Sexual assault: An overview and implications for counselling support

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REVIEW

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Abstract

Sexual Assault (SA) is a major public health and pervasive social problem that transcends socio-cultural bounds; with myriad bio-psychosocial effects on victims/survivors and the wider community. Indeed, survivors of SA suffer the effects of assault for a lifetime. A key aspect for practitioners working with individuals, families and communities affected by SA is to understand the background, nature and extent of the problem; as well as important medicolegal considerations and support services.

Key Words

Sexual assault, rape, counselling.

Introduction

SA is a pervasive global problem with myriad health repercussions. It involves various forms of non-consensual sexual contact that transpire across all societies and cultural groups.¹⁻⁵ Although accurate research on SA has been limited by under-reporting and inconsistencies surrounding the operationalisation of SA, it is estimated that approximately 13% of women and 3% of men worldwide, experience SA^{7,8}, with profound effects on physical and psychological health.^{4,8}

SA has been described as a human rights and social justice problem that violates various international human rights

standards by the discrimination of its victims, and the sequelae of physical and psychological injury that succeed the crime.^{1, 2, 5} The Declaration on the Elimination of Violence Against Women recognises that SA is:

a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of the full advancement of women, and that violence against women is one of the crucial social mechanism by which women are forced into a subordinate position compared to men. (° p.1)

Accordingly, it is suggested that sociocultural norms and sexist policies and practices that disallow women equal rights with men, legitimise and sexualise violence against men for individual gratification and political means.⁵ This renders women more vulnerable to SA by denying them effective alternatives, and forcing them to remain in violent situations.

Consequently, SA is more visible in male-dominant societies, where masculine ideologies emphasise dominance, physical strength, honour and superiority over women.¹⁰ Nonetheless, the historical perception of men as sexually aggressive and women as sexually passive in attitude and behaviour, is widespread in most societies.^{4,5,11} Such perceptions contribute largely to the manifestation and perpetuation of victim-blaming myths about SA, by the way they become harmfully engrained in social norm, custom and law; placing blame on survivors while minimising the seriousness of the crime and responsibility of the perpetrator. Hence, many survivorsⁱ of SA, experience stigma and ostracism from their family

ⁱ The terms 'victim' and 'survivor' are used differently throughout this paper. The term 'victim' is a statement of fact from a legal stance (i.e. the person is a victim of crime¹⁴); but owing to its connotations of powerlessness, the term 'survivor' is used to emphasise strength and capacity for survival. The present paper aims to use the terms according, except in situations where ease of reading attracts the use of the term 'victim/survivor'.

and the wider community, creating various barriers to disclosing SA.¹²

Consequently, SA survivors often present unexpectedly across various health institutions, making it important for practitioners to have knowledge of SA, and; its subsequent socio-legal, psychosocial and physiological effects.^{3, 7, 13} Such knowledge is an essential part of optimal healthcare for survivors. It not only ensures the adequate identification and assessment of SA, but that survivors are treated with respect, provided with accurate information to assist in their decision of whether or not to make a police report, and are provided appropriate medical, psychological and social support.

Defining SA

To understand the myriad effects of SA, it is first important to operationally define the problem, so as to avoid difficulties in identification which arise from narrow definitions and esoteric labels.³ Despite attempts to delineate types of SA in the literature, the most common theme in widely-accepted definitions is the occurrence of non-consensual sexual contact from one human being to another. Certainly, terms such as “rape”, “sexual abuse” and “sexual violence” have been increasingly considered synonymous and interchangeable.⁵ As such, the World Health Organization has defined SA as:

any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work. (¹⁰ p. 149)

For the purposes of legal taxonomy, SA includes rape, but ‘rape’ is more specifically defined as:

physically forced or otherwise coerced penetration – even if slight – of the vulva or anus, using a penis, other body parts or an object. (¹⁰ p. 149)

Thus, according to this definition, SA may take many forms and manifest under varying circumstances. For example, a person may be sexually assaulted by a person of any age, sex/gender; as well as by one or several individuals (e.g. gang-rape). Additionally, SA may take place in any setting, including the home, workplace, school, prison, open spaces and in vehicles. The perpetrator may be of any or no relationship to the victim, including a date, acquaintance, friend, family member, intimate partner, former intimate partner, colleague, authority figure or stranger. Other forms of SA may include, but are not limited to:

- *rape within marriage or dating relationships;*
- *rape by strangers;*
- *systematic rape during armed conflict;*
- *unwanted sexual advances or sexual harassment, including demanding sex in return for favours;*
- *sexual abuse of mentally or physically disabled people;*
- *sexual abuse of children;*
- *forced marriage or cohabitation, including the marriage of children;*
- *denial of the right to use contraception or to adopt other measures to protect against sexually transmitted diseases;*
- *forced abortion;*
- *violent acts against the sexual integrity of women, including female genital mutilation and obligatory inspections for virginity;*
- *forced prostitution and trafficking of people for the purpose of sexual exploitation. (⁴ p. 149-50)*

To understand SA, it is also important to comprehend ‘coercion’ as it affects victim/survivors granting free and voluntary consent. Specifically, an individual may be coerced into SA through:

threats of physical violence, threats of withholding benefits (such as a promotion at work or a good grade), psychological pressure or blackmail. Agreement in such circumstances does not amount to freely given consent. The same is true in cases of sexual acts involving individuals who are unable to give consent, that is to say, individuals who are not capable of understanding the significance of the act or of indicating their consent or refusal (e.g. those who are incapacitated due to the effects of alcohol and/or drugs, or those with a mental disability); such acts would also be described as nonconsensual. (¹⁰ p. 6)

Despite collective understandings of what constitutes SA, these terms often have different meanings and implications across situations and locales; most significantly between legal, medical, social, national and provincial definitions.¹⁰ Accordingly, it is important for practitioners to be aware of the legal definitions of SA within their own jurisdiction.

The extent of SA

Despite the ubiquity of SA, prevalence statistics are often limited by biased reports (e.g. hospitals only reporting violent rape¹²), and; disclosure issues plaguing survivors of SA, including: retribution from the assailant,

mistreatment by police, stigma, guilt and a desire to forget the event.^{7,8,15,16}

There is a consensus in the literature that the majority of SA victims are female, and most perpetrators are male and know their victims.¹⁷⁻¹⁹ Nevertheless, researchers have also identified SA toward males as a growing issue.²⁰ Australian criminology records indicate that in 2006, the victim was female in 84% of recorded SAs, with 66% occurring in dwellings.²¹ It was also reported that 40% and 47% of SAs were perpetrated by a family member for females and males respectively; while 38% of offences were perpetrated by a non-family member known to the victim. A growing number of studies across various countries have also indicated that up to one-third of women indicate that their first sexual experience was unwanted and forced.¹⁰

In many countries, a considerable proportion of women who experience physical violence, also experience SA. Indeed, population-based studies of Intimate Partner Violence (IPV) indicate that 6–46% of women report experiences with attempted or completed rape by an intimate or ex-partner in their lives.^{10, 22} It is further reported that rape and IPV account for 5–16% of lives lost to women of reproductive age.²³ With regards to SA against children from surveys of adult survivors, estimates indicate that 7–36% of girls, and 3–29% of boys have experienced child SA.⁵

While SA is often perpetrated by people close to the victim/survivor, there are various well-documented manifestations of SA perpetrated by strangers. For example, gang rape is reported across many countries; with US figures indicating that one out of every 10 SAs are perpetrated by two or more individuals.^{24,25} The sexual trafficking of women and children for prostitution is also becoming a growing area of international crime, with estimates indicating that 1–2 million women and children are trafficked each year for sexual exploitation.²⁶ Various studies also indicate that sex workers frequently report instances of physical and SA, particularly in countries where sex work is illegal.^{27,28} SA toward patients in healthcare facilities is also widely reported, spanning: sexual offences toward patients; harassment of female nurses, and; the medical practice of clitoridectomy, forced gynaecological exams and abortion, as well as inspections of virginity.¹⁰ SA is also used commonly as a strategy in various armed conflicts, past and present, to threaten community ties and sometimes to 'ethnically cleanse'. Finally, marriage has been documented as an often 'legal' form of SA against women, where children are unable to give or withhold consent, often under feared and forced circumstances.^{29, 30}

Risk factors for SA

One of the most common manifestations of SA is that which occurs by an intimate partner, suggesting that being married or cohabiting with a partner is a risk factor for SA.^{10,31} Women may also be at greater risk of SA as they become more educated and thus empowered. Certainly, Jewkes and colleagues¹⁰ observe that:

The likely explanation is that greater empowerment brings with it more resistance from women to patriarchal norms, so that men may resort to violence in an attempt to regain control. The relationship between empowerment and physical violence is an inverted U-shape – with greater empowerment conferring greater risk up to a certain level, beyond which it starts to become protective. (p. 158).

Similarly, low socioeconomic status is noted to be a risk factor, having an inverse relationship with IPV; of which SA is a subtype.^{10, 22} Low socioeconomic status may also force people into vocations which carry a high risk of SA (e.g. sex work); in addition to creating pressure to acquire or maintain jobs and study, which may place people at risk for SA from individuals who can promise each. Moreover, children from poor families may have less parental supervision from an inability to afford childcare, and:

Poor women and girls may be more at risk of rape in the course of their daily tasks than those who are better off, for example when they walk home on their own from work late at night, or work in the fields or collect firewood alone. (¹⁰ p. 158)

A history of prior SA is also reported as one of the strongest predictors of revictimisation for women^{10,22}, with some victim/survivors frequently engaging in more exaggerated sex role stereotypic behaviours (i.e. submissive behaviours); being closer acquainted with perpetrators³², and; reporting more concern about embarrassment and rejection than prevention of SA.³³

Other well-documented risk factors include younger women and people with psychopathological and physical difficulties, who are reported to be at greater risk for SA owing to increased vulnerabilities, and a diminished likelihood of disclosure.^{22,31} The consumption of alcohol and drugs is another risk factor that may make it more difficult for people to protect against, interpret and act on warning signs of SA; as well as placing people in locales where there is a greater risk of encountering a perpetrator.^{31,34} Finally, having many sexual partners is

another documented risk factor for SA for many people.^{31,34,35}

Consequences of SA

The sequelae following SA are numerous and varied, and can affect a victim/survivor's physical and mental health, and social well-being.^{36,38,39} Individuals experiencing SA report a range of physical injuries, and in extreme cases, death. Non-genital physical injuries typically include:

bruises and contusions; lacerations; ligature marks to ankles, wrists and neck; pattern injuries (i.e. hand prints, finger marks, belt marks, bite marks); anal or rectal trauma. (⁵ p. 13)

Gynaecological complications are also consistently reported in rape, including:

vaginal bleeding or infection, fibroids, decreased sexual desire, genital irritation, pain during intercourse, chronic pelvic pain and urinary tract infections. (¹⁰ p. 162)

Pregnancy may also result from the rape of women, and; has been observed to reduce a woman's ability to see her sexuality as something she has control over, resulting in a reduction in the use of contraceptives and subsequent increase in pregnancy.¹⁰ Moreover, HIV and other sexually transmitted infections (STIs) are recognised as consequences of rape; with survivors assaulted by intimate partners and sex work at highest risk.⁴⁰

SA has also been associated with a variety of psychological complaints³⁶⁻³⁹, including:

rape trauma syndrome...; post-traumatic stress disorder...; depression; social phobias (especially in marital or date rape victims); anxiety; increased substance use or abuse; suicidal behaviour...; chronic headaches; fatigue; sleep disturbances (i.e. nightmares, flashbacks); recurrent nausea; eating disorders; menstrual pain; sexual difficulties. (⁵ p. 13-4)

One of the most widely reported psychological effects of SA in the literature is the experience of Rape Trauma Syndrome³⁶ (RTS); a two-phase syndrome, consisting of acute and long-term responses. Herein, the acute phase is a 'disorganised' phase typified by expressive outward emotions, or; a controlled and calm manner with little outward emotion. The long-term 'reorganisation' phase of RTS commonly involves various lifestyle changes (e.g. change in telephone number and/or residence); as well as the manifestation of nightmares and phobias related to people, crowds and sexual activity.

As well as affecting victim/survivors, Remer and Ferguson⁴¹ note that:

[Sexual] victimization has a ripple effect, spreading the damage in waves out from victims to all those with whom they have intimate contact. (p. 407)

Morrison, Quadara and Boyd⁴² observe that people related to the victim/survivor of SA, such as family members, peers, colleagues or community members, often experience the effects of trauma, sometimes with symptoms similar to the victim/survivor.

Implications for counselling practice

The literature has widely recognised the importance of attending to two important areas when counselling SA survivors: 1) acute post-SA needs, and; 2) the enduring effects of SA.^{7, 37, 39, 43} Regarding acute post-SA care, counsellors may be of great value when assisting with decision-making, and the provision of social support and limited legal information. Poirier³⁹ reports that practitioners working during this period should anticipate RTS and provide appropriate support and encouragement to connect with related external services.

For survivors presenting within 72 hours of experiencing SA, particularly rape, it is noted that decision-making assistance may be offered in assisting the client to report the crime to the police; highlighting the low rate of convictions, but importance of this period for detecting perishable evidence (e.g. spermatozoa and genital injury) which may contribute to a successful prosecution.^{7,39} If a client decides to report SA to the police, counsellors also legally assist by the mandated recording of the client's consent, behavioural and psychological state information, to provide as evidence.⁷ In many parts of the world, counsellors are also required to report incidents of SA to police that involve minors and individuals with cognitive impairment, as each are considered incapable of making accurate decisions regarding their well-being.⁴⁴ Counsellors may also act as advocates for survivors undergoing medicolegal examinations for SA, in the absence of an appointed advocate, family member or partner/friend.⁴⁵ Finally, providing written information about STI, pregnancy and support services is an important counselling service to survivors of SA, especially when clients present in a distressed, disoriented or drug-induced state; all of which may reduce their recollection of information.^{7,39,44,46}

As SA is a frightening and occasionally life-threatening experience, the literature widely advocates the provision

of psychosocial therapy and support services for survivors, and peripherally-affected partners and family.^{7,39,43} In general, psychotherapeutic work involves takes such as: defining and acknowledging SA; assisting in normalising a client's symptoms and experience through psychoeducation (e.g. dispelling rape myths), which may contribute to self-blame, guilt, shame, depression and anxiety; as well as working to increasing client confidence, coping skills and trust in others.^{36,38,39,44,46} Various psychotherapeutic interventions, particularly cognitive-behavioural and feminist therapies, have been documented to be particularly effective in the treatment of psychological, psychosexual and psychosomatic concerns associated with SA.³⁷

The literature also supports the encouragement of screening for STIs and unwanted pregnancy for survivors of rape, as these problems have been reported to be prevalent, even in low frequencies.^{7, 39, 44, 46} In particular, referral to support services such as *"community agencies, volunteer groups, medical and other professionals, rape crisis centers, women's centers, and shelters"* (⁴⁷ p. 53) can provide critical support for survivors. For example:

Often staffed by community volunteers, many of whom are survivors themselves, the [rape crisis] center is usually well-respected by police, medical personnel, and other community groups. Psychologists and other trained mental health professionals sometimes provide pro bono services as supervisors, trainers, consultants, or counselors for special needs clients. Usually working on a sliding scale, these centers provide badly needed self-help and facilitated groups that make it possible for those who do not specifically need psychotherapy to get therapeutic interventions. Often, private therapists can refer their individual therapy clients to one of these groups that then provides adjunct therapeutic intervention. Rape crisis counselors can assist clients in legal situations, medical crises, and location of other resources. (⁴⁷ p. 50-1)

In addition to working with survivors, counsellors may also be involved in work with perpetrators of SA, as well as; contributing to programmes aimed at education to address gender issues and the myriad impacts of SA.¹⁰

Conclusion

SA is acknowledged as a crime stemming from social injustice and inequality, whose recognition has broadened the scope of the crime over the past few decades.⁴⁷ A broader understanding of the nature of SA can assist health practitioners to more effectively recognise and respond to the presenting needs of survivors and their loved ones.

Moreover, with various psychological and physical health consequences following SA, counselling can help survivors experiencing trauma in regaining a sense of control, independence and trust following their experiences; while reducing self-blame, guilt and various related psychological symptoms. The survivor's recovery may be further facilitated when the counsellor utilises cognitive and feminist approaches, psychoeducation and referral to self-help groups during therapy; as well as working closely with related community services aimed at providing specialised support for survivors of this crime.

References

1. Amnesty International USA [homepage on the Internet]. A fact sheet on sexual violence: A human rights violation. 2005 [cited 2011 Jun 7]: [2 p.]. Available from: www.rwlg.org/education/sexualviolence.pdf.
2. Heise LM, Ellsberg M, Gottemoeller M. Ending violence against women. Pop Rep [serial on the Internet]. 1999 [cited 2011 Jun 7]; 27(4): [44 p.]. Available from: <http://www.infoforhealth.org/pr/l11/violence.pdf>.
3. Ballard MB, Alessi HD. Counselling sexual abuse and rape victims. In: Burlew LD, Capuzzi D, editors. Sexuality counseling. New York: Nova Science; 2002: 307-26.
4. Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R. Sexual violence. In Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, editors. World report on violence and health. Geneva, Switzerland: World Health Organization; 2002: 141-81.
5. World Health Organization [homepage on the Internet]. Guidelines for medico-legal care for victims of sexual violence. 2003 [cited 2011 Jun 7]: [154 p.]. Available from: http://www.who.int/violence_injury_prevention/publications/violence/med_leg_guidelines/en/.
6. Mein JK, Palmer CM, Shand MC, Templeton DJ, Parekh V, Mobbs M, Haig K, Huffam SE, Young L. Management of acute adult sexual assault. MJA. 2003; 178(5): 226-30.
7. Spitzberg BH. An analysis of empirical estimates of sexual aggression victimization and perpetration. Violence and Victims. 1999; 14: 241-60.
8. Hurst C, MacDonald J, Say J. Routine questioning about non-consenting sex: a survey of practice in Australasian sexual health clinics. Int J STD AIDS. 2002; 14(5): 329-33.
9. United Nations General Assembly [homepage on the Internet]. Declaration on the Elimination of Violence against Women. 1993 [cited 2011 Jun 7]: [about 6 p.]. Available from: <http://www.un.org/documents/ga/res/48/a48r104.htm>
10. Jewkes R, Garcia-Moreno C, Sen P. Sexual violence. In Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, editors. World report on violence and health. Geneva, Switzerland: World Health Organization; 2002: 147-74.

11. Mollica RF, Son L. Cultural dimensions in the evaluation and treatment of sexual trauma: an overview. *Psy Clin N Am*. 1989; 12: 363–79.
12. Neame A, Heenan M. Responding to sexual assault in rural communities. ACCSA Briefing. 2004 [cited 2011 Jun 7]; 3:[p.1-23]. Available from: http://www.aifs.gov.au/acssa/pubs/briefing/acssa_briefing3.pdf.
13. Sommers MS, Buschur C. Injury in women who are raped: what every critical care nurse needs to know. *DCCN*. 2004; 23(2): 62-8.
14. Yarrow Place Rape and Sexual Assault Service [homepage on the Internet]. Information for students. 2005 [cited 2011 Jun 7]:[41 p.]. Available from: http://www.yarrowplace.sa.gov.au/pdffiles/student_information_booklet_2007.pdf.
15. Crome S. Male survivors of sexual assault and rape. ACSSA Warp. 2006 [cited 2011 Jun 7]; 2:[p. 1-8]. Available from: www.aifs.gov.au/acssa/pubs/wrap/acssa_wrap2.pdf.
16. Waliski A, Herring RD. A study of the community services available for male SA victims. SA Report. 2005 [cited 2011 Jun 7]: 9(2) [8 p.]. Available from: <http://www.aifs.gov.au/acssa/pubs/wrap/w2.html>.
17. Stevens L. A practical approach to gender-based violence: a programme guide for health care providers and managers. NY, United Nations Population Fund; 2001.
18. Tjaden P, Thoennes N. Full report of the prevalence, incidence, and consequences of violence against women: findings from the National Violence Against Women Survey. Washington, DC, Office of Justice Programs, National Institute of Justice. 2000 [cited 2011 Jun 7]:[71 p.]. Available from: www.ncjrs.gov/pdffiles1/nij/183781.pdf.
19. Watts C, Zimmerman C. Violence against women: global scope and magnitude. *Lancet*. 2002; 359: 1232–7.
20. Scarce M, Rubenstein WB. Male on Male Rape: The Hidden Toll of Stigma and Shame. Perseus Publishing; 2001.
21. Australian Institute of Criminology. Australian Crime; Facts and Figures 2005. Canberra, Australia. 2006 [cited 2011 Jun 7]:[about 8 p.]. Available from: <http://www.aic.gov.au/publications/current%20series/facts/1-20/2005/3%20crime%20victimisation.aspx>.
22. Acierno R, Resnick H, Kilpatrick DG, Saunders B, Best CL; Risk factors for rape, physical assault, and post-traumatic stress disorder in women: examination of differential multivariate relationships. *J Anx Dis*. 1999; 13: 541–63.
23. Murray CJL, Lopez AD. (Eds.) The global burden of disease: a comprehensive assessment of mortality and disability from diseases, injuries and risk factors in 1990 and projected to 2020. Geneva, World Health Organization.1996.
24. Doedens W. Clinical management of rape survivors: guide to assist in the development of situation specific protocols. Geneva, World Health Organization. 2001. WHO/RHR/02.08.
25. World Health Organization. Report of the Consultation on Child Abuse Prevention. Geneva, World Health Organization. 1999. WHO/HSC/PVI/99.1.
26. Miko FT, Park G. Trafficking in women and children: The US and international response. Washington, DC: The Library Congress, Congressional Research Service; 2002. RL 30545.
27. Barnard M. Violence and vulnerability: conditions of work for streetworking prostitutes. *Soc Hlth Ill*. 1993; 15: 683-705.
28. Church S, Henderson M, Barnard M, Hart G. Violence by clients towards female prostitutes in different work settings: questionnaire survey. *BMJ* 2001; 322: 524–25.
29. George A. Sexual behavior and sexual negotiation among poor women and men in Mumbai: an exploratory study. Baroda, Sahaj Society for Health Alternatives; 1997.
30. Sharma V, Sujay R, Sharma A. Can married women say no to sex? Repercussions of the denial of the sexual act. *J Fam Welfare*. 1998; 44(1): 1-8.
31. Sochting I, Fairbrother N, Koch WJ. Sexual assault of women: prevention efforts and risk factors. *Viol Aga Women*. 2004; 10(1): 73-93.
32. Knowles KB. Sexual revictimization: a comparison of single incident versus recidivistic rape victims on symptom severity, definitions, attributions, coping strategies, and precautionary behaviors. *Diss Abs Int*. 1993; 53(8): 4376B.
33. Norris J, Nurius PS, Dimeff, LA. Through her eyes: Factors affecting women's perception of and resistance to acquaintance sexual aggression threat. *Psy Wom Q*. 1996; 20: 123-45.
34. Crowell NA, Burgess AW, editors. Understanding violence against women. Washington, DC, National Academy Press; 1996.
35. Fergusson DM, Horwood LJ, Lynskey MT. Childhood sexual abuse, adolescent sexual behaviours and sexual revictimization. *Child Abuse Negl*. 1997; 21(8): 789–803.
36. Burgess AW, Holmstrom LL. Rape trauma syndrome. *Am J Psychiatry*. 1974; 131(9): 981-86.
37. Astbury J. Services for victim/survivors of sexual assault: Identifying needs, interventions and provision of services in Australia. *Aus Inst Fam Studies*. 2007; 6 [cited 2011 Jun 7]: [about 11 p.]. Available from: <http://www.aifs.gov.au/acssa/pubs/issue/i6.html>
38. Jones JL, Whitworth JM. Emergency evaluation and treatment of the sexual assault victim. *Top Emerg Med*. 2002; 24(4): 47-61.

39. Poirier M. Care of the female adolescent rape victim. *Pediatr Emerg Care*. 2002; 18(1): 53-9.
40. Lamba, H. & Murphy, S.M. (2000). Sexual assault and sexually transmitted infections: An updated review. *International Journal of STD & AIDS*;11: 487-491.
41. Remer R, Ferguson RA. Becoming a secondary survivor of sexual assault. *J Coun Dev*. 1995; 73(4): 407-13.
42. Morrison Z, Quadara A, Boyd C. "Ripple effects" of sexual assault. *Aus Inst Fam Studies*. 2007; 7 [cited 2011 Jun 7]: [about 12 p.]. Available from: <http://www.aifs.gov.au/acssa/pubs/issue/i7.html>
43. Tomlinson DR, Harrison J. The management of adult male victims of sexual assault in the GUM clinic: a practical guide. *Int J STD AIDS*. 1998; 9: 720-5.
44. McConkey TE, Sole ML, Holcomb L. Assessing the female sexual assault survivor. *Nurs Pract*. 2001; 26: 28-30, 33-34, 37-39.
45. Edwards JR, Milinkovic-Balog D. Ch 41: Sexual assault. In: Sherry E, Trieu L, Templeton L, editors. *Trauma*. Oxford: Oxford University Press; 2003.
46. DeLahunta EA, Baram DA. Sexual assault. *Clin Obstet Gynecol*. 1997; 40: 648-660.
47. Walker LEA, editor. Rape and Sexual Assault. In: *Abused women and survivor therapy: A practical guide for the psychotherapist*. Washington, DC, US: American Psychological Association. 1994: 23-53.

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