British Journal of Psychology Research
Vol.7, No.4, pp. 1-11, August 2019
Published by European Centre for Research Training and Development UK (www.eajournals.org)

PSYCHOLOGICAL EFFECTS OF RAPE: EXPERIENCES FROM SURVIVORS ATTENDING SELECTED POST-RAPE CARE CENTRES IN KENYA

Lucy Jemutai Kibet
Kenyatta University

ABSTRACT: *Rape leads to long lasting physical, psychological, sexual and reproductive health effects on rape survivors which need to be addressed at post-rape care centres. Although there are studies conducted on the prevalence of rape in Kenya, there is limited information on the effectiveness of psychological interventions provided to rape survivors in the existing post-rape care centres. Therefore, the study sought to ascertain the psychological effect of rape on survivors in selected post-rape care centres in Nairobi and Uasin-Gishu Counties in Kenya. The study was guided by the Crisis theory by Caplan. The study utilized a descriptive survey research design. The target population were rape survivors aged between 10-45 years who had attended at least three psychological interventions while the key informants were the counsellors in these centres. Purposive sampling was used to obtain a sample of 44 rape survivors and 9 key informants from the two selected post-rape care centres. Consent forms were issued to the adult participants (18 years and above) to sign. The participants (10-17 years) were given assent forms after they were made to understand about the purpose of the research in the presence of their parents or guardians. The data was collected by use of structured questionnaires developed by the researcher. The researcher assisted the primary school children and illiterate participants through Swahili translation of items in the questionnaire. The data collected was analysed using simple descriptive and inferential statistics. Majority of participants, 73%, were female while 27% were male. Moreover, 72.7% of the participants were aged between 10 and 17 years while 27.3% were above 18 years. The psychological effects experienced by all (100%) rape survivors were: sadness, anxiety, revengeful feelings, difficulty in sleeping, experiencing terrifying dreams, avoiding people, experiencing feelings of being re-raped, feelings of intense fear, feelings of stigma and bitterness. This study recommends that implementers should put emphasis on: adequate provision of legal services, follow-up, family counselling, outreach services, community sensitization, adequate financial support to create more post-rape care centres, expansion of the existing centres, hiring more skilled counsellors and enhancing continuous professional development.*
KEYWORDS: psychological effects, rape, survivors, post-rape care centres, Kenya

INTRODUCTION

The need to protect the dignity of every person has been emphasized the world over. One of the threats to such dignity has been that posed by sexual violence directed at a person. There are varying definitions of sexual violence. The WHO (2002) defines sexual violence 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 relationships to the victim, in any setting, including but not limited to home and work”. Sexual

Print ISSN: 2055-0863(Print), Online ISSN: 2055-0871(Online)

violence takes many forms, one of which is rape. According to Krug, Dalhberg, Mercy, Zwi and Lozano (2002), rape is any physical, psychological, forceful act, unwanted comments or advances attempted to obtain sexual act, by another person, regardless of existing relationships with the victim, in any place.

According to Jewkes, Sen and Garcia-Moreno (2002), rape is any physical forced penetration, of the vulva or anus, using an object, penis, or other body parts. There is evidence that rape is experienced worldwide. For instance statistics show that one out of three women worldwide has experienced rape (Keesbury & Askew, 2010). In the United States of America, one among every six American women has been a victim of rape during their life time (WHO, 2005). Similarly, in the same report of WHO (2005), in Europe, Sweden was reported to have the highest rate of rape incidences.

In Africa, rape has been a common problem. Statistics suggest that the Democratic Republic of Congo bears the burden of the problem with about 2,000,000 rape survivors with women being victimized at the rate of one in every minute (American Foundation for AIDS Research, 2005). Similarly, it was reported that 47% in Zambia and 59% in Ethiopia females have experienced rape (Keesbury & Askew, 2010). Closer home, in East and Central Africa, rape incidences have been widely reported. According to a multi-country study by Maternowska, Keesbury and Kilonzo (2009), in East Africa 59% of women had experienced rape.

Kenya has not been spared from the incidences of rape either. Cases of rape are increasing at an alarming rate in the Kenyan society (Onyango-Ouma, Ndung'u, Barasa & Birungi, 2009). Rape occurs every half an hour in Kenya (Onyango-Ouma *et al*., 2009; Gender Violence Recovery Centre, 2008). While women and girls are the most affected by rape, they are not the only ones who suffer. Boys form another large proportion of rape survivors while adult men and the handicapped are minority groups who have also been affected but are often neglected in research and interventions (Interagency Gender Working Group, 2006).

According to Nairobi Women Hospital (Gender Violence Recovery Centre, 2008), the cases of rape doubled during the days of post-election violence. This high prevalence of rape reported in Nairobi Women Hospital was similar to the findings of situational analysis carried out in Moi Teaching and Referral hospital (Ranney *et al.,* 2008). In a nutshell evidences reveal that rape is a global issue that affects all people of all age groups in both developed and developing countries. However, the studies reveal that the prevalence of rape has been high during political conflicts among women and children. Rape leads to negative physical, sexual and reproductive health and psychological effects on the survivor (Keesbury *et al.*, 2011).

Psychological Effects of Rape on Rape Survivors

Rape has been defined as a medical emergency, which destroys the lives of children, women and men. It destroys families and damages the community (Medical Research Council, 2009). According to Burgess and Holmstrom (2001), rape violates an individual's rights. It can lead to profound negative physical, psychological, sexual and reproductive health effects on the survivor (Keesbury *et al.,* 2011). Rape survivors can suffer from a number of short- and long-term psychological effects. The immediate psychological effects includes but not limited to; feelings of

Print ISSN: 2055-0863(Print), Online ISSN: 2055-0871(Online)

helplessness, self-blame, high levels of anxiety, intense fear, confusion, shock, and numbness (Vickerman & Margolin, 2009). Some of the common long-term psychological effects of rape are PTSD, phobias, anxiety, sexual dysfunction, alcohol and drug abuse, high risk sexual behaviours, and depression (Stratham *et al.*, 1998).

According to Rees *et al.* (2011), in a study among 4,451 Australian women aged between 16 and 85 who had a history of violence, rape survivors have severe psychological effects throughout their lives. These survivors were found to have mental and physical challenges, decreased quality of life and took increased days off work. Similarly, Coid, Petruckevitch, Chung, Richardson, Moorey and Feder (2003) found that women who experienced rape in childhood were five times diagnosed with PTSD in comparison to non-victims.

Rape survivors are also more likely to suffer from depression, suicide, and other mental health problems. The rate of lifetime depression among childhood rape survivors were higher at 52% compared to 27% among non-victims (Saunders, Kilpatrick, Hanson, Resick & Walker, 1999). A separate investigation showed that childhood rape was associated with an increased risk of a serious suicide even after accounting for the effects of previous psychological problems in a twin's history of suicidal behaviours (Stratham *et al.*, 1998). Survivors of childhood rape have also been shown to be at greater risk of eating disorders and problem of alcohol use later in life (Galaif, Stein, Newcomb & Bernstein, 2001).

Research on depression has produced mixed findings. Some researchers have found no association between depression and adulthood sexual victimization (Coid *et al.*, 2003). Others have found high rates of depressive disorders among rape survivors. A study by Stratham *et al.* (1998) found associations between rape, suicidal behaviours and alcohol and drug use, however, these effects varied by specific type of rape (Coid *et al.*, 2003). Psychological effects typically increase in severity over the first three weeks before a progressive decline over the next three months. For many survivors, these feelings would resolve themselves within this period. However, for others, effects continued far longer and of those who developed PTSD at three months, half still suffered the condition. In a study by Kilpatrick, Resick and Veronen (1981) adult rape survivors were found to experience confusion, anxiety, and fear for one year after rape. High levels of anxiety and fear as well as clients still meeting PTSD diagnostic criteria have been found up to 16 years after the event (Ellis, Atkenson & Calhoum, 1981).

Ongoing research attention to mental health outcomes has also been driven by evidence that survivors' responses are largely complex and unique to each individual (Briere & Jordan, 2004). Some individuals experience severe psychological effects or long-term distress, whereas others do not. The diversity in outcomes could be attributed to characteristics of the violent acts, survivor attributes, environmental conditions, and availability of social support and resources (Cohen & Roth, 1987). The literature reviewed above suggests that effects of rape could be long lasting among rape survivors. Therefore, there was need to establish the psychological effects of rape on survivors in post-rape care centres in Kenya.

Print ISSN: 2055-0863(Print), Online ISSN: 2055-0871(Online)

Statement of the Problem

Incidences of rape have been increasing at an alarming rate in the Kenyan society. This is supported by many studies carried on the prevalence of rape which found that rape occurs every half an hour in Kenya (Gender Violence Recovery, 2008; Onyango-Ouma *et al.*, 2009). Despite the high prevalence of rape in Kenya, rape has received insufficient attention from service designers, policy-makers and researchers to recognise that rape causes long lasting psychological harm (Maternowska, Keesbury & Kilonzo, 2009). The WHO (2004) recognizes the need to strengthen the quality of services offered to rape survivors. There is evidence that psychological interventions play a role in psychological recovery of rape survivors. Comprehensive high quality post-rape care services have been found to hasten the rate of reduction of psychological effects of rape on survivors (Keesbury *et al.*, 2011; Keesbury & Askew, 2010). Therefore, the question arises as to whether the psychological interventions provided at post-rape care centres in Kenya are effective. There have been many studies on effectiveness of psychological interventions provided to rape survivors done in USA, Europe and Australia (Jaycox, Zoellner & Foa, 2002), but very little has been done in Africa. In Kenya few studies have been carried out on the effectiveness of psychological interventions provided to rape survivors at post-rape care centres. This prompted the researcher to undertake this study to ascertain the psychological effect of rape as a means of determining the best interventions for survivors in selected post-rape centres in Kenya.

MATERIALS AND METHODS

The study utilized a descriptive research design which combined both qualitative and quantitative approaches. The research design was appropriate for the study as the researcher described the mean scores and the significance of associations and significant differences between the various variables and groups. The independent variables were the psychological interventions while the dependent variables were the psychological effects. The study was carried out in post-rape care centres, namely Nairobi Women Hospital (NWH) in the Nairobi County and the Moi Teaching and Referral Hospital (MTRH), in Uasin-Gishu County both in Kenya. The Nairobi Women Hospital was founded in 2001 and the first of its kind in the East and Central Africa region, which focuses on women and children's health care and also attend to male rape survivors. MTRH is the second largest referral hospital in Kenya which serves as a referral for the Western region of the country. The post-rape care centre at MTRH called Centre for Assault Recovery Eldoret (CAR-E) was established in 2007. Purposive sampling was used to select the two counties of Nairobi and Uasin-Gishu. These two post-rape care centres were purposively sampled because they are among the well-established centres in Kenya that received relatively large number of rape survivors compared to other centres in the country.

The target population were rape survivors aged 10-45 years and key informants were psychological counsellors at the selected post-rape care centres. According to health records statistics in the two selected centres, Nairobi Women Hospital received an average of two hundred and thirty rape survivors monthly while sixty rape survivors attended Moi Teaching and Referral Hospital (Said, Awori & Odula, 2008). Therefore, a total number of two hundred and ninety rape survivors constituted the target population. The target population of this study were rape survivors who had attended at least three psychological intervention sessions in Nairobi Women Hospital and Moi Teaching and Referral Hospital post-rape care centres. This study population of rape survivors

Print ISSN: 2055-0863(Print), Online ISSN: 2055-0871(Online)

comprised those able to understand and communicate clearly and therefore severely mentally challenged rape survivors were excluded in the sample

New rape survivors (those rape survivors who had received less than three psychological interventions sessions) were excluded in the target population because they would not be able to assess the effectiveness of psychological services provided to post rape survivors. This was because the new rape survivors had received few psychological interventions provided to them and therefore might have experienced insignificant reduction of psychological effects. Purposive sampling was used at the two selected centres to achieve a sample size of 44 participants. This sample was 20% of the total population of two hundred and ninety which is in accordance to the minimum acceptable sample for a survey of a small population (Gay, 1992). In addition, nine psychological counsellors who attended to rape survivors at the selected post-rape care centres in Kenya were key informants who also provided information that complemented that which was to be obtained from the rape survivors.

The research instruments for this study were researcher's developed structured questionnaires. The first research instrument was a questionnaire to be completed by the rape survivors who were minors aged ten to seventeen (10-17) years while the second research instrument was a questionnaire to be completed by those aged eighteen to forty five (18-45) years. Key informants who were the psychological counsellors completed the third instrument. The respondents who agreed and came on the appointment date were assured of confidentiality and explained the nature of research and allowed to ask any questions for clarity. They then signed an already prepared written consent to take part in the study from each of the two research site. After the research instruments had been administered to the respondents by the researcher, gathered data from the questionnaires in both quantitative and qualitative forms were generated. The quantitative data obtained were edited, coded, tabulated, analysed and summarized using descriptive statistics such as means, frequencies and percentages. This was aided by Statistical Package for Social Sciences (SPSS) version 9.X. The qualitative data on the other hand was collected, recorded, and analysed thematically.

RESULTS

The study sought to investigate the psychological effects of rape on survivors. A list of psychological effects commonly experienced by rape survivors according to literature was provided. Participants were required to tick from the list psychological effects that they may have experienced as well as add any other. Table 1 below indicates the frequency and percentage of respondents who experienced each psychological effect.

Print ISSN: 2055-0863(Print), Online ISSN: 2055-0871(Online)

Table 1: Frequency of Psychological Effects Experienced

Effect	Frequency	Percent
Shock	43	97.7
Numbness	9	20.5
Embarrassment	43	97.7
Sadness	44	100.0
Anxiety	44	100.0
Anger	41	93.2
Trusting people	29	65.9
Denial	24	54.5
Feeling of worthlessness	43	97.7
Revengeful feelings	44	100.0
Difficulty in sleeping	44	100.0
Experiencing terrifying dreams	44	100.0
Avoiding people	44	100.0
Experiencing feelings of being re-raped	44	100.0
Feelings of intense fear	44	100.0
Feelings of stigma	44	100.0
Guilty feelings	43	97.7
Loss of appetite	43	97.7
Unable to control myself	43	97.7
Pains	41	93.2
Hate towards others	42	95.5
Bitterness	44	100.0
Insecurity	42	95.5
Irritability	33	75.0
Physical illness	28	63.6
Mental instability	26	59.1
Relations difficulties	36	81.8
Helplessness	43	97.7
Hopelessness	41	93.2
Difficulties functioning sexually	6	13.6
Multiple sexual partners	7	15.9

The findings in Table 1 show that psychological effects experienced by all (100%) of rape survivors include sadness, anxiety, revengeful feelings, difficulty in sleeping, experiencing terrifying dreams, avoiding people, experiencing feelings of being re-raped, feelings of intense fear, feelings of stigma and bitterness. The least commonly experienced psychological effects were difficulties functioning sexually (13.6%), having multiple sexual partners (15.9%) and numbness (20.5%).

The participants were also asked to indicate the severity of the psychological effects of rape experienced, using a Likert scale where very low = 1, low = 2, moderate = 3, high = 4 and very high =5. A score of 1 indicated least severe while a score of 5 most severe. The means of each psychological effect was calculated. The findings were as shown in Table 2 below.

Print ISSN: 2055-0863(Print), Online ISSN: 2055-0871(Online)

Table 2: Severity of Psychological Effects Experienced

Effect	Mean Severity of Psychological Effect
Hopelessness	4.8
Helplessness	4.8
Bitterness	4.8
Feeling of worthlessness	4.7
Feelings of intense fear	4.7
Pains	4.7
Hate towards others	4.7
Feelings of stigma	4.6
Embarrassment	4.6
Shock	4.6
Unable to control myself	4.5
Guilty feelings	4.5
Experiencing terrifying dreams	4.5
Revengeful feelings	4.4
Anxiety	4.4
Difficulty in sleeping	4.3
Sadness	4.3
Loss of appetite	4.3
Insecurity	4.0
Experiencing feelings of being re-raped	3.9
Avoiding people	3.8
Anger	3.6
Relations difficulties	3.5
Irritability	3.3
Physical illness	3.0
Mental instability	2.6
Denial	2.4
Trusting people	1.5
Numbness	0.8
Difficulties functioning sexually	0.7
Multiple sexual partners	0.7

As shown in Table 2 above, bitterness, helplessness and hopelessness were the most severe psychological effects experienced with a mean of (4.8), followed by feelings of worthlessness, intense fear, pains and hatred towards others all with a mean of (4.7). Difficulties functioning sexually and multiple partners (0.7) were the least severe psychological effects experienced because these effects only applicable to adults who were the minority in this study.

DISCUSSION

The study sought to investigate the psychological effects of rape on survivors attending selected post-rape care centres in Kenya. The research findings revealed that psychological effects which

Print ISSN: 2055-0863(Print), Online ISSN: 2055-0871(Online)

all (100%) the rape survivors experienced were: sadness, anxiety, revengeful feelings, difficulty in sleeping, experiencing terrifying dreams, avoiding people, experiencing feelings of being re-raped, feelings of intense fear, feelings of stigma and bitterness. The other psychological effects that were also experienced by a large number (97.7%) of rape survivors were shock, embarrassment, feelings of worthlessness, guilt feelings, loss of appetite, unable to control self and helplessness.

The findings of this study agreed with those of Vickerman and Margolin (2009) and Kilpatrick, Resick and Veronen (1981) who carried out a study on rape treatment outcomes and found that majority of rape survivors experienced the following psychological effects: numbness, confusion, feelings of helplessness, denial, self-blame, fear, hyper-arousal and high levels of anxiety. These findings imply that there is need to identify psychological effects of rape on survivors so that appropriate psychological interventions could be provided to facilitate psychological recovery. However, the selected post-rape care centres in Kenya do not have standardized psychological effects scientific assessment tools for rape survivors. These are necessary in early identification of psychological effects and provision of appropriate psychological interventions to rape survivors. This is because majority of the rape survivors are children who may not describe clearly the psychological effects they are experiencing hence the need of standardized psychological effects assessment tools.

In terms of severity of psychological effects experienced, the following were identified as the most severe experiences: bitterness, helplessness and hopelessness, with a mean of (4.8), followed by feelings of worthlessness, intense fear, pains and hatred towards others, with a mean of (4.7). The fact that the feelings of helplessness, hopelessness and worthlessness are severely experienced is significant because these are feelings commonly associated with depression, as supported by the findings of Sarkar and Sarkar (2005). This means that rape is likely to lead to mental illnesses if no or ineffective psychological interventions are provided to rape survivors at post-rape care centres. Therefore, early identification of psychological effects is very important in the psychological recovery of rape survivors.

In this study difficulties in functioning sexually and having multiple sexual partners with a mean of (0.7) were the least severe psychological effects experienced by rape survivors. The findings were similar with those of Stratham *et al.* (1998) and McNally, Bryant and Ehlers (2003), who identified common psychological effects of rape to include high risk sexual behaviours and sexual dysfunction. The findings of this study, however, differed with those of Stratham *et al.* (1998) in that those identified with sexual dysfunction and having multiple sexual partners were few and severe among the rape survivors under the study. This was because majority of the participants in the current study were children who are not sexually active.

The study finding agreed with Crisis Theory of Caplan (1964) that guided the study which showed that rape is a stressful event which affects a person's sense of psychological and social integrity leading to major disorganization and/or disintegration of personality. The Crisis Theory helps in the understanding of the need to identify psychological effects of rape which points to the importance of the provision of psychological interventions as an important resource to prevent the severity of psychological effects of rape on rape survivors.

Print ISSN: 2055-0863(Print), Online ISSN: 2055-0871(Online)

CONCLUSION

The sought to identify the psychological effects experienced by most rape survivors and the level of severity of each psychological effect. The fact that the feelings of helplessness, hopelessness and worthlessness were severely experienced is significant because these are feelings commonly associated with depression. The findings of the study show that rape survivors suffer from long-term psychological ill health due to inability to cope with the many psychological effects experienced after rape. This means that rape has potential to have many long-term psychological effects on the survivors that require provision of effective psychological interventions.

RECOMMENDATIONS

To improve the effectiveness of psychological interventions provided to rape survivors at post-rape care centres in Kenya, the implementers should put emphasis on development of a standardized psychological effects assessment tool for identifying the level of severity of each psychological effect experienced by rape survivors rather than concentrating only on immediate personal needs. Moreover, to improve the overall effectiveness of psychological interventions provided to rape survivors in post-rape-care centres, there should be a review of the interventions provided to ensure adequate provision especially of the legal services, follow-up and family counselling.

REFERENCES

American Foundation for AIDS Research (2005). *Gender-Based and HIV among Women: Assessing the Evidence*. Retrieved from http://www.amfar.org/amfar-publications/

Briere, J., & Jordan, C. E. (2004). Violence against women: Outcome complexity and implications for assessment and treatment. *Journal of Interpersonal Violence, 19*, 1252-1276.

Burgess, A., Holmstrom, L. (2001). Rape trauma syndrome. *American Journal of Psychiatry, 131*(9), 981-985.

Caplan, G. (1964). *Principles of Preventive Psychiatry*. New York: Basic Books.

Cohen, L. J., & Roth, S. (1987). The psychological aftermath of rape: Long-term effects and individual differences in recovery. *Journal of Social and Clinical Psychology, 5*, 525-534.

Coid, J., Petruckevitch, A., Chung, W-S., Richardson, J., Moorey, S., & Feder, G. (2003). Abusive experiences and psychiatric morbidity in women primary care attenders. *British Journal of Psychiatry, 183*, 332-339.

Ellis, E. M., Atkinson, B. M., & Calhoun, K. S. (1981). An assessment of long-term reaction of rape. *Journal of Abnormal Psychology, 90*, 263-266.

Galaif, E. R., Stein, J. A., Newcomb, M. D., & Bernstein, D. P. (2001). Gender differences in the prediction of problem alcohol use in adulthood: Exploring the influence of family factors and childhood maltreatment. *Journal of Studies on Alcohol, 62*, 486-493.

Print ISSN: 2055-0863(Print), Online ISSN: 2055-0871(Online)

Gay, L. (1992). *Educational research: Competencies for Analysis and Application* (4th ed.). New York: Mc Millan.

Gender Violence Recovery Centre (2008). *Support to the Gender Violence Recovery Centre, annual reports, April 2007 till March 2008, Nairobi Women's Hospital*. Nairobi, Kenya.

Interagency Gender Working Group (2006). *Addressing Gender-Based Violence through USAID's Health Programs: A Guide for Health Sector Program Officers*. Washington DC: IGWG/USAID.

Jaycox, L. H., Zoellner, L., & Foa, E. B. (2002). Cognitive-behavioral therapy for PTSD in rape survivors. *Journal of Clinical Psychology, 58*, 891-906.

Jewkes, R., Sen, P., & Garcia-Moreno, C. (2002). Sexual violence. In E. Krug, L. Dahlberg, J. A. Mercy, A. B. Zwi, & R. Lozano (Eds.), *World report of violence and health*. Geneva: World Health Organization.

Keesbury, J., & Askew, I. (2010). *Comprehensive responses to gender based violence in low-resource settings: Lessons learnt from implementation*. New York, NY: Population Council.

Keesbury, J., & Askew, I., Wanjiru, M., Chiyaba, G., Wilson, K., & Simmonds, F. N. (2011). *Comprehensive Responsive Responses to sexual violence in East and Southern Africa: Lessons Learned from Implementation.* Lusaka: Population Council.

Kilpatrick, D. G., Resick, P. A., & Veronen, L. J. (1981). Effects of a rape experience: A longitudinal study. *Journal of Social Issues, 37*(4), 105-122.

Krug, E. G., Dahlberg, L. L., Mercy, J. A., Zwi, A. B., & Lozano, R. (Eds) (2002). *World report on Violence and Health.* Geneva: World Health Organization.

Maternowska, C., Keesbury, J., & Kilonzo, N., (2009). *Sexual Violence: Setting the research agenda for Kenya.* Nairobi, Kenya.

McNally, R. J., Bryant, R. A., & Ehlers, A. (2003). Does Early Psychological Intervention Promote Recovery from Posttraumatic Stress? *American Psychological Society, 4*(2), 45-79.

Medical Research Council (2009). *Shattered Lives: Immediate Medical Care Vital for Sexual Violence Victims.* Brussels: Medecins San Frontieres.

Onyango-Ouma, W., Ndung'u, N., Barasa, N., & Birungi, H., (2009). *The making of Kenya sexual violence act, 2006: Behind the scene.* Nairobi: Kwani Trust.

Ranney, L., Rennert, E, M., Spitzer, R., Chitai, M. A., Mamlin, S. E., & Mabeya, H. A. (2008). A Novel ED-based sexual assault centre in Western Kenya: description and analysis of treatment patterns. *Emergency Med. J., 28*(11), 927-31.

Rees, S., Silove, D., Chey, T., Ivancic, L., Steel, Z., Creamer, M. & Forbes, D. (2011). Lifetime Prevalence of Gender-based Violence in Women and the Relationship with Mental Disorders and Psychosocial Function. *JAMA: Journal of the American Medical Association, 306*(5), 513-521.

Said, H., Awori, K. O., Odula, P. (2008). Gender-associated violence at a women's hospital in Nairobi, Kenya. *East African Medical Journal,* 85(7), 347-54.

Print ISSN: 2055-0863(Print), Online ISSN: 2055-0871(Online)

Sarkar, N.N., Sarkar, Rina, (2005). Sexual assault on women. Its impact on her life and living in society. *Sexual and Relationship Therapy, 20*(4), 407-419.

Saunders, B. E., Kilpatrick, D. G., Hanson, R. F., Resick, H. S., & Walker, M. E. (1999). Prevalence, case characteristics, and long-term psychological correlates of child-rape among women: A national survey. *Child Maltreatment, 4*, 187-200.

Stratham, D. J., Heath, A. C., Madden, P. A. F., Bucholz, K. K., Beirut, L., Dinwiddie, S. H., Slutske, W. S., Dunne, M. P., & Martin, N. G. (1998). Suicidal behaviour: An epidemiological and genetic study. *Psychological Medicine, 28*, 839-855.

Vickerman, K. A., & Margolin, G. (2009). Rape Treatment Outcome Research: Empirical Finding and the state of the literature. *Clinical Psychology Review, 29*, 431-448.

World Health Organization (2002). *World report on violence and health: summary*. Geneva, Switzerland: WHO.

_____ (2004). *Preventing Violence: A Guide to Implementing the Recommendations of the World Report on Violence and Health*. Geneva: WHO.

_____ (2005). *WHO, Multi-Country Study on Women's Health and Domestic Violence against Women; Summary Report of Initial Results on Prevalence, Health Outcomes and Women's Responses.* Geneva, Switzerland: WHO.

Print ISSN: 2055-0863(Print), Online ISSN: 2055-0871(Online)