and pubescent girls or boys.

Children tend to see other people as close, other people are very important for their life so they can experience the abuse as a pleasurable activity. Moreover, in many cases, the abuser avoids painful or violent methods and the abuse can be a source of pleasant sensations. The younger the child, the harder it is for them to talk about such experiences. Children communicate in ways which are proportionate to their age, and so people close to them often don’t understand what they are trying to say. This is why the abuse might not be addressed at that time, and it surfaces later, oftentimes in their adulthood. In such a case, problems in relationships arise.

The consequences of childhood sexual abuse might unfold much later, many years after the abuse itself. This usually happens during transitioning to new developmental stages, most often when transitioning to adolescence – the perception of sexual abuse can change, and so the consequences of abuse can arise a long time after the attacks. Sometimes, as their personality fully develops and they experience first relationships, adolescents re-live their trauma, experience humiliation and deep degradation and see past experience for what it is – abuse. In most severe cases, displacement defense mechanism is employed and so the distressing event is displaced out of consciousness.

Children often do not understand what the person close to them does when they abuse them, as illustrated by the following case study. A man had sexually abused a young girl in her early childhood stage. He looked after her, they saw each other frequently, she was emotionally attached to him. When her parents discovered what was happening, they stopped all contact and told the girl that the man was sick. During her early childhood stage, she decompensated, not because of the sexual abuse but because she lost a person who was so emotionally close to her. Later, however, during puberty she realized what happened, she felt guilty and had trouble understanding why no one had protected her from him.

Furthermore, I would like to draw attention to the fact that children in the early stages of their development are harmed not only by the sexual abuse itself but also by how society reacts.

Early Childhood

Early childhood is a stage of playing, magic, fantasy, and learning – even about the urogenital system as it is a phallic stage. Children at this age focus their attention on genitals, which brings them pleasant and pleasurable sensations; children usually start to masturbate when they are about 4 years old. It is crucial not to talk about these acts negatively from the outset. This developmental stage is full of fairy tales and stories that children enjoy and sometimes they get engulfed by them. Sometimes, it can exceed their understanding and then the children might employ confabulations and fantasy. There is some misunderstanding – among the general public and also the professionals – about the expression "confabulation". Confabulation does not equal lie; it is common for children up to 6 or 7 years old to create stories and fill in the gaps. Then they defend this version they have created, and they absolutely believe it to be true. However, this does not mean that a child would simply invent an event that has not happened. Furthermore, children usually do not lie about such serious realities and if they do, they are quite probably being indoctrinated by an adult and it should be fairly easy to discern falsehoods. The memories of children at this age are not reliable, sometimes they can have false memories because they are quite suggestible at this stage of their lives.

High levels of suggestibility are another phenomenon typical for early childhood. During this developmental stage, children are very susceptible, uncritically accepting of anything an

adult as an authority figure does or says. This phenomenon sometimes makes the investigation difficult because the child does not understand the questions. If someone asks the child a question in an unsuitable manner, they can start feeling like their memory is incomplete, and so they might feel the need to add something to the story. This way they fall prey to unintentional suggestions. Only an experienced interrogator can avoid this – by only asking questions that are neutral and impartial. Children adjust their answers to the person who asks the questions; they try to give a complete answer, please the interviewer. They can sense what someone wants them to say and answer accordingly. There is a high risk of suggestibility in children. The older the child, the less suggestible they are.

Another aspect to keep in mind is perception of details in early childhood. Children can be very bright, attentive, and they can notice many details if they are interesting and important to them, and these are different from those an adult would need to notice. Children are unable to perceive the outside world in a complex manner. The assumption that you know a child gave a true statement if they gave you a lot of details, is false.

Besides, it is necessary to mention that time orientation and quantification skills differ in early childhood. At this age, children understand that there is a past and a future, but they focus on the present. They cannot tell the time; they cannot answer questions such as: When did it happen? How long ago? How many times? Usually, the children do not know the answer.

In following the above-mentioned aspects of perception and behavior in early childhood, it is also necessary to bring attention to how important the interrogating person is. The way they initiate contact, what words and types of questions they use, how they maintain eye contact – all of these are very significant. It is crucial to maintain eye contact, otherwise, they will not be able to hold the child's attention.

Those who interrogate children should consider the fact that if a child is restless, fidgety, if they misbehave, it does not necessarily mean they are not victims of sexual abuse. They might be tired, or they might be avoidant (which is one of the symptoms of PTSD). At the same time, if a child does not have these symptoms it does not mean the crime did not happen.

Middle Childhood

During middle childhood, morality is very important to children. Moral realism is typical for this developmental stage – children judge actions based on their consequences, not on the motives. If the child has revealed something an adult has done and people around them get angry and their reaction is too strong or dramatic, the child starts to feel shame and guilt and it might impact the way they tell the story.

It is also a stage of latency; sexual urges lie dormant. Which means that if there is accelerated sexual behavior, e. g. masturbation, we need to pay attention.

Apart from games and personal interests, children's duties come to the forefront as they start their compulsory education. Their psyche, perception, logical thinking, and memory changes too. Their speech and their ability to perform tasks develop. Children do not have sufficient life experiences, so they do not know and understand what is important and what is less so. During the investigation and the extraction of information (interrogation and questioning), we should bear in mind that if 6-9-year-old children are repeatedly questioned they tend to fill gaps in their stories using their fantasy and then they believe everything they said to be true. Sometimes, this is perceived as lying, however, children are not aware of it, they just try to fill the gaps in their memory. This is completely normal in children in this developmental. This is not the case with neurotically or psychopathically inclined people where innocent lies can transform into pathological lying and possibly a mental disorder.

During this stage, the mental orientation in space and time improves. However, answers to questions about size and space are oftentimes exaggerated. The same is true about noticing details for early and middle childhood – children are attentive, bright, they can notice little things and share fascinating insights that adults would oftentimes miss or doubt.

However, children in this stage still cannot recall the order, length, and frequency of activities.

Authorities and Their Approach Towards Child Victims

Until this point, we have talked solely about the children. We also need to focus our attention on professionals (e.g. interrogators, observers) who come into direct contact with children during investigations of sexually motivated crimes against them.

Authorities often tend to be suspicious of anything children tell them, and they tend to trivialize it. It is a big issue with experts being too rigid and judging the victims' behavior based on the behavior of their own children who behave very differently. That is a huge mistake. It is crucial to help professionals who are interested in this area to evolve their skills and knowledge.

Many professionals are specializing in helping child victims and they can help quite significantly in the course of an investigation. If the procedure is mishandled by being inexpert or unsuitable it can harm the investigation. School psychologists tend to focus on bullying – oftentimes, they are unable to work successfully with sexual abuse victims. That is why they – quite frequently – diagnose something different (such as ADHD), and because of it a whole serious of other problems follow (being referred to a psychiatrist, etc.). Even psychiatrists can misdiagnose these children and prescribe them with medication that might keep their central nervous system from developing properly. In case of a police investigation,

only professionals with extensive knowledge of child psyche should come in contact with child victims. Unfortunately, there are almost no such professionals among police officers. If the questions are asked improperly or repeatedly due to incompetency it can lead to the loss of authenticity, avoidance, and unexpected behaviors that can be a sign of PTSD. Some prosecutors and judges oftentimes lack a thorough understanding of the context and of the specifics of dealing with child victims, they do not understand confabulation and fabulation or the behavior of mentally disabled children. All the above-mentioned professions lack case supervision. Expert witnesses in psychology should be specialized in clinical psychology (oftentimes they are not), they are usually overburdened, not specialized in a certain area and they tend to get rigid. Similarly, there are not enough expert witnesses in the field of pediatric gynecology.

Case Studies

The above-mentioned topics and issues can be demonstrated using selected case studies of investigations of sexually motivated crimes against children:

Case study A

A 9-year-old girl coming from a troubled family (child and family services were involved in the past), sexually abused by someone she knew. There was a fault in the attitude of police and expert witnesses – the girl had been interrogated repeatedly; the experts allegedly have not listened to recordings from past interrogations. They did not believe her because she was perceived as “troubled”, even though she behaved well in school for example. The fact that she has been sexually abused was finally established even though there had been many difficulties along the way. Later it became obvious that there was a lack of professional care. The only service that was provided was the Centre of Educational Care. Three years after that, she participated as an accomplice in a case where her younger sister was sexually assaulted by her classmate (there was a possibility that the older sister had instigated it). At the forefront, there is accelerated sexual behavior and socially pathological behavior. The way the interrogation was set was inappropriate – there was some pressure, improper questions, excessive questioning, blame. The question is whether this girl really is an “accomplice” or rather a victim, and how the situation will develop in the future since she hasn´t received any professional psychological help in the form of systematic psychotherapy.

Case study B

A 6-year-old girl coming from a dysfunctional family environment with the presence of domestic violence and alcohol abuse. We have recognized that the girl had CAN syndrome (Child Abuse and Neglect). She had been sexually abused by her stepfather. Primarily, the police believed what the girl confided in them. The girl´s testimony was repeatedly extracted, and as a result of this, during interrogations, she was more distant from her experience, so she did not seem as authentic anymore. She tried to avoid the topic, she

rolled on the floor. The public prosecutor concluded she was “ill-mannered and hyperactive”. This statement further influenced how the case was seen from that time on. However, trying to avoid a topic or an interrogation altogether can be a symptom of Posttraumatic Stress Disorder. In the end, the decision to initiate public prosecution in criminal proceedings had been annulled.

Conclusion

As it is evident from enclosed case studies, the attitude during investigation of sexually motivated crimes against children, especially the manner of direct work with child victims of sexual violence, can seriously impact not only the future development of the investigation, but also, more importantly, the victim´s perception, the impact of trauma on victim´s understanding of the event, and therefore how well the child victim will deal with the trauma. It is crucial for helping professionals to be informed about the specifics of sexually motivated crimes against children, as well as how they psychologically affect the child so that the negative impact of trauma on the children´s lives and development can be minimized.

References

Dušková, Z. a kol. (2004). Obraz problematiky týraného, zneužívaného a zanedbávaného dítěte v letech 1992-2003. Praha: Dětské krizové centrum.

Resilience and the Impact of Sexual Violence Trauma from Expert Witness´ Point of View

PhDr. Štěpán Vymětal, PhD.

Expert Witness

About the Author

PhDr. Štěpán Vymětal, Ph.D. is a psychologist specializing in crisis, disaster, and trauma psychology. Since 2001 he has been working at the Psychological Service of the Ministry of Interior. He takes part in educating crisis intervention specialists of different backgrounds, he is a lecturer at Charles University, and he also takes part in international projects concerning psychological intervention in major emergencies and psychosocial support in crisis. At the same time, he works as an expert witness. He represents the Czech Republic in EFPA´s Standing Committee on Crisis, Disaster and Trauma Psychology.

Summary

This paper informs us how resilience and vulnerability play a role in what impact sexual trauma will have on a victim. Resilience and vulnerability are factors affecting the probability of Posttraumatic Stress Disorder. It explains why there is no such thing as a typical victim of sexual violence and why some victims may be perceived as untrustworthy. The author puts together findings about how trauma manifests and how it affects the victim and puts it in the context of expert reports and how they strongly influence both the ruling in criminal proceedings and the victim itself.

Introduction

Expert reports often serve as important evidence in legal proceedings of sexually motivated crimes, and they are an important source for the final decision. At the same time, if the expert report is inaccurate or improper it can lead to criminals being released, and to nonnegligible secondary or tertiary victimization of sexual violence victims. Therefore,

expert witnesses must know and understand the specifics of trauma resulting from sexual violence, the consequences it has on the victim, their life, emotions, perception, etc., and also the reasons why some victims are more resilient than others. If expert witnesses have this knowledge, they are able to assess whether a type of behavior is a manifestation and result of trauma, even though the type of behavior could be perceived by some as evidence that the victim is not trustworthy. Expert witnesses do not have the authority to assess evidence, however, it is useful to notice whether the victim is consistent throughout hearings, and to respond accordingly.

Why There is No Such Thing as a Typical Victim of Sexual Violence

There is no single generalized model that could predict whether a sexual violence victim will develop Posttraumatic Stress Disorder (PTSD). Many factors are affecting whether a person will be traumatized or whether they will develop PTSD. These can be divided into two groups – resiliency and vulnerability factors. These include personal history, personality traits, state of health, other aspects of their life, and the context of the assault. Also, the intensity, duration and frequency of violence (nonrecurring, recurring, long term), and the type of relationship between the victim and the perpetrator (a close person, someone familiar, a stranger).

At the same time, it is necessary to remember that sexual violence is not the same as rape. Many acts qualify as sexual violence, including pressuring or coercing mentally defenseless people. Sometimes the threat concerns the victim itself, but it can also threaten people close to them, animals or objects of great subjective value. It is also necessary to remember that anyone can become a victim of sexual violence. Even though most of the victims are women and children, men are affected too. There are no “typical victims” of sexual violence – not only do the forms of sexual violence and its impacts differ, the gender/sex and age of the victims does too.

Vulnerability and Resilience

The ability to survive sexual violence without serious mental health consequences and to recover quicker is strengthened by resilience factors such as having a stable job, good health, solid social support, specific personality structure (maturity, optimism, etc.). Vulnerability factors, on the other hand, weaken the victim and worsen the consequences of trauma. These can be economic and emotional dependency on the perpetrator, specific personality structure (submission, introversion, interpersonal dependency, self-efficacy, low self-esteem, impulsivity, adaptation difficulties, etc.), social exclusion, mental health issues or history of trauma. Resilience and vulnerability can also be affected by secondary victimization. Inappropriate or insensitive behavior or questions during the first contact with professionals, institutions or other people can have a negative impact on the victim’s life and

self-image and it can lead to self-blame. Seemingly innocuous signs of distrust may harm the victim and worsen the impact of the situation. Not to mention the cases when professionals or others trivialize or downplay the victim's experiences.

When analyzing cases, it is necessary to consider the differences between individual victims regarding their vulnerability and resilience. A common problem is persisting emotional attachment to the perpetrator, someone close to the victim. In such cases, victims tend to make excuses for violent behavior or cover it. If the perpetrator is someone they do not know, they might feel a persistent and omnipresent sense of danger. If the victim were abused by someone close to them, it can lead to learned helplessness and adopting passive defensive strategies (not fighting back during the assault). Defense mechanisms – displacement, rationalization, or denying that the aggressor is at fault, justifying their behavior or blaming someone else – can hinder the understanding of the feelings and position of the victim.

Symptoms of Trauma and Seemingly Untrustworthy Victims

With some experts not familiar with the subject of sexual violence (e.g. police, doctors, teachers, judges, expert witnesses, …), some symptoms and consequences of trauma may give them the impression that a victim is untrustworthy. However, it is essential to remind ourselves that some reactions are just typical and normal symptoms of trauma. For example, memory loss, numbness, dissociation, or passivity as a defense strategy. Dependency on the perpetrator, fear that the violence will continue, severe mood swings and past negative experience with competent authorities may lead the victim to drop charges and refuse to testify which makes them seem untrustworthy. Dissimulation – covering, denying and obscuring symptoms of trauma – is another common phenomenon in victims of sexual violence. With some sexual abuse child victims whose behavior becomes overly sexual, we see that sometimes the behavior is perceived as a cause, not a consequence of the traumatic experience. We should pay particular attention to specific dynamics and different value systems of partners from different cultures. In some cases, testimony and its content may be influenced by getting psychotherapeutic help early. However, from a moral point of view, this is completely okay because the mental health of victims is the absolute priority. The chances for recovery are increased by receiving treatment and support early on.

Complex PTSD and International Classification of Diseases (ICD–11)

From a professional viewpoint, the impact of sexual violence (but also childhood abuse, etc.) oftentimes results in a non-typical clinical picture – a different set of symptoms from usual posttraumatic stress disorder symptoms. PTSD manifests differently in individuals who have experienced long term, repeated or protracted trauma. That is why a new diagnostic category was created – **complex posttraumatic stress disorder (C-PTSD)**, which is actually

more common than standard PTSD. The diagnosis is included in the International Classification of Diseases, 11th Revision, and it is being used abroad. In the Czech Republic, the new revision will become binding in 2022; however, us experts should already give it some thought, and we should explain its specifics to experts from different professions. C-PTSD develops as a disruption of self-organization due to repeated experience of interpersonal trauma when the individual has no chance of escape – which is typical for many victims of sexual violence and/or abuse in childhood. Complex posttraumatic stress disorder includes some PTSD symptoms and also symptoms of **emotional dysregulation** (deactivation – emotional numbness or hyperactivation – it takes a long time to calm down), **negative self-concept/self-image** (self-humiliation, feelings of failure and worthlessness) and **problems in interpersonal relationships** (difficulties in maintaining emotional closeness, reduced ability to work, study, etc.). These aspects are encapsulated in the term disruption of self-regulation. C-PTSD definition makes diagnosing significantly easier – as it can be based on symptoms, not aspects of traumatic experience; oftentimes, individuals do not remember the traumatic experience, so it cannot be used for diagnosis. Currently, the International Trauma Questionnaire (ITQ) is being adapted in the Czech Republic as a new diagnostic tool. It is used for distinguishing whether a client has PTSD or C-PTSD, and it does so using two sets of nine easy questions (Cloitre et al., 2018).

When speaking of trauma, we should note that prolonged grief disorder (PGD) is newly included in ICD-11; and acute stress disorder (ASR) is no longer a part of ICD-11 because now it is defined and understood as a normal reaction to extreme situations.

Using Modern Technology in Psychological First Aid

Recently, a new mobile application has been released in the Czech Republic. It is called *První Psychická Pomoc* (PPP; Psychological first aid), and it was created by the Department of Crisis, Disaster and Trauma Psychology (a part of Czech-Moravian Psychological Society) with the support from Fire Rescue Service of the Czech Republic (HZS ČR) and CZ.NIC. It is intended for the integrated public rescue system and also for NGO representatives (once they undergo basic training on how to provide first psychological aid). The purpose of the application is to always have some kind of a tool at hand when working with victims. It teaches basic principals of first aid, defense mechanisms, what behavior to expect from victims, how to deal with stress in a crisis, etc. It also takes into consideration the specific needs of specific groups – foreigners, people with disabilities, different responses to stress in different age groups, etc.

Conclusion

Every sexual violence incident, interpersonal context, victim experience, and consequences trauma has on the lives of victims can differ. There is no typical victim nor a typical sexual

violence incident. Victims experience trauma differently, and the consequences it has on their perception, emotions, health and other areas of their life differ too. Even though sometimes the behavior of victims seems ambivalent, unreadable or strange, it is a normal response to a traumatic experience. The ability to reflect the experience, manifestation, and consequences of trauma, resilience and vulnerability factors, and to use current expert knowledge in this area (e.g. the new diagnostic category of PTSD) can help considerably with having a sensitive, relevant and effective approach towards sexual violence victims. Expert witnesses can use this knowledge to adequately contribute to resolve a given situation and to reach a just outcome of legal proceedings.

References

Cloitre et al. (2018). The International Trauma Questionnaire: development of a self-report measure of ICD-11 PTSD and complex PTSD. *Acta Psychiatrica Scandinavica*, *138*(6), 536-546.

Systems of Support for Victims of Sexual Assault in the United States

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About the Author

Jennifer Landhuis is the Director of the Stalking Prevention, Awareness, and Resource Center (SPARC), an AEquitas initiative. Landhuis has over 22 years of experience as an educator and advocate on the issues of stalking, domestic violence, and sexual assault. Prior to joining SPARC, Jennifer was the Director of Social Change at the Idaho Coalition Against Sexual & Domestic Violence. Earlier in her career, Jennifer spent eleven years as an advocate and educator for local domestic violence/sexual assault community-based crisis centers. Landhuis graduated from Midland University with a Bachelor of Arts degree in Youth and Family Ministry and from the University of Cincinnati with a Master of Science degree in Criminal Justice. She is an adjunct professor at Boise State University.

Summary

This article summarizes the role of each of the key components of Sexual Assault Response Teams (SARTs) – the existing system of support for victims of sexual assault in the USA. It describes the role and approach of each member, including Sexual Assault Nurse Examiners (SANEs), victim advocates, the police and prosecutors. The article also focuses on trauma-informed response as an effective approach for working with sexual assault victims as it minimizes the risk of secondary victimization and victim-blaming.

Introduction

In the United States, jurisdictions around the country are using Sexual Assault Response Teams (SARTs) to serve sexual assault victims. SARTS are coalitions of agencies that include

victim advocates, law enforcement officers, forensic medical examiners, prosecutors and forensic scientists (forensic labs). SARTs work together to develop an interagency approach to working with victims. SARTs are victim-centered, understanding the trauma that victims of sexual assault experience can often be made worse if the victim encounters responders who are not trauma-informed.

Sexual Assault Nurse Examiners

SARTs focus on building their internal response within their respective disciplines, as well as building a collaborative response to victims of sexual assault. One primary component of a sexual assault response team is the medical professional. In the United States, it used to be that victims of sexual assault had to go to an emergency room to have a physical exam done. There they would often wait several hours for an exam and then have an exam done by the emergency room doctor. This was not the best scenario and the sexual assault advocacy field worked to change that response. Now in many jurisdictions there are Sexual Assault Nurse Examiners. Nurses who have undergone specialized training to perform forensic exams on sexual assault patients. In the United States, victims have several options. They can choose to just have a medical exam and not report the crime to the police, they can choose to report to the police or they can choose to have the evidence collected and held on to until they decide if or when they want to make a criminal report. This is often referred to as a Jane Doe exam, where the evidence is collected and stored but a victim chooses not to report the sexual assault to law enforcement. SANE's are registered nurses a go through specialize training, typically 40 hours of classroom instruction plus clinical instruction on how to properly gather evidence. The use of SANE's is a best practice recommendation in the United States and evidence has found that SANEs often collect better evidence than emergency room physicians who do not have specialized training. SANEs are responsible for gathering all the forensic evidence as well as gathering some of the information for the law enforcement investigation. Law enforcement is not present in the exam room, usually only the SANE and ideally a victim advocate who attends to the victim's emotional needs. For more information on SANEs and the protocol for SANEs please see The Sexual Assault Forensic Examination Technical Assistance.

Victim Advocates

Victim advocates, or what would be very similar to social workers in the Czech Republic, are one of the core members of SARTs and often are the agency that is leading the SART. In the United States, there are community-based advocates, that work for a non-profit agency and there are victim witness specialists, advocates who are working for a police department or prosecutor's office. Community-based advocates work with victims regardless of whether they choose to report to the criminal justice system. For example, they can provide one on

one crisis intervention, access to support groups, and accompaniment to a medical exam. These community-based advocates have a high level of confidentiality and need permission from the victim to speak with other responders about the case. Victim witness specialists work for the police or prosecutor, so if the case is not prosecuted or charged the do not work with the victim beyond the end of that case. They also have a lower level of confidentiality because they work for the government agency. Both play a role in sexual assault cases by assisting the victim with their emotional needs and advocating on their behalf as they work with other disciplines like the police or courts. For more information on the role of a victim advocate in a SART could be find here.

Police

A third component of a SART is law enforcement. In the United States, victims have the option of whether they want to make a report to the police. They can see an advocate or receive medical attention without making a criminal report. Law enforcement typically has a first responder, or patrol officer that answers emergency calls. Seasoned officers with more experience and training are often detectives or investigators and may be assigned to a Crimes Against Persons unit. In sexual assault cases, sometimes a patrol officer takes the initial report and then it is given to the detective or investigator and other times a detective is called out immediately to respond to a hospital, for example. Law enforcement ideally receives specialized training on working with victims of sexual assault to understand the impacts of trauma, what is often referred to as a trauma-informed response or trauma-informed interviewing. The training they receive focuses on the way trauma impacts a victim's emotions and memory. Law enforcement learns to conduct interviews in a way that recognizes that victims of sexual assault have varied emotional and behavioral reactions to a trauma and that their memory may be impaired as a result of that trauma. The focus of a trauma informed response is to get as much information as possible from a victim without inflicting additional trauma from having to answer lots of questions, tell their story numerous times or being accused of lying because they can't remember parts of what happened during the sexual assault. For more information on the types of training law enforcement receives to be trauma-informed, see End Violence Against Women International.

Prosecutor

The last component of the team is the prosecution, which also focuses on providing a trauma-informed response. Prosecution of sexual assault can be difficult, but projects in the United States encourage prosecutors to look beyond conviction rates as the primary measure of effectiveness in sexual violence prosecutions and to implement practices that advance the goals of justice, victim safety, and offender accountability. The Model Response

to Sexual Violence for Prosecutors serves as a comprehensive tool for making decisions on office policy and individual cases of sexual violence.

Trauma-Informed Response

Responders, including advocate across the United States, benefit from understanding trauma. Dr. Rebecca Campbell, a psychology professor at Michigan State University is thought to be one of the leading experts on the issue of trauma and sexual assault. For information highlighting Dr. Campbell's work and others regarding trauma response, please see The Neurobiology of Trauma: Webinar Series, Adult Sexual Assault: A Trauma Informed Approach and Adult Sexual Assault: A Trauma Informed Approach.

Throughout the process of recovery from sexual assault, victims benefit from ongoing advocacy and support. Victims of sexual assault benefit from crisis intervention that is based on re-empowering victims, validating their feelings and assisting them in reconnecting. Victim advocates assist victims by normalizing reactions to trauma, providing crisis education, referrals and follow-up contact. Critical questions that help establish trust include: What has the victim done so far to help themselves, what would they like to do but haven't yet and what are they not willing to do? These questions help victims explore their options and allow for advocates to educate victims about resources and support options. Many advocacy agencies in the United States offer hotlines that are answered 24 hours a day 7 days a week to provide support and referrals to victims of sexual and domestic violence. These same organizations offer crisis intervention, education and support, including peer-based support groups. Support groups have proven to be very beneficial for victims of sexual assault. They normalize common reactions and help victims connect with much-needed support. One example of a sexual assault support group curriculum could be Circle of Hope: A Guide for Conducting Effective Psychoeducational Support Groups.

Conclusion

The systems of support for victims of sexual assault are not perfect and are in a constant state of improvement, evaluation and revision. While there is still much work to be done, much progress has also been made during the last several decades.

References

AEquitas. (undated). *Model Response to Sexual Violence for Prosecutors* (RSVP) [online]. Retrieved from: <https://aequitasresource.org/wp-content/uploads/2018/09/Model-Response-to-Sexual-Violence-for-Prosecutors-RSVP-An-Invitation-to-Lead.pdf>.

End Violence Against Women International. (undated). *Documents*. [cit. 12.11.2019]. Retrieved from: < https://www.evawintl.org/Library/Documents.aspx?FileType=&CategoryID=387>.

National Sexual Violence Resource Center. (undated). *Victim Advocates* [online]. [cit. 12.11.2019]. Retrieved from: <https://www.nsvrc.org/sarts/toolkit/3-3#victimadvocates>.

National Sexual Violence Resource Center. (undated). *IN-SERVICE /ROLL CALL TRAINING VIDEO. Adult Sexual Assault: A Trauma Informed Approach* [online]. [cit. 12.11.2019]. Retrieved from: <https://www.nsvrc.org/sites/default/files/elearning_facilitators-guide-trauma-informed-response-sexual-assault.pdf>.

National Sexual Violence Resource Centre. (2014). *Adult Sexual Assault: A Trauma Informed Approach* [online]. [cit. 12.11.2019]. Retrieved from: < https://www.nsvrc.org/elearning/22288>.

SAFEta.org. (undated). *The Sexual Assault Forensic Examination Technical Assistance.* [online]. [cit. 12.11.2019]. Retrieved from: <https://www.safeta.org/page/Protocols>.

Sexual Assault Kit Initiative. (undated). *The Neurobiology of Trauma: Webinar Series* [online]. [cit. 12.11.2019]. Retrieved from: <https://sakitta.org/toolkit/index.cfm?fuseaction=tool&tool=48>.

Washington Coalition of Sexual Assault Programs (2014). *CIRCLE OF HOPE: A Guide for Conducting Effective Psychoeducational Support Groups*. Available also online: <https://www.wcsap.org/resources/publications/tips-guides/support-group-guides/circle-hope>.

Health, Recovery and the impact of Social Support after Sexual Assault

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Lisa Arntzen is a social worker, family therapist, researcher and activist. She received her bachelor's degree in social work and her master's degree in family therapy. Currently, she works at the Norwegian Centre for Violence and Traumatic Stress, specifically in the section for trauma, catastrophes and forced migration - children and youths. She has a long experience working as a social worker with victims of sexual violence, with people experiencing eating disorders, children and adolescents in crisis, or as a project manager for projects focusing on gender-based violence. She was nominated for the Oslo Citizen of the year award by Aftenposten in 2011 and for the Plan Norway's Girl Award in 2013 and 2014 for her work on women's rights and against violence and sexual abuse.

Summary

This article summarizes the impact sexual violence can have on victims' health, both physical and mental. It is based on a number of Norwegian and Swedish studies. The article emphasizes the importance of social support. Social support can take the form of professional help (from both organizations and individuals such as doctors, social workers or the police) or the support victims can get from their social network, i.e. family, friends and significant others. Having social support can significantly improve recovery from sexual assault, its effects, and its consequences. Having others respond appropriately is especially important in speeding up the recovery process and reducing the impact of trauma.

Introduction

When we talk about the sexual violence or sexual assault, it is necessary to talk also about its impacts on victims, which may be severe. This article focuses on the potential health consequences of sexual assault, the role which the social support does play in the healing process and how and if it is possible to recover from the trauma of the sexual assault.

Prevalence and potential health consequences

According to the national survey on violence and rape in Norway (2014), one in ten women and one in hundred men are victims of rape during their lifetime. Additionally, one in three women and one in ten men will experience some form of sexual abuse during their lifetime. Nearly half of the female victims (49%) experienced the assault before the age of 18 and nearly one-third (29%) had never told anyone about the assault (Thoresen & Hjemdal, 2014).

The same study showed that victims of violence and rape report a poorer state of mental health compared to non-victims. Victims report higher levels of mental health problems such as depression, anxiety and post-traumatic stress reactions. A Swedish study showed that approximately half of rape victims meet the criteria for post-traumatic stress disorder (PTSD) or depression six months after the assault (Tiihonen, 2015). There is a clear link between the amount of violence categories and level of mental health problems (Thoresen & Hjemdal, 2014). This means that for example, if a person experience violence during childhood and then experience rape later in life, he/she is more likely to have higher level of mental health problems. The phenomenon is known as “cumulative trauma”. It means that the damages of later trauma can become more severe due to prior traumatic experiences.

Not all dramatic situations create a trauma. Whether the experience becomes a trauma is determined by elements of the situation and by how it is being handled by the person and surroundings afterwards. This is why social support and help services are important. Rape victims show a variety of reactions after the assault, and some even experience a low amount of reactions. During my time as a practitioner in clinical work, I have met many victims who, even when they suffer a great deal, go straight back to work and continue with their daily life. For some it is important to try maintaining “normality” even if reactions are present. It can give them a sense of control and hope in a chaotic situation.

Victims of rape may suffer from physical health problems after the assault. Some of these problems might be physical injuries, headache, nausea, back and neck pains, pelvic pains, digestion problems or sexually transmittable diseases (Stein et.al. 2004; Garcia-Moreno et.al. 2013). The list can go on, but the examples above is shown to highlight possible outcomes on physical health that can affect the victims quality of life both in the acute faze and later after the assault. For some victims, physical and mental health problems affect their ability to study, work or participate in social life. It can lead to isolation and problems in close relations. In the end, victims may suffer from long term mental health consequences. These include for example PTSD, depression and anxiety. Some victims turn to substance abuse and self-harm to deal with difficult emotions. Sometimes to the extent that they have suicidal thoughts. There are also studies showing that eating disorders can occur after sexual abuse. Other long-term consequences can be drop out of school or absence from work, isolation and trust issues or violent and aggressive behavior (Dyregrov, 2008). Previous studies have found that victims exposed to violence and sexual abuse in early life have an

increased risk of being exposed to new violence later in life. This phenomenon is known as *revictimization* (Resnick et.al.2012; Aakvaag & Strøm, 2019).

Prior research on health consequences

Previous research on sexual assault in youth and adult life have primarily focused on potential health consequences, revictimization, therapeutic interventions and substance abuse. Some studies have followed rape victims over time, but many of these have had a low response rate and high dropout (Campbell, Sprauge & Sullivan, 2011). Although we know much about potential health consequences, we still know little about the occurrence of conditions other than PTSD. There is a need for more knowledge on how victims are doing over time, focusing on both psychological, physiological and social factors. Additionally, we have little knowledge on whether help services actually meet victims' needs for help and how this may affect their health going forward.

Help services in Norway

Just to give you an idea of how the help services look like in Norway, here are some of the most frequent used services provided to sexual assault victims and what help they provide:

- **Sexual Assault center:** Psychosocial support and medical care, including forensic examination
- **Crisis center:** Shelter/safe place to stay and psychosocial support
- **Support Center for Rape Victims:** Advice and information, psychosocial support
- **Local doctor:** Medical care, follow up over time
- **Referral to therapist:** Therapy
- **Police:** Reporting the case, restraining order, safety alarm etc.
- **Lawyer:** Free legal aid throughout the legal process and assistance in seeking compensation.

Victims may turn to one or more of the above and sometimes different services depending on where they are in the process after the assault. In Norway, there are approximately 25 Sexual Assault Centers located in either hospitals or emergency rooms, 47 Crisis Centers and 20 Support Centers for Rape Victims.

Social support

Social support is one of the key factors in retrieving good health after sexual assault (Brewin, Andrews & Valentine, 2000). The support may come from professional helpers as well as from friends, family or significant others. Previous research show that victims meet a variety

of reactions from their social network (Ullman et.al. 2010). Receiving supportive reactions from the social network may increase the chances that victims seek professional help, and it may decrease the risk of long-term health consequences. On the contrary, lack of support can lead to isolation and create barriers to seeking professional help or reporting to the police (Aakvaag & Strøm, 2019).

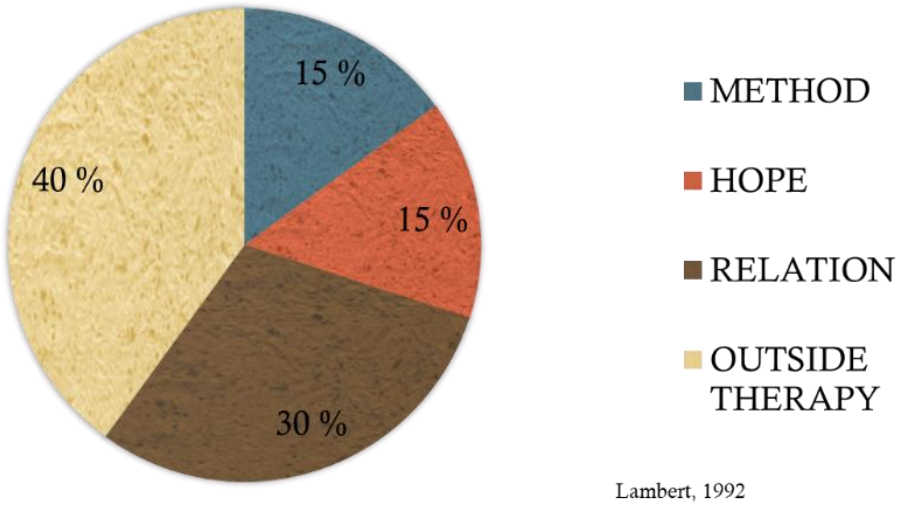
In a recent study rape victims said that 1) they did not receive sufficient information about how and where to get help, 2) that professional caregivers lacked knowledge about rape trauma reactions and effective therapeutic interventions, and 3) that their social network (e.g. friends and family) did not get any advice on how to support the victim (Arntzen, 2019).

Recovery

As we have seen, the potential health consequences of sexual assault are many and can be severe. Therefore, it is highly important that we send a message of hope to all victims of sexual assault: Healing is possible. During my practice, I have met many victims who recover and go back to living happy and meaningful lives. What is important to know, is that the path to recovery vary between victims, and what works for some, may not be right for others.

Previous studies on therapeutic interventions indicate that cognitive behavioral interventions, exposure interventions and eye movement desensitization (EMDR) are effective at improving mental health, but statistical tests of comparative effectiveness did not demonstrate that one intervention was significantly more effective than the other was. Perhaps there is something to the notion that “all treatment is better than no treatment”, but more research is needed.

While we are discussing effective treatments, it is worth knowing that the method chosen in therapy is not the only factor that contributes to improvement. As the following table shows, factors such as the clients’ hope of improvement, the client’s perception of the relationship between her/him and the therapist and factors outside therapy also contributes. Factors outside therapy has the largest percentage and can for example include having healthy social relationships, meaningful work or studies, a steady financial situation or a general feeling of life quality.



Lambert, 1992

Conclusion

As professional caregivers, we have a unique and important task in providing help that may increase health prognosis for victims of sexual assault. To do that, we must create safe environments to increase chances that victims expose their experiences, and when they do, we must let them know that we believe and support them. To prepare for the task, we must educate ourselves on common reactions and latest research on effective therapeutic interventions. We need more research in order to develop our institutions so that they meet victims need for help and support. We must increase public knowledge about help services and offer support and advice to the victim's social network.

References

Aakvaag, H. F. og Strøm, I. F. (Red.). (2019) Vold i oppveksten: Varige spor? En longitudinell undersøkelse av reviktimisering, helse, rus og sosiale relasjoner hos unge utsatt for vold i barndommen (Nasjonalt kunnskapssenter om vold og traumatisk stress nr. 1/2019) Oslo: Nasjonalt kunnskapssenter om vold og traumatisk stress

Ahrens C. E., Cabral G. Og Abeling S. (2009) Healing or Hurtful: Sexual Assault Survivors` Interpretations of Social Reactions from Support Providers. Psychology of Women Quarterly, 33 (1), 81–94. https://doi-org.ezproxy.hioa.no/10.1111/j.1471-6402.2008.01476.x

Ahrens, C. E., Stansell, J. og Jennings, A. (2010) To tell or not to tell: The impact of disclosure on sexual assault survivors´recovery. Violence and Victims, 25 (5), 631-648.

Andrews, B., Brewin, C. R. og Rose, S. (2003) Gender, Social Support and PTSD in Victims of Violent Crime. Journal of Traumatic Stress, 16 (4), 421 – 427.

Arntzen, L. (2019) Sosial støtte etter voldtekt: Buffer eller byrde? En kvalitativ studie om opplevd sosial støtte for kvinner som har vært utsatt for voldtekt. Masteroppgave. Oslo: Oslo Metropolitan University

Campbell, R., Sprauge, H. B. & Sullivan, C. M. (2011) Longitudinal Research With Sexual Assault Survivors: A Methodological Review. Journal of Interpersonal Violence

Campbell R, Ahrens CE, Sefl T, Wasco SM, Barnes HE. (2001). Social reactions to rape victims: healing and hurtful effects on psychological and physical health outcomes. Violence and Victims, 16 (3), 287-302.

Dahl, S. (1993). Rape – A hazard to health. Oslo: Universitetsforlaget

Dyregrov, A. (2008) Voldtekt – vanlige reaksjoner. Bergen: Senter for krisepsykologi.

Garcia-Moreno, C., Pallitto, C., Devries, K., Stockl, H., Watts, C., & Abrahams, N. (2013). Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: Department of Reproductive Health and Research, World Health Organization

Lambert , M.J. (1992). Implications of Outcome Research for Psychotherapy Integration. I: Norcross J.C. & Goldfried, M.R. (red.). Handbook of Psychotherapy Integration. New York: Basic

Parcesepe, A. M., Martin, S., Pollock M. D. & Garcia-Moreno, C. (2015) The effectiveness of mental health interventions for adult female survivors of sexual assault: A systematic review. Agression and violent behavior.

Resnick, H. S. et.al. (2012) Assault related substance use as a predictor of substance use over time within a sample of recent victims of sexual assault. Addictive Behaviors 2012;37:914-92

Smith, C. P. & Freyd, J. J. (2014) Institutional Betrayal. American Psychologist, 69(6), 575-587

Stein, M. B. Et.al. (2004) Relationship of sexual assault history to somatic symptoms and health anxiety in women. General Hospital Psychiatry. 2004;26:178-183

Tiihonen. A. M. (2015) Consequences of rape: injuries, posttraumatic stress, and neuroendoctrinological changes. Avhandling. Stockholm: Karolinska Institutet

Trickett, P. K., Noll, J. G., & Putnam, F. W. (2011). The impact of sexual abuse on female development: lessons from a multigenerational, longitudinal research study. Dev Psychopathol, 23(2), 453-476. doi:10.1017/S0954579411000174

Thoresen, S. og Hjemdal, O. K. (Red.). (2014). Vold og voldtekt i Norge. En nasjonal forekomststudie av vold i et livsløpsperspektiv (Nasjonalt kunnskapssenter om vold og traumatisk stress nr. 1/2014) Oslo: Nasjonalt kunnskapssenter om vold og traumatisk stress

Ullman, S. E., & Brecklin, L. R. (2003). Sexual assault history and health-related outcomes in a national sample of women. Psychology of Women Quarterly, 27(1), 46-57.

Ullman, S. E., Foynes, M. M. og Tang, S. S. S. (2010). Benefits and Barriers to Disclosing Sexual Trauma: A Contextual Approach. Journal of Trauma and Dissociation, 11 (2), 127 – 133.

Østby, L. og Stefansen, K. (2017) Nettverkets betydning etter seksuelle overgrep. Tidsskrift for psykisk helsearbeid, 14 (3), 210 – 220.

Gaps in Social Services System for Sexual Violence Victims in the Czech Republic

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Summary

This article addresses the gaps in the social services system for sexual violence victims in the Czech Republic. It touches upon the Czech public being quite indifferent to sexual violence and the impact it has on the victims, and it shows how the approach is different here and abroad – by showing us good practice from Norway where there is comprehensive and consecutive social work services system for sexual violence victims.

Introduction

Even though, lately, sexual violence has become a more discussed topic thanks to many campaigns and projects increasing awareness about this phenomenon in both general public and professionals, the support and help for sexual violence victims is still relatively unavailable and the social services network is insufficient. The main difficulty sexual violence victims face in social and other services is the fact that these are not specialized for helping

these victims and it is only a peripheral issue for them (e.g. organizations specialized in intimate partner violence, not sexual violence specifically).

Non-existent Network

In the Czech Republic, there is not a single organization specialized solely in different types of sexual violence which could comprehensively tend to the specific needs of sexual violence victims. ProFem is an organization closest to this ideal – it specializes in helping domestic violence victims and also in sexual violence, whether it happens in a close intimate relationship or whether the perpetrator is a stranger. ProFem offers psychosocial support, psychotherapeutic, and legal services for sexual violence victims, and also a crisis support chat so victims can talk about their traumatic experience anonymously.

Persefona (Persefona, online) offers similar services (legal, psychological, social) to victims of domestic and sexual violence, their friends and family, and also to people with anger issues. The main objective of this organization is to provide long term, comprehensive help to adult victims of domestic violence, sexual abuse, and rape, in the South Moravian Region.

Bílý kruh bezpečí (Bílý kruh bezpečí, online) focuses on helping victims of crime, including victims of sexual violence crimes. They offer their psychological and legal assistance via a network of branches located in all larger towns in the Czech Republic. Bílý kruh bezpečí operates a nonstop hotline for victims of crime and sexual violence: 116 006.

Dětské krizové centrum (Child Crisis Centre; DKC, online) specializes in helping underage victims of sexual violence and their family and friends regarding the CAN (Childhood Abuse and Neglect) syndrome. DKC offers immediate crisis assistance, legal counseling, and it also operates a hotline and chat services.

Konsent (Konsent, online) engages in rape and sexual harassment prevention. Konsent organizes public debates, makes videos, collaborates with similar organizations, raises public awareness, organizes workshops on sexual violence prevention, and operates a support group.

SASA (SASA – Sexual Assault Survivors Anonymous, online) is a spiritual self-help group for women and men who are guided by a set of 12 Suggested Steps and 12 Traditions as borrowed from AA (Alcoholic Anonymous). The group is not lead by a professional (there is no therapist working in their group).

The list of the above-mentioned services is not complete; however, it illustrates the scope of help that is available to sexual violence victims in the Czech Republic. Crucially, social services for sexual violence victims should not be fragmented. It is of utmost importance that victims do not need to describe their traumatic experiences many times to many different people in many different places. We absolutely lack a center where victims could

get the support, care, and treatment they need – all in one place. There are no nonstop crisis centers or hotlines that could address the specific needs of sexual violence victims day-and-night. Currently, they can contact the general crisis centers and hotlines that are not specialized in treating sexual violence victims, so they oftentimes cannot advise them where to go next and what to do next so the victims can, for example, secure the evidence needed for potential criminal proceedings. Also, victims often experience unprofessional responses from interrogators, doctors, psychologists, and psychotherapists. Sexual violence is still a taboo subject in our society and many myths are surrounding it. This hurts victims, their feelings of safety, and their ability to process their traumatic experiences for good.

Acute Medical Assistance

Even though there is a recommendation for how to proceed during a post-sexual assault examination, or how to collect samples for future use in potential prosecution, professional organizations such as Česká lékařská komora (Czech Medical Chamber; ČLK) or Česká gynekologická a porodnická společnost (Czech Gynecological and Obstetrical Society; ČGPS) do not state them in their procedures, and therefore, they cannot recommend them to their members.

In response to a direct question of how patients who were sexually assaulted are to be treated in healthcare institutions, ČLK states (Mach, 2019, personal communication):

- "Every medical practitioner is required to provide **urgent** care for a patient consisting of first aid, if life or health is **in serious danger**, for example when a patient is significantly bleeding.

- If an ambulatory healthcare provider in gynecology realizes they are **not sufficiently equipped** to examine a sexual violence crime victim, they can recommend to the patient to seek an examination in a gynecology and obstetrics department in their hospital.

- By law, they are also entitled to refuse to provide non-urgent care if their capacity is full.

- According to Act No. 48/1997 Sb., about public health insurance providers, and its subsequent amendments, health insurance providers have an obligation to **guarantee health care and medical services** to those insured. Therefore, if a patient does not succeed in finding medical assistance in a given specialty, they are required to ensure they get the medical service they need."

By contrast, ČGPS states (Velebil, 2019, personal communication):

- „There is no statewide recommendation for how to proceed during a post-sexual assault/rape examination.
- There is no time limit for proceeding with the examination, the examination is carried out upon request from law enforcement authorities.
- There is no list of gynecological departments or medical professionals capable of storing biological materials."

Inspiration from Norway

In comparison to Norway, where proFem drew some inspiration as to how to develop services for sexual violence victims in the future, currently, in the Czech Republic, the services for sexual violence victims are absolutely insufficient. In Norway, there is a network of centers for sexual violence victims across the whole country and many of them are 24/7, including a crisis hotline. Most of these centers provide or arrange subsequent care in the form of psychotherapy, all of them provide self-help or therapist-led group psychotherapy. Apart from these centers, there are crisis centers near medical facilities that serve to recognize and assist victims in the post-assault acute phase. There they receive psychological support, physical injury treatment, as well as acquire evidence by having their samples collected and stored for up to 6 months. This gives them the opportunity (and enough time) to decide whether they want to file criminal charges.

Conclusion

As described above, the Czech Republic fails to adequately support and care for victims of sexual violence. It is essential to create services oriented specifically at sexual violence victims, and it should be a priority when considering creating networks of social services in all regions of the Czech Republic. The first steps should be - creating nonstop crisis hotlines and gradually creating centers that would be safe spaces for all sexual violence victims, no matter whether they choose to press criminal charges (and they need to have evidence secured and stored for subsequent criminal proceedings, as well as basic medical treatment) or they just need support and help with dealing with their traumatic experience and leading a full life.

References

Bílý kruh bezpečí. (nedatováno). *Úvod.* [online]. [cit. 12.11.2019]. Dostupné z: <https://www.bkb.cz/>.

Dětské krizové centrum. (nedatováno). *Dětské krizové centrum*. [online]. [cit. 12.11.2019]. Dostupné z: < https://www.ditekrize.cz/o-detskem-krizovem-centru/>.

Konsent. (nedatováno). *O nás.* [online]. [cit. 12.11.2019]. Dostupné z: <https://konsent.cz/o-nas-2/>.

Mach, J. *Odpověď na dotaz ze dne 12. srpna 2019, týkající se povinnosti lékařů oboru gynekologie vyšetřit pacientku, která byla obětí trestného činu znásilnění.* [elektronická pošta]. Message to: simona.simickova@profem.cz. 4.9.2019. [cit. 12.11.2019]. Osobní komunikace.

Persefona. (nedatováno). *O Persefoně* [online]. [cit. 12.11.2019]. Dostupné z: <https://www.persefona.cz/o-nas>.

SASA – Sexual Assault Survivors Anonymous (nedatováno). O nás [online]. [cit. 12.11.2019]. Dostupné z: <https://sasa.obetiznasilneni.cz/cz/o-nas>.

Velebil, P. *Dotaz na specifické kompetence a praxi gynekologů.* [elektronická pošta]. Message to: lidka.brichcinova@profem.cz. 11.10.2019. [cit. 12.11.2019]. Osobní komunikace.

Transgenerational Trauma Transmission

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About the Author

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Summary

Using examples from several analyses and researches focusing on holocaust survivors and their next generations, this paper illustrates intergenerational trauma transmission theory which can be used for apprehending the consequences and links in other traumatic experiences – for example, sexual violence. The text answers the question of whether a traumatic experience tends to bring disorders and difficulties, or rather the mobilization of individual's abilities and resiliency. It also introduces terms such as conspiracy of silence or cut-off. At the end of the text, it introduces a transgenerational transmission model as a tool or a framework for understanding and explaining the complex phenomenon of transgenerational transmission of trauma.

Introduction

During World War Two sexual violence reached mass levels. There was sexual violence when the German Army advanced to the Eastern Front, and when the Soviet Army advanced to Berlin and elsewhere. Questions associated with the transmission of these traumas and trauma in general are the axis of this short text which is based on chapters for a new book

Transgenerační přenos (nejen) holocaustu (Transgenerational transmission of [not only] holocaust).

Trauma – Mobilizing Resilience or Causing Inconvenience?

The basic question is – does trauma bring disorders, malfunction, and difficulties, or does it mobilize abilities and resilience. There is one group of research that claims that the second generation of holocaust survivors is healthy, however, in contrast to others, they do have mental health issues. Israeli studies show that overall functioning and dealing with stress in the second generation corresponds to the control sample, however, at the same time, it is clear that in certain circumstances the second generation functions differently and there is a stronger tendency to be traumatized by war conflict (Solomon, 1998). Good over-all functioning and dealing with stress is great news – most of the previous research was made of clinical studies on psychopathology, and therefore, it might have created a more pessimistic image than generalized studies. As Coles (2011) summarizes: "From the therapeutic work that has been done with survivors and their children and grandchildren, we get a clearer idea that adults may unconsciously and unwittingly traumatize their infants through the anxieties that they project on to their children".

Transgenerational Transmission of Trauma Impacts

Recently, epigenetics uncovers some things that sensitive psychotherapists have known for a long time. Peter Teuschel (2007) states when discussing a transgenerational case study: "at the beginning of Vanessa's therapy we had trouble finding anything of substance when we were trying to relate her symptoms to her biography"; elsewhere he states: "…she sat before me *(a female client)* like an heiress inheriting the experience of victims, and I sat opposite her as an heir inheriting the experience of the perpetrator … historical responsibility for history, mostly proclaimed by politics, became a living experience in therapy setting"; yet elsewhere he writes: "… Exactly when examining mental disorders in women and men of the post-war generation … we should create an overview of transgenerationally transmitted feelings of shame and guilt " (str. 176).

Framework for Understanding Transgenerational Transmission

Model for transgenerational transmission – multidimensional, multidisciplinary, integrative framework (Trauma and the Continuity of Self: A Multidimensional, Multidisciplinary Integrative Framework; TCMI; Danieli, 1998) should serve as an antidote against reductionist impulses trying to find a simple explanation for a complex phenomenon. A difficult situation impacts an individual who is interconnected with small and big groups. According to Danieli, to experience trauma means to experience injury, disturbance, feeling of getting stuck,

fixation. The scope and duration of trauma can be captured by the term conspiracy of silence or the effort to "cut off" the past. This may impact individual's vulnerability and increase their tendency to re-traumatization in the future; it may also increase their resilience against stressors. Integrating trauma concerns not only the individual themselves but also a wider social circle around them. With time, the scar may become smaller, pale, or heal.

Conclusion

Self-assessment is one piece of the puzzle in trying to understand the intergenerational transmission of trauma. However, knowing that psychotherapists accentuate uncommunicated, unverbalized, and unconscious displays, we cannot immediately deny the existence of transgenerational transmission of trauma "en bloc". In contrast to opinions based on above mentioned meta-analyses saying that transgenerational transmission does not exist, there are statements from clinical psychologists, e.g.: "trauma transmissions are always transgenerational in multiply determined and nonlinear ways" (Salberg, 2015, p. 80), or: „many survivors have – in good faith – tied their children – the second generation – to uncommunicated contents of their souls as if they were existential riddles" (Klímová, 2014, p. 33). It is apparent that transmission of trauma – owing to its complexity and obscurity – will remain an interesting and inspiring topic for psychotherapists and clinical psychologists.

References

Coles, P. (2011). *The uninvited guest from the unremembered past. An exploration of the unconscious transmission of trauma across the generation*. London: Karnac Books.

Danieli, Y. (Ed.) (1998). *International handbook of multigenerational legacies of trauma*. New York, NY: Plenum Press.

Klímová, H. (2014). *Rodina a trauma*. Praha: Irene Press.

Salberg, J. (2017). The texture of traumatic attachment: Presence and ghostly absence in transgenerational transmission. In J. Salberg & S. Grand (Eds.), *Wounds of history: Repair and resilience in the trans-generational transmission of trauma* (pp. 77-99). New York, NY: Routledge/Taylor & Francis Group.

Solomon, Z. (1998). Transgenerational effects of the holocaust. The Israeli Research Perspective. In: Y. Danieli (Ed.), *International handbook of multigenerational legacies of trauma* (pp. 69-83). New York, NY: Plenum Press.

Teuschel, P. (2007). *Tajemství předků - Transgenerační přenos jako výzva a šance*. Praha: Portál.