SEXUAL ASSAULT AND FORMAL SERVICE USE: UNDERSTANDING HELP-SEEKING AMONG WOMEN LIVING IN POVERTY

by

Victoria Kar-Yan Sit

A thesis submitted in conformity with the requirements for the degree of Master of Arts
Graduate Department of Applied Psychology and Human Development, Ontario Institute for Studies in Education
University of Toronto

© Copyright by Victoria Kar-Yan Sit (2015)
SEXUAL ASSAULT AND FORMAL SERVICE USE: UNDERSTANDING HELP-SEEKFING AMONG WOMEN LIVING IN POVERTY
Master of Arts (2015)
Victoria Kar-Yan Sit
Graduate Department of Applied Psychology and Human Development
University of Toronto

Abstract

Despite the extensive and often long-lasting sequelae of sexual assault, a significant majority of survivors do not seek assistance from formal support sources. While past research has identified factors that influence help-seeking among survivors, limited attention has been paid to the role of socioeconomic status in shaping these decisions. Guided by Liang and colleagues’ (2005) three-stage help-seeking model, this qualitative study aims to develop an in-depth, contextualized understanding of the help-seeking processes of sexual assault survivors living in poverty, along with suggestions on how formal service use rates and experiences can be improved. Semi-structured interviews were conducted with fifteen women, and thematic analysis was applied to the data. Results reveal a number of barriers and illustrate the ways in which limited resources contribute to decisions to delay help-seeking, avoid certain support sources, or not seek help altogether. Drawing upon participants’ recommendations, implications for formal services and future research are discussed.
Acknowledgements

First, I would like to express my sincere appreciation to my supervisor, Dr. Lana Stermac, for her guidance, support, and encouragement throughout my Master’s degree. Her expertise, insights, and passion in this field of research continue to be inspiring to me, and were invaluable to this project. I would also like to thank my second reader, Dr. Margaret Schneider, for giving her time generously to thoughtfully reviewing this study.

I would also like to take this opportunity to acknowledge the strong and courageous women who volunteered their time and energy to participate in this study. I am thankful for their willingness and openness to sharing their experiences and knowledge, and allowing us to learn from them.

My thanks are also extended to my family and friends for the support they have given me over the past two years. Finally, I would like to acknowledge the Social Sciences and Humanities Research Council for providing the funding support that helped make this project possible.
# Table of Contents

Abstract........................................................................................................................................ii

Acknowledgements...................................................................................................................iii

Table of Contents.......................................................................................................................iv

List of Appendices.....................................................................................................................vii

CHAPTER 1: Introduction and Literature Review .........................................................................1

Introduction.................................................................................................................................1

Sexual Assault and Violence among Women Living in Poverty .................................................3

Understanding Vulnerabilities to Violence among Women Living In Poverty .......................6

Help-Seeking among Sexual Assault Survivors..........................................................................10

Barriers to Help-Seeking...........................................................................................................12

Feelings of Shame, Self-Blame and Fear of Judgment from Others .........................................13

The Belief that the Rape was not a Rape....................................................................................14

Perceptions of Specific Service Providers..................................................................................15

Rape Myths and “The Classic Rape”..........................................................................................16

Poverty-Related Barriers to Help-Seeking................................................................................18

Issues of Accessibility................................................................................................................19

Conceptualization of Psychological Issues................................................................................20

The Stigma of Mental Illness......................................................................................................22

Feelings of Self-Blame and Fear of Judgment and Discrimination from Others ...................23

Negative Perceptions of Specific Service Providers...............................................................25

The Current Study.....................................................................................................................27
### CHAPTER 2: Methods

**Research Design** .................................................................................................................. 29

**Participants** ............................................................................................................................. 30

**Procedure** .................................................................................................................................. 31

**Data Analysis** ............................................................................................................................. 36

### CHAPTER 3: Results ................................................................................................................. 38

**Sexual Assault Characteristics and Consequences** ................................................................. 38

**Characteristics of the Sexual Assaults** ................................................................................. 38

**The Impacts of Sexual Assault** ............................................................................................... 40

- Psychological and emotional effects. ....................................................................................... 40
- Changes in beliefs and attitudes. ............................................................................................... 43
- Isolation and maladaptive coping behaviours. ....................................................................... 45

**Influential Factors in the Help-Seeking Process** ................................................................. 46

- **Stage One: Appraising and Defining the Problem** ............................................................ 47
  - Conceptualization of medical and mental health issues. ....................................................... 47
  - Conceptualization of sexual assault. ...................................................................................... 52
- **Stage Two: Deciding to Seek Help** ..................................................................................... 55
  - Intrapsychic barriers. ............................................................................................................ 55
  - Issues of accessibility. ........................................................................................................... 60
  - The absence of informal support. ......................................................................................... 63
- **Stage Three: Selecting a Support Source** ............................................................................ 67
  - Perceptions of and past experiences with specific support sources. ............................... 67
  - Fear of retaliation. ............................................................................................................... 74
Recommendations for Improving Utilization and Quality of Formal Services .......................... 76

Changes to Service Provider Attitudes and Behaviours .......................................................... 78

Increased Accessibility of Information ...................................................................................... 82

Opportunities for Empowerment ............................................................................................. 86

CHAPTER 4: Discussion ............................................................................................................. 91

Discussion .................................................................................................................................. 91

Influential Factors in Help-Seeking Processes .......................................................................... 93

Recommendations for Improving Utilization and Quality of Formal Services ....................... 96

Conclusion ................................................................................................................................. 102

References ................................................................................................................................. 106
List of Appendices

Appendix A: Recruitment Flyer .................................................................120
Appendix B: Information Letter and Consent Form .................................121
Appendix C: Interview Guide .................................................................124
Appendix D: List of Resources ..............................................................130
CHAPTER 1: Introduction and Literature Review

Introduction

Over the past few decades, societal recognition of sexual violence as a critical social and public health issue has grown. Yet, the prevalence of rape and sexual assault remains high and has been relatively unchanged since the 1990s (Casey & Nurius, 2006; Kilpatrick, Resnick, Ruggiero, Conoscenti, & McCauley, 2007; Perreault & Brennan, 2010). Nationwide probability surveys conducted in the United States reveal that between 17.6% and 20.4% of women will experience a completed rape in their lifetimes (Kilpatrick et al., 2007; Plichta & Falik, 2001; Tjaden & Thoennes, 2006). While data on lifetime prevalence is not readily available in Canada, the General Social Survey (GSS) indicates that in 2009, there were 34 incidents of sexual assault per 1,000 women (Hotton Mahony, 2011). Estimates vary somewhat across studies due in part to differences in research methodologies (cf. Kilpatrick, 2004; Koss, 1993), but nonetheless illustrate the pervasiveness of these forms of sexual violence.

Sexual assault is an injurious, traumatic, and potentially life-threatening event with myriad and often long-lasting consequences. Findings from nationally representative samples consistently reveal that sexual assault victims face higher risks for several psychological disorders, including posttraumatic stress disorder (PTSD), other anxiety disorders, major depressive disorder, and substance use disorder compared to both non-victims (Kilpatrick et al., 1997; Kilpatrick et al., 2007; Kimerling & Calhoun, 1994), and victims of non-sexual violence, crime, and other traumas (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Plichta & Falik, 2001). Reviewing the research on the mental health impacts of sexual assault, Campbell, Dworkin and Cabral (2009) reported that 17% to
65% of women survivors will develop PTSD, while 73% to 82% will experience fear and/or anxiety, and 12% to 40% will experience generalized anxiety. Additionally, between 13% and 51% will meet the diagnostic criteria for depression, 23% to 44% will experience suicidal ideation, and 2% to 19% will attempt suicide. Alcohol dependence develops among 13% to 49% of sexually assaulted women, while 28% to 61% will use illegal substances.

In addition to poor mental health, sexual assault is associated with a range of physical health difficulties (see Golding, 1999 for a review). These include gynecologic problems (e.g., pelvic or menstrual pain, sexual dysfunction), chronic pain issues (e.g., chronic headaches, back pain), gastrointestinal disorders (e.g., abdominal pain, indigestion), neurologic disorders (e.g., fainting, paralysis), and chronic diseases (e.g., diabetes, arthritis) (Golding, 1994, 1999). Perhaps unsurprisingly, sexual assault survivors are also at an increased risk of poorer self-reported health (Golding, 1994; Golding, Cooper, & George, 1997; Kimerling & Calhoun, 1994), and of reporting that a physical health condition interfered with daily activities, employment or mobility (Golding, 1994). These mental and physical health difficulties can emerge within weeks of the assault, and can last many years after the traumatic event itself (Cohen & Roth, 1987; Golding, 1994; Kessler et al., 1995).

Given the extensive sequelae of sexual assault, it is concerning that only a small minority of survivors seek assistance from formal support providers, such as law enforcement officials, medical or mental health professionals, and community-based agencies (Fisher, Daigle, Cullen, & Turner, 2003; Kilpatrick et al., 2007). While it may be the case that some rape victims are not reaching out because assistance is not needed, some research is suggestive of high levels of unmet needs within this population (e.g., Kimerling & Calhoun, 1994; Tjaden & Thoennes, 2006). Accordingly, a large body of research has
focused on identifying barriers to help-seeking among sexual assault survivors. However, to my knowledge, no studies have directly examined this issue for women living in poverty, who in fact are disproportionately victimized (Bachman & Saltzman, 1995; Walby & Allen, 2004). Yet, broader research on formal service use among those living in poverty highlights the existence and significance of poverty-specific barriers to help-seeking. The present study extends the literature by investigating factors that shape the formal help-seeking decisions of sexually assaulted women who are experiencing poverty, and illuminating changes needed to enhance utilization of and experiences with formal services.

**Sexual Assault and Violence among Women Living in Poverty**

Rather than being driven by sexual desire or arousal, sexual assault is an act of violence, perpetrated with the intention of exerting, gaining, or maintaining power and control over the less powerful. As such, although people of all class, sex, age, and ethnocultural groups can be and are victims of rape and sexual assault, membership in certain demographic groups increases the likelihood of being targeted. The greater victimization of women compared to men, for example, is well-documented. The British Crime Survey (BCS) revealed that women were far more likely than men to experience both serious sexual assault (7% vs. 1.5%) and other forms of sexual assault (24% vs. 5%) (Walby & Allen, 2004). Similarly, the National Violence against Women Survey (NVAWS) found that 17.6% of women had experienced a completed rape compared to three percent of men (Tjaden & Thoennes, 2006). Other national statistics include that rates of sexual assault and rape that are 10 times higher for women than for men (Bachman & Saltzman, 1995), and that women comprise between 85% and 87% of rape victims, while men account for the majority of perpetrators (Hotton Mahony, 2001; Tjaden & Thoennes, 2006).
Lower socioeconomic status (SES) is also associated with increased vulnerability to this form of violence. Those living in poverty constitute one of the largest marginalized groups in society, facing exclusion from and oppression within not only dominant economic, but also political and social, institutions. As a consequence of this disenfranchisement on multiple fronts, the poor face an elevated risk of exposure to a multitude of stressful and traumatic events, one of which is violent victimization (Bassuk et al., 1996; Browne & Bassuk, 1997). Women with limited social and economic resources are particularly vulnerable to various forms of gender-based violence, such as intimate partner violence (IPV), sexual assault, and rape. Using multiple measures of SES, the BCS found that both household income and the ability to find money on short notice predicted past-year victimization (Walby & Allen, 2004). More specifically, rates of both IPV and sexual assault were two or more times higher among women whose household income was less than £10,000 compared to women in households earning over £20,000, and among women for whom it was impossible to find £100 on short notice compared to women for whom this task was easy. Similarly, the National Crime Victimization Survey (NCVS) showed that women with household incomes below $10,000 were more likely to be sexually assaulted in the past year compared to women with household incomes above $10,000 (57.1 vs. 36.1 per 1000), and also experienced a higher risk of IPV (Bachman & Saltzman, 1995). Large community samples of low-income and poor women yield lifetime prevalence rates of sexual and physical assault as high as 75 and 92% (Bassuk et al., 1996; Breton & Bunston, 1992), and past-year incidence rates of sexual assault ranging from 9.4% to 14% (Henslin, Robinson, Baker, & Gelberg, 2007; Kushel, Evans, Perry, Robertson, & Moss, 2003).
Among impoverished women, these risks are further exacerbated by homelessness. Homeless populations are frequently excluded from national representative surveys because of the reliance on addresses or telephone numbers to create sampling frames (Ambrosio, Baker, Crowe, Hardill, & Jordan, 1992; Cohen & Roth, 1987; Kilpatrick et al., 2007). However, data from community samples of low-income and poor women consistently demonstrate that homeless women are at high risk of being sexually assaulted in their lifetimes even compared to low-income housed women (D’Ercole & Streuning, 1990; Kushel et al., 2003) and to homeless men (Padgett & Struening, 1992; Wenzel, Koegel, & Gelberg, 2000). This pattern has also been observed among the poor in Toronto, Canada, where the present study was conducted. For example, Stermac & Paradis (2001) compared the victimization experiences of homeless and housed women who received assistance from a hospital-based sexual assault care centre in Toronto. Significantly higher rates of childhood physical and sexual abuse (50.4 vs. 29.6%), and adult physical and sexual assault (69.6 vs. 40.2%) were found among homeless women compared to housed women. Homeless women were also significantly more likely to report experiencing at least one prior victimization incident (78.5 vs. 51.4%) and to report that they had experienced all four types of victimization (23.7 vs. 6.1%) (Stercmac & Paradis, 2001). In one sample of homeless women recruited from shelters and drop-in centres in Toronto (n = 84), 64.3% reported lifetime physical assault, 39.3% reported lifetime sexual assault, and 28.6% reported both (Breton & Bunston, 1992). Moreover, well over two-thirds of victims had experienced multiple physical or sexual assaults. In Ambrosio and colleagues’ (1992) study of homeless women in Toronto, 46.2% had been physically assaulted, 43.3% had been sexually harassed or assaulted, and 21.2% had been raped during the past twelve months alone.
Findings on ethnocultural group differences in sexual victimization rates are mixed. While some studies have found that ethnic minority women face higher rates of rape and sexual assault compared to Anglo-American women (e.g., Henslin et al., 2007; Kilpatrick et al., 2007), others have found higher rates of sexual assault among Anglo-American women compared to women from some ethnic minority groups (e.g., Burnam et al., 1988; Kushel et al., 2003). In two national studies, although rates of victimization did not differ by visible minority status, Native American/Aboriginal women reported significantly higher rates of sexual assault/rape (Cohen & Maclean, 2004; Tjaden & Thoennes, 2006). Still others have not found differences in levels of victimization by visible minority status or ethnicity (e.g., Hotton Mahony, 2011; Walby & Allen, 2004). Discrepancies across studies may be attributable in part to the confounding effects of socioeconomic status, among other contextual factors (cf. Bryant-Davis, Chung, & Tillman, 2009; Hien & Ruglass, 2009). Indeed, some studies on IPV have found that when SES is controlled for, ethnic group variations in victimization rates shrink significantly or disappear altogether (see Hien & Ruglass, 2009 for a review). Overall, then, existing research demonstrates a strong link between victimization and limited financial resources, and highlights the alarming risks to personal safety faced by women living in poverty.

Understanding Vulnerabilities to Violence among Women Living In Poverty

A large body of literature sheds light on individual and contextual factors that contribute to the heightened risk of victimization for poor women. First, a number of individual characteristics that are linked to sexual victimization are prevalent among impoverished women. For example, as described above, extensive histories of physical and sexual victimization beginning in childhood and continuing through to adulthood are all too
common among poor women (Bassuk et al., 1996; Browne & Bassuk, 1997). Unfortunately, having prior experiences of victimization is one of the most consistent predictors of sexual assault and rape (Tyler et al., 2000). In the NVAWS, women who reported being raped before age 18 were twice as likely to be raped after they turned 18 (18.3 vs. 8.7%; Tjaden & Thoennes, 2006). Longitudinal data from the NWS showed that after controlling for age, race, education, and substance use, the risk of experiencing a sexual assault during the two-year follow-up period was four times higher among women with a history of victimization compared to women with no such history (Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997). Moreover, this relationship was linear, whereby the risk was about 200% higher with one past victimization, 400% higher with two prior victimizations and 1000% higher with three or more prior victimizations, compared no assault history.

Women experiencing poverty often endure a range of health difficulties. Lower SES is associated with higher prevalence rates of major depressive disorder, anxiety disorders including PTSD, psychotic disorders, personality disorders, and substance use disorders (Henslin et al., 2007; Kessler et al., 1995). Poor women are also more likely to report suicide attempts, to rate their health as fair or poor (vs. good or excellent), and to report a disability, compared to more affluent women (Finkelstein, 2001; Plichta & Falik, 2001). Unfortunately, sexual victimization is strongly predicted by psychological and physical health issues, including major depression, personality disorder, psychotic disorders, substance dependence, and physical limitations (Burnam et al., 1988; Cohen & Maclean, 2004; Padgett & Struening, 1992; Simons et al., 1989). While this relationship certainly reflects the negative health impacts of sexual violence, it also speaks the ways in which poor health heightens vulnerabilities to victimization. Mental and physical disabilities can impair abilities to
identify unsafe situations, practice vigilance and engage in self-protective behaviours; reduce the likelihoods of both reporting crimes to law enforcement officials and being believed; and increase the chances of being targeted by perpetrators who perceive these weaknesses (Goodman et al., 2001; Kilpatrick et al., 1997).

Second, certain contextual factors associated with low SES create vulnerabilities to victimization. For example, having limited disposable income or social support can hinder one’s ability to engage in precautionary measures that can enhance their safety. Driving oneself home, taking a taxi, and sleeping in a secure residence can be considered protective strategies that reduce the risk of victimization, but may not be options for poor individuals who instead may be forced to walk or sleep in the streets at night (Walby & Allen, 2004). Avoiding or escaping environments that are dangerous or where past victimization has taken place (e.g., an abusive home, a high-crime neighbourhood) by setting up an independent household or re-locating, can be a potentially daunting or impossible task (Walby & Allen, 2004). Poverty may also compel individuals to engage in activities that increase their proximity to high-risk areas and situations. Common survival strategies, such as panhandling, collecting recyclables, selling goods on the street, and working in the sex trade industry, bring individuals into contact with physical spaces, situations, and people (e.g., pimps, drug suppliers) that may be unsafe (Henslin et al., 2007; Kushel et al., 2003; Tyler et al., 2000). Indeed, sleeping outside in public places and relying on deviant survival strategies have been linked to higher risks of physical and sexual victimization among poor women (Simons et al., 1989; Wenzel et al, 2000; Whitbeck & Simons, 1993).

In sum, this body of research highlights the elevated risk of victimization faced by low-income and poor women by virtue of their predisposition to individual risk factors, as
well as their restricted access to precautionary and protective behaviours. It also calls attention to the importance of an improved understanding of the factors that influence the help-seeking decisions of sexually victimized women experiencing poverty. Higher rates of psychological and emotional difficulties are perhaps unsurprising given the extensive traumatic histories common among poor women, and the everyday stresses and challenges associated with poverty. Prior traumatic and stressful life events and day-to-day violence, discrimination, exploitation and struggles for survival can increase vulnerabilities to mental disorders such as anxiety and depression and exacerbate the extent of mental health impacts of later sexual assaults (Follette, Polusny, Bechtle, & Naugle, 1996; Goodman, Saxe, & Harvey, 1991; Ullman & Brecklin, 2002). Poor women are also more likely to be victims of rapes that are more violent and involve physical coercion (Stermac & Paradis, 2001), circumstances which, along with perceived life threat during the assault and physical injury, are strong predictors of PTSD (Ozer, Best, Lipsey, & Weiss, 2003; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993). Indeed, there is some evidence that among sexual assault survivors, women who have lower incomes or educational attainment, or are unemployed suffer greater health consequences compared to their higher-earning, more educated, employed counterparts (e.g., Cohen & Roth, 1987, Ullman & Brecklin, 2002; Ullman & Filipas, 2001). Thus, women living in poverty must cope with not only a higher threat of being sexually assaulted, but also the physical, psychological, and social consequences of more violent assaults, prior traumas and stressful events, and the everyday adversity and challenges of socioeconomic disadvantage. A greater understanding of the unique factors influencing help-seeking decisions of these women is critical to ensuring that their potentially high levels of need are met.
Help-Seeking among Sexual Assault Survivors

As noted above, despite the extent of the psychological, physical and social consequences of sexual victimization, many survivors do not appear to receive the help that they may need. Although between one-half to two-thirds of sexual assault victims will eventually tell someone about the incident, the large majority of these disclosures are made to informal helpers (e.g., friends, relatives) and only a small proportion of victims will seek formal assistance (see Ullman, 1999 for a review). In two random community samples of sexual assault victims, less than one-third reported seeking help from mental health workers (16.1% to 27%), medical professionals (9.3% to 16%), rape crisis centres (1.9% to 5%) or religious clergy (3.9% to 5%) for matters related to the assault (George, Winfield, & Blazer, 1992; Golding, Siegel, Sorenson, Burnam, & Stein, 1989). Nonrandom samples have yielded somewhat higher rates of formal help-seeking, with as many as 39%-52% of victims receiving mental health services, 27%-43% receiving medical care, 26%-39% reporting to law enforcement officials, 14%-21% contacting a rape crisis centre, and 7.6%-18% contacting someone from religious community (Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; Filipas & Ullman, 2001). While low rates of formal service use could reflect a lack of need among survivors, some evidence suggests that this is not the case.

For example, the BCS found that over three-quarters of rape victims (78%) endured at least one physical or mental injury in addition to the assault itself, such as depression and emotional distress (52%), and substantial bruising or bleeding (17%) (Walby & Allen, 2004). A considerable proportion of women also reported difficulties trusting others (38%), decreases in socialization (15%), insomnia (21%), and suicide attempts (5%). At the same time, two out of five survivors of rape (40%) had not told anyone about the assault (Walby &
Allen, 2004). Among those who had, the majority reached out to an informal support source, such as a friend, relative, neighbour or co-worker (57%) or a romantic partner (15%). In contrast, a mere 6% had sought help from a counsellor or therapist, and 2% or less had sought help from various types of community-based agencies where mental health support may have been provided (e.g., rape crisis centre, women’s centre, victim support agency) (Walby & Allen, 2004). Among women rape survivors in the NVAWS, despite significant psychological impacts, only one-third of the sample (33%) sought mental health treatment, and only 36 percent of those who sustained physical injuries (32% of the sample) received medical care (Tjaden & Thoennes, 2006). Similarly, in a large convenience sample, although rape victims demonstrated higher levels of psychological symptoms compared to non-victims, rates of mental health service utilization did not differ between the two groups (Kimerling & Calhoun, 1994).

The underreporting of rape and sexual assault has long been documented, and recent studies indicate a persistent reluctance among victims to report their experiences to law enforcement officials. Decades of research reveal that police reporting rates for sexual assault and rape are alarmingly and consistently low (e.g., Bachman, 1998; Koss, Gidycz, & Wisnieski, 1987). Data from the 1999 National Crime Victimization Survey (NCVS) shows that fewer than one-third (28.3%) of all rapes and sexual assaults were reported to the police, making these crimes the most underreported of all violent crimes (i.e., robbery, aggravated assault, simple assault) (Rennison, 2000). Even lower rates were found in other national surveys conducted in the U.S. and Britain between 1991 and 2006, where only 12% to 19.1% cases of rape against women were reported to the police (Kilpatrick et al., 2007; Tjaden & Thoennes, 2006; Walby & Allen, 2004). As some researchers have noted (e.g., Kilpatrick et
al., 2007; Walby & Allen, 2004), survey questions often assess only whether the crime was reported to the police, and do not distinguish between rapes reported by the victims themselves and those by other individuals.

These findings suggest that low rates of formal help-seeking among sexual assault survivors cannot be attributed to absence of need only. Rather, many survivors are not accessing services from health professionals, community-based organizations, or the criminal justice system in spite of being tremendously impacted by the assault, suggesting that other considerations are at play in determining whether sexual assault victims reach out. While disclosing sexual victimization experiences to informal support providers provides an opportunity for victims to receive social and emotional support, reporting to formal services is necessary for survivors to access tangible resources, such as medical and mental health treatment, justice and protection, advocacy, and financial compensation. Understanding the factors underlying women’s underutilization of services is important in order to improve access to formal assistance for rape-related issues.

**Barriers to Help-Seeking**

The significance of this issue is reflected in the large and growing body of literature focused on understanding the factors underlying low rates of help-seeking among survivors of sexual assault and rape. Much of this research is based on survivors’ self-reported reasons for deciding not to seek assistance and has been conducted on samples of university students as well as the general population. A number of common barriers that deter or present challenges to help-seeking for sexual assault survivors have been established.
Feelings of Shame, Self-Blame and Fear of Judgment from Others

A range of intrapsychic factors have been found to discourage help-seeking among sexual assault survivors. Shame, self-blame, and concerns about being stigmatized or blamed by others for the assault have been cited by many survivors as reasons for electing not to seek formal assistance (Starzynski, Ullman, Filipas, & Townsend, 2005; Tjaden & Thoennes, 2006; Walsh et al., 2010). In several studies, feelings of embarrassment and self-blame, and the desire for no one to find out about the assault emerged as the most common deterrents to sexual assault survivors reporting the rape to the police (Kilpatrick et al., 2007; Tjaden & Thoennes, 2006), along with the fears that nothing will happen to the perpetrator, while the victim herself is blamed and doubted (Kilpatrick et al., 2007; Koss et al., 1988). Many victims also decide against talking to the police because of concerns over retaliation from the perpetrator (Bachman, 1998; Kilpatrick et al., 2007; Walby & Allen, 2004); in the NVAWS, where only 19% of rapes were reported, the most common for not reporting rape was fear of offender, endorsed by over 1 in 5 women (Tjaden & Thoennes, 2006).

Negative self-judgments and fear of negative judgments from others can also prevent women from receiving post-assault health care for their injuries. One nationally representative sample of U.S. women found that being sexually assaulted by a known perpetrator increased the odds of women self-rating their health as fair or poor (2.8 times), reporting a disability (3.5 times) and reporting a chronic condition (2.1 times), while also increasing the odds of recalling a time when embarrassment or discomfort had stopped them from discussing a medical issue with a doctor (Plichta & Falik, 2001). In Sturza and Campbell (2005)’s study of women sexual assault survivors, of those who had obtained prescription drugs through a doctor, half of them did not disclose the assault to the
practitioner, most often because of fear of judgment. Unfortunately, these sentiments are not uncommon among survivors and can lead women to ultimately decide to stay silent about the assault.

The Belief that the Rape was not a Rape

Help-seeking decisions can be affected by the way in which rape victims understand their experiences of victimizations. Koss, Dinero, & Seibel (1988) first documented the phenomenon of the “unacknowledged rape victim,” one whose experience of victimization meets the criminal and legal definition of rape but who does not label it as such. In a large sample of women college students, the authors reported that almost half of stranger rape victims and over three-quarters of acquaintance rape victims did not define their experiences as rape; instead the experience was described as crime but not a rape, a miscommunication, or not a crime at all. Following this seminal research, several studies have confirmed that many rape survivors do not characterize their experiences as rape, with implications for help-seeking.

Perhaps unsurprisingly, rape victims who do not believe that a rape has been committed are significantly less likely to disclose the assault to either informal or formal support providers (Layman, Gidycz, & Lynn, 1996; Littleton, Axsom, Radecki Breitkopf, & Berenson, 2006; Littleton, Radecki Breithopf, & Berenson, 2008). In a sample of university students, two of the most commonly endorsed reasons for not using any formal services after a sexual assault were the beliefs that the incident was a private matter and that it was not serious (Walsh et al., 2010). Engagement with the criminal justice system may be particularly affected as coming forward to the police is likely to be dependent on whether the victim believes that a crime or injustice has been committed. Indeed, across multiple studies,
the most frequently cited reasons for non-reporting include the belief that the experience was “not really rape” or a crime (Koss, 1993; Kilpatrick et al., 2007), and the belief that the incident was a private, personal, or trivial matter, rather than a police matter (Bachman, 1998; Kilpatrick et al., 2007; Tjaden & Thoennes, 2006). Tendencies to minimize or distort the gravity of the perpetrator’s actions and the act itself, then, can serve as barriers to help-seeking.

**Perceptions of Specific Service Providers**

Help-seeking decisions can also be influenced by views of support providers, as survivors have little reason to reach out to certain support sources if they do not believe their efforts will yield positive results. Research has shown that friends and relatives are not only the most common recipients of disclosures, but they are also perceived by survivors to be among the most helpful of all support sources (cf. Ullman, 1999; Filipas & Ullman, 2001; Golding et al., 1989), followed by rape crisis centres and mental health workers (Campbell et al., 2001; Golding et al., 1989). Low rates of disclosure to other support sources may be rooted in doubts that the desired assistance will be received. For example, studies examining low police reporting rates reveal strong concerns about treatment in the criminal justice system, with many victims attributing their decisions not to report to a lack of faith in the willingness or ability of law enforcement officials and the courts to take their claims seriously and to refrain from bias or victim-blaming (Bachman, 1998; Golding et al., 1989). In national studies, over one-quarter of women rape victims attributed their non-reporting to doubts that the police would do much (Walby & Allen, 2004) and over one-third cited fear of negative treatment by police officers or lawyers (Kilpatrick et al., 2007).
At times, these perceptions may be based in past help-seeking or disclosure experiences, either of their own or of others in their social networks. In telling somebody about the sexual assault, victims open the door to the possibilities of receiving positive as well as negative reactions (Ullman & Filipas, 2001). Positive responses, such as believing and being there for the victim, are associated with positive outcomes such as posttraumatic growth and greater post-assault adjustment (Borja et al., 2006; Ullman, 1996), while negative reactions, such as blaming or patronizing the victim, have been linked to poorer post-assault adjustment and greater severity of post-traumatic stress disorder symptomology (Campbell et al., 2001; Ullman, 1996; Ullman & Filipas, 2001). The term “secondary victimization” has been used to refer to the victim-blaming responses rape survivors frequently receive from service providers that can lead to greater depression and anxiety following disclosure (Campbell et al., 1999; Williams, 1984), such as questioning the victim about her sexual history or use of alcohol during the incident, or advising her not to press charges. Such responses may explain why approximately half of survivors who disclose to doctors, the police, and legal professionals report feeling blamed, hurt, or dissatisfied by the responses they received (Campbell et al., 2001; Sturza & Campbell, 2005; Tjaden & Thoennes, 2006). Moreover, the receipt of negative disclosure reactions can discourage future disclosures due to concerns of having similar experiences again (Ahrens, 2006). Doubts that the desired assistance will be received can deter help-seeking in general, or may influence decisions about who to disclose to.

**Rape Myths and “The Classic Rape”**

A discussion about the help-seeking barriers experienced by sexual assault survivors would not be complete without a discussion of the influence of rape myths. Rape myths are
a cohesive set of pervasive, stereotypical beliefs about what constitutes a “real” rape, rape victim, and rapist (Burt, 1980; Estrich, 1987; Williams, 1984). As Lonsway and Fitzgerald (1994) explain, rape myths are “attitudes and beliefs that are generally false but are widely and persistently upheld” that “serve to deny and justify male sexual aggression against women” (p. 134). Included among them are the ideas that women’s clothing choices or behaviours are the cause of rape; that women lie about rape out of regret for a consensual sexual act or a desire to hurt the accused; and that verbal and physical resistance by women are just ways of “playing hard to get” (Lonsway & Fitzgerald, 1994). Complementing these beliefs are additional myths that describe “the classic rape” (Williams, 1984), in which the victim, typically a White, middle-class, sexually conservative woman, is randomly attacked by a stranger in a dark, deserted public place, struggles with the attacker resulting in serious physical injuries, and is overpowered by the perpetrators’ use of physical coercion or a weapon (Estrich, 1987; Williams, 1984). Ultimately, the widespread perpetuation and acceptance of these myths function to minimize and discredit the sexual assault experiences of women whose personal attributes and rape characteristics deviate from this scenario, with implications for their help-seeking decisions.

The detrimental impact of rape myths on help-seeking behaviours is perhaps most apparent in the incident- and victim-related characteristics that are correlated with disclosure. Victims are more likely to engage in formal help-seeking when the rape involves a stranger, the use of weapon or severe physical force, a fear of death or injury, physical injuries sustained by the victim, and when alcohol is not used by the victim (Bachman, 1998; Campbell et al., 2001; Golding et al., 1989; Kilpatrick et al., 2007). In short, victims tend to seek formal assistance when their experiences more closely mirror the stereotypical ideas of
what a “real rape” and a “real rape victim” looks like. Victims’ own perceptions and feelings about the rape may also be influenced by these myths; in fact, victims whose experiences do not fit “the classic rape” are less likely to acknowledge their experiences as rape, more likely to blame themselves, and more likely to believe that they will be blamed by others (Layman et al., 1996; Littleton et al., 2008), all of which are associated with nondisclosure. In short, the internalization of these rape myths shapes how women perceive their own sexual victimization experiences, which in turn affects their ability and willingness to seek help both informally and formally.

These patterns are troubling given that the circumstances under which many cases of rape occur do not fit into this scenario. Research consistently shows that the large majority of sexual assaults are perpetrated by known assailants and not strangers; take place in private rather than public settings; and involve the use of alcohol and psychological threats as tools of coercion, instead of physical violence (Kilpatrick et al., 2007; Plichta & Falik, 2001; Tjaden & Thoennes, 2006; Walby & Allen, 2004; Williams, 1984). Moreover, some evidence suggests that victims of acquaintance rapes experience greater anxiety, depression, and use of psychotropic drugs, compared to both non-victims and victims of stranger assaults (Plichta & Falik, 2001). Low rates of help-seeking among rape survivors, then, may be indicative of the pervasiveness of rape myths that result in rapes being minimized, perpetrators being excused, and victims being blamed.

**Poverty-Related Barriers to Help-Seeking**

Unfortunately, while much attention has been paid to identifying help-seeking barriers among sexual assault survivors, few studies have sought to examine how socioeconomic status affects decision-making processes. Yet, the literature on help-seeking
barriers among low-income and poor individuals in the general population strongly suggests that this question warrants further exploration. Research has affirmed the existence of instrumental barriers (e.g., cost, transportation) while qualitative studies in particular have illuminated the significance of additional psychosocial factors that affect service use decisions among low SES groups.

**Issues of Accessibility**

Perhaps the most apparent barriers to help-seeking faced by poor individuals are issues related to accessibility. One national study revealed that Canadians from low-income households were 10 times more likely to report unmet healthcare needs due to accessibility issues (i.e., cost and transportation problems) compared to members of more affluent households (Chen & Hou, 2002). In Canada, while basic medical and emergency services are covered by various government programs (e.g., provincial health insurance, social assistance programs), many health care services, such as counselling, dental and vision care, and prescription drugs, are not. For working poor, unemployed, and homeless Canadians with minimal disposable incomes and without extended health care benefits, user fees for services can be experienced as unattractive if not altogether prohibitive (Stewart et al., 2005; Williamson & Fast, 1998; Williamson et al., 2006), especially when additional related costs such as transportation and childcare are factored in (Williamson & Fast, 1998). As a result, low-income individuals in Williamson et al. (2006) reported being restricted to using community-based services and programs that had minimal or no user fees, which were sometimes felt to be of lower quality, and forgoing health care services which were not publicly covered.
Additional challenges to accessibility arise from transportation, childcare, time, and lack of knowledge. In a study of perceived barriers to mental health care among low-income women, Alvidrez & Azocar (1999) reported that while cost was the most frequently endorsed barrier (83%), 70% of women identified at least one other instrumental barrier (i.e., issues related to transportation, time, or childcare). Reliance on public transportation can make travelling to and from a clinic or agency difficult, especially if the location is not on a bus route, the route is indirect resulting in longer commuting times, or schedules are unreliable (Anderson, Blue, Holbrook, & Ng., 1993; Stewart et al., 2005). Long wait times coupled with restricted business hours can deter service use for individuals who cannot afford to take time off work or who lack job security (Anderson et al., 1993; Stewart et al., 2005; Miranda & Green, 1999). Exacerbating these challenges is the scarce availability of affordable, reliable childcare options and of mental health treatments in low-income neighbourhoods (Alvidrez & Azocar, 1999; Miranda & Green, 1999). Finally, limited access to a residential or mobile phone line or to the Internet can make it difficult to book, change, or cancel appointments (Dupéré, O’Neill, & De Koninck, 2012; Miranda & Green, 1999), and can contribute to a lack of awareness about existing services (Anderson et al., 1993). Together, these studies reveal the greater toll in regards to time, energy, and money that help-seeking can take on individuals living in poverty, which in turn can deter them from utilizing services.

**Conceptualization of Psychological Issues**

Just as the way rape is labelled can affect help-seeking decisions, so too can the way that psychological disorders or mental health are understood. Individuals living in poverty may be inclined to downplay the severity or significance of symptoms of psychological
distress in the face of more concrete and immediate stressors related to basic needs, such as unemployment, safety, and shelter (Levy & O’Hara, 2010). In Dupéré and colleagues’ (2012) qualitative study of barriers to accessing health care and social services among men living in poverty, many participants explained that they had not sought help for mental or physical health problems because these were not perceived as serious in light of the health problems of other people they encountered in their daily lives, or the more pressing practical problems related to poverty and homelessness that they faced. Frequent ongoing and unexpected life stressors that arise in lives of impoverished women may interfere with their ability to prioritize psychological and physical health concerns after a sexual assault.

The lived experience of poverty can also create cultural differences in the way poor individuals and typically middle-class health care providers conceptualize and understand psychological issues. In Anderson and colleagues’ (2006) qualitative study of barriers to mental health care among distressed, low-income mothers, a common theme that arose across the in-depth interviews was the rejection of the bio-medical model of anxiety or depression which roots these disorders in the individual and thus views them as therefore treatable with medication and/or psychotherapy. Many participants defined their own psychological distress as a “normal, in fact inevitable, response to a difficult life,” (p. 934) and believed that addressing external daily life stressors (e.g., challenges meeting basic needs of food, shelter, and security) rather than internal causes, was needed for improved psychological well-being (Anderson et al., 2006). These sentiments were echoed by the men in Dupéré and colleagues’ (2012) study, who criticized the perceived common practice among health professionals of prescribing medication to treat their symptoms, rather than exploring and addressing the source of their problems. In fact, across studies of low-income
participants, there appears to be a widely held view that psychotropic drugs are overprescribed, carry undesirable side effects, and are often unnecessary (Abrams, Dornig, & Curran, 2009; Dupéré et al., 2012; Nadeem, Lange, Miranda, 2008), with some studies finding that medication is the least preferred mental health treatment, below group counselling and individual therapy (Alvidrez & Azocar, 1999; Nadeem et al, 2008).

The Stigma of Mental Illness

For mental health treatment specifically, the stigma of mental illness may deter individuals from accessing services from psychologists, psychiatrists, and counsellors, and encourage seeking assistance from physicians rather than mental health workers, if they perceive this to be more acceptable. In a province-wide survey of Ontario residents ($N = 8116$), half of those who sought help for psychological issues contacted a medical professional (i.e., general practitioner or family doctor) (49.9%), while fewer than one in five reached out to psychiatrists (24.1%) or social workers (22%), and only one in ten sought help from each of psychologists or clergy members (Lin, Goering, Offord, Campbell, & Boyle, 1996). Some studies have found a stronger endorsement of stigma-related concerns among lower SES groups, as well as ethnic minority groups, compared to higher SES and dominant ethnic groups (Anderson et al., 1993; Chen & Hou, 2002; Levy & O’Hara, 2010). In Alvidrez & Azocar’s (1999) study, 42% of the sample of low-income women anticipated at least one stigma-related barrier to seeking mental health care, such as embarrassment, fear of what others think, or disapproval from others, with stronger endorsement among women who identified as Latina and Asian American (vs. white or Black) and with lower levels of education. In focus groups of poor women, Miranda & Green (1999) described a common view of mental illness as a problem that could be overcome by changing one’s mindset, and
belief that mental health treatment use would be associated with being crazy or weak. Similarly, many of the participants in Stewart et al.’s (2005) study rooted their low formal health service use in a desire to be self-reliant, the perceived shame associated with certain services, and a preference for self-education, self-diagnosis and treatment, and informal support to improve their health. Such findings are congruent with the conceptualization of mental illness as an issue that can be overcome by willpower (e.g. Dupéré et al., 2012), and with evidence indicating that poor individuals have a higher tendency to rely on informal supports compared to more affluent individuals (Levy & O’Hara, 2010). Although the stigma surrounding mental illness is a barrier that is confronted by individuals of all backgrounds, it may have particular salience for low-income men and women who may be coming up against multiple other sources of shame in their daily life.

**Feelings of Self-Blame and Fear of Judgment and Discrimination from Others**

As noted above, self-blame lowers the likelihood of post-sexual assault help-seeking, and can be a barrier to help-seeking in general among poor individuals. Many of the men in Dupéré and colleagues’ (2012) study talked about a reluctance to seek assistance because they believed that the issues they were experiencing (e.g., drug and alcohol abuse, gambling addiction, psychological stress) were their own fault and could only be solved by them “pulling themselves together.” In addition, Dupéré and colleagues (2012) noted that feelings of responsibility sometimes appeared to be internalized from past interactions with service providers who had placed blame on these men for their problems, and attributed them to a lack of willpower to change. Although this has not been explored directly, it is possible that sexual assault survivors living in poverty may be more primed to hold self-blaming cognitions related to the assault due to past tendencies to engage in self-blame, or past
experiences of being blamed for their situations by others. In one study of sexual assault and post-assault experiences among African American women (n = 495), less educated women reported more characterological self-blame than more educated women (Long, Ullman, Starzynski, Long, & Mason, 2007).

Fear of poor treatment from service providers is another common reason that low-income individuals do not seek help. An abundance of research reveals that, unfortunately, these treatment-related concerns are often grounded in prior negative interactions. Qualitative studies on the help-seeking experiences of low-income and poor people are rife with illustrative examples of incidents in which participants felt they had been ignored, judged, dismissed or patronized by workers at health care facilities and community-based agencies (e.g., Anderson et al., 2006; Dupéré et al., 2012; Stewart et al., 2005). Moreover, this treatment was frequently perceived to be unfairly rooted in stereotypes (e.g., that they had a drug or gambling addiction, impaired intellectual capacities, or were welfare recipients), and to be a continuation of the stigmatization and discrimination they faced in their everyday lives, not only because of their class position, but also their gender, ethnicity, or appearance (Anderson et al., 1993; Stewart et al., 2005). Fears of receiving similar treatment in the future deterred them from returning to specific service provider or agency, or sometimes from seeking help in general (Anderson et al., 2006; Dupéré et al., 2012; Stewart et al., 2005). For example, in Anderson and colleagues’ (2006) study, low-income mothers described being made to feel powerless by staff at community agencies which in turn made them reluctant to seek help for emotional distress for fear of being viewed as inadequate caregivers for their children. In Williamson et al., (2006), 40% of low-income participants attributed their decisions to stop using a service to being treated rudely, dismissed, coldly or
judged based on their SES, while about half noted that being treated in a caring, empathetic, non-judgemental and respectful manner increased their likelihood of returning. While dissatisfaction with past experiences can deter future help-seeking, conversely, positive interactions can encourage service use.

**Negative Perceptions of Specific Service Providers**

Concerns over poor treatment may also be specific to certain types of service providers. As discussed above, sexual assault survivors often doubt the ability or willingness of law enforcement officials to provide effective assistance and to refrain from bias. These concerns may be heightened among women living in poverty due to past experiences with the police. Engagement in deviant economic survival strategies (e.g., panhandling, selling drugs) increases the likelihood of having negative interactions with the police, which may in turn reduce the willingness of poor individuals to seek help from the police when they are victimized. Indeed, among homeless victims of crime, the main reasons for deciding against reporting the incident included a mistrust of the police, fear of making oneself known to the police, and past experiences of inaction (Newburn & Rock, 2006). Furthermore, having a record of negative encounters with police officers or a criminal record may raise concerns that they will not be viewed as legitimate rape victims of a “real” rape and will be treated accordingly, particularly if the victims were engaged in deviant or criminal activities (e.g. selling or using drugs, selling sex) at the time of or leading up to the assault.

Poor perceptions of health professionals have also been documented in past research on help-seeking among the poor. Across many studies, low-income women experiencing psychological or emotional distress expressed the belief that medical and mental health care workers would be quick to label them with a diagnosis and prescribe medication, a practice
that left participants with the impression that health care professionals lacked the ability or willingness to be empathetic, respectful, and to take the time to understand their concerns (e.g., Abrams et al., 2009; Anderson et al., 2006; Levy & O’Hara, 2010). For some, these concerns arose from past experiences of receiving treatments that they perceived as inadequate or incorrect, or of being refused treatment altogether (Abrams et al., 2009; Anderson et al., 1993; Dupéré et al., 2012). For women whose limited access to social and economic resources renders it difficult to exert control over multiple aspects of their lives, whether help-seeking experiences are experienced as disempowering or create opportunities to exercise agency can be an important determinant of service use.

This body of research demonstrates that there are many factors underlying help-seeking processes among impoverished populations which can deter formal service use. These include issues related to accessibility, such as cost, transportation and childcare, as well as psychosocial factors, such as beliefs and attitudes about oneself and others and past experiences of discrimination. Additionally, findings from qualitative studies demonstrate the perceived attitudes and behaviours of service providers in particular, appear to be a critical factor in service use decisions, and that the ability of providers to listen, understand, and show empathy and respect were valued. Concerns about judgement and treatment by others were also salient in sexual assault survivors’ self-reported reasons for not seeking assistance, and are likely to be compounded for those living in poverty, who can be stigmatized and blamed not only for the assault but also for their socioeconomic position. Unfortunately, while much attention has been paid to identifying help-seeking barriers among sexual assault survivors, more research is needed to better understand the role of
socioeconomic status in shaping the help-seeking decisions for sexual assault-related issues among women living in poverty who, in fact, are at a higher risk of victimization.

The Current Study

To the author’s knowledge, no studies have yet been conducted on barriers to help-seeking among women in poverty who have been sexually assaulted. The present study is aimed at addressing this gap by exploring the factors that shape help-seeking processes among sexually victimized women who are experiencing poverty, guided by Liang and colleagues’ (2005) help-seeking model. Drawing from the broader help-seeking literature, Liang, Goodman, Tummula-Narra and Weintraub (2005) conceptualize a three-stage help-seeking process, in which defining the problem, deciding to seek assistance, and choosing a specific support source are distinct components. The authors stress that in reality, this process is often dialectical rather than linear. The first stage focuses on how victims interpret the problem (e.g., the sexual assault itself or the impacts of it), the second stage on how victims evaluate the costs and benefits of seeking help, and the third on how victims identify appropriate support sources. At each of these stages, women confront various individual, interpersonal and sociocultural factors that can facilitate or deter help-seeking.

Although this model of help-seeking was developed for victims of IPV, it has been found to be relevant in past studies of disclosure among sexual assault survivors (e.g. Walsh et al., 2010). For example, the ways in which rape or mental illness is understood are factors in the first stage of the model, while factors such as self-blame and fears of negative judgements by support providers can serve as barriers at the second stage. Doubts that the desired assistance will be received can deter help-seeking in general, or may influence decisions on who to disclose to in the third stage of the help-seeking process.
The goal of this study is to extend the literature on help-seeking processes among sexual assault survivors by illuminating factors that influence service use decisions among survivors living in poverty. Thus, the research objectives are as follows: 1) to explore individual, interpersonal, and sociocultural factors that facilitate and/or deter post-assault help-seeking at each of the three stages of the help-seeking process; and 2) to develop recommendations for formal support providers that can encourage higher rates of service use and positive experiences with service providers for this marginalized population.
CHAPTER 2: Methods

Research Design

Methodological decisions were guided by a feminist standpoint epistemology that begins at the assumption that members of marginalized and oppressed groups in society have the potential to develop more complete views of social reality, compared to members of more powerful groups (Harding, 1987; Smith, 1987). As Hartsock (1983) explains, marginalized persons develop their own perceptions of the world based on their material conditions; yet, through their social interactions, they also cultivate an understanding of the values, beliefs, and attitudes of the dominant group around which society is structured. Thus, women and the poor, for example, have insight into both the dominant views of social reality as well as their own minority view, a condition that renders them invaluable sources of knowledge, and experts on their own lived experiences. Consistent with this epistemology is a standpoint approach to inquiry (Harding, 1987; Hartsock, 1983; Smith, 1987) that is aimed at privileging and making visible what is often overlooked, dismissed, and concealed, by “giving voice” to the lived experiences and perspectives of marginalized groups so that a more complete and accurate understanding of social reality can be achieved. As many proponents of this approach have pointed out (e.g. Smith, 1987), the aim is to not to provide a description of women’s accounts of their experiences; rather, it is to situate their understandings of these experiences within a wider social context and social relations in which these women are located. Taking this one step further, Hesse-Biber & Leavy (2007, p. 55) have argued that, ideally, the purpose of research should be “[to] understand the world through the eyes and experiences of oppressed women and apply the vision and knowledge of oppressed women to social activism and social change.”
Qualitative, semi-structured interviewing was chosen as a method of data collection, as it allowed the interviewer to create space for participants to freely explore and describe their experiences and perceptions, while limiting the reliance on researcher-determined focuses of inquiry. As prior research on this issue is limited, semi-structured interviews were also appropriate, given their suitability for exploring new ideas and insights with specific research questions in mind (Braun & Clarke, 2006; Patton, 2002). Thematic analysis was used to identify patterns (themes) within and across transcripts, with the aim of capturing the ways in which these women made meaning of their help-seeking decisions, while also seeking to situate these understandings within the broader context of their lives, as well as existing literature on help-seeking among sexual assault survivors and individuals living in poverty. Consistent with the methodological approach and research objectives, the overarching goal of the study was to provide a detailed, contextualized account of common themes pertaining to individual, interpersonal, and sociocultural factors that impacted help-seeking decisions at any or all of the three stages in Liang and colleagues’ (2005) help-seeking model. As well, the study aimed to use this knowledge, together with suggestions solicited from the women themselves, to formulate recommendations for improving use and quality of services among this marginalized population.

Participants

Thirty-seven individuals initially contacted the principal investigator expressing interest in participating in the study. Of these individuals, ten could not be reached for screening interviews because no contact information was provided or no contact was made after multiple attempts, and six individuals did not meet the eligibility criteria, most often because of current involvement in a court case. Of the twenty-one women who were eligible
to participate, five could not be reached to schedule an interview or to re-schedule one they had missed because their phone numbers were out of service. Finally, although sixteen interviews were conducted, one interview could not be completed as the participant had difficulties staying awake, and thus was not included in the dataset.

The sample was comprised of 15 women, ranging from 21 to 64 years of age ($M = 42.3, SD = 12.9$). In terms of relationship status, three women were currently married or in common-law relationships, five women were divorced, and seven had never been married. Eleven women reported that they had children, and seven had children 18 years of age or younger. The sample was ethnically diverse; four women self-identified as Canadian, two as Aboriginal, one as Hispanic, one as African, and seven did not identify with any ethnicity. Regarding educational history, five had some post-secondary education, two had graduated high school, and eight had not completed high school. At the time of the interview, all of the women were receiving some type of social assistance ($11 = Ontario Disability Support Program, 4 = Ontario Works$), which placed their annual income below the poverty line (Poverty Free Ontario, n.d.), and were living in subsidized supportive or transitional housing ($n = 13$), or were homeless (i.e., living at a shelter or with a friend; $n = 2$). Four women reported that they supplemented their social assistance with part-time work, as sex workers or peer outreach workers, and eleven women were unemployed.

**Procedure**

Participants were recruited from community-based organizations and agencies in the Greater Toronto Area, Canada that provide programs, services, and support for low-income individuals. A comprehensive and varied list of organizations was compiled via a Google search, and included shelters, employment resource centers, community health centres, food
banks, churches, and drop-in centers offering counselling, advocacy, self-health groups and educational programs, victim services, and housing services. Organizations serving men only, emergency shelters serving victims escaping abusive intimate partners, and legal aid clinics were not contacted to reduce the need to turn down interested persons due to ineligibility. Rape crisis centers were also excluded so as to avoid oversampling participants who had sought help for sexual assault-related concerns.

Agency staff members were contacted via email or in-person to explain the nature of the study and to ask if it would be possible to disseminate information about the study (e.g., post flyers, attach flyers to electronic newsletters) through the agency. The recruitment flyer (see Appendix A) invited women aged 18 or older, who self-identified as living in poverty, and who had experienced a sexual assault within the past five years that had resulted in psychological or emotional distress to participate in a study about decisions to seek help or not to seek help after a sexual assault. Potential participants learned of the study via the posted flyers or through word-of-mouth from staff members, and contacted the principal investigator via email or telephone for additional information about the study. Initial screening interviews were conducted over the phone to check that interested women were eligible to participate (i.e., met the inclusion criteria outlined in the flyer, were fluent in the English language, and were not experiencing a severe cognitive impairment, in circumstances of immediate crisis, or currently involved in a legal case). Potential participants were provided with additional information about the study and given an opportunity to ask questions, and those who were eligible and interested were invited set up an interview time.
Data collection took place between February 2014 and May 2014. Data were collected via in person, semi-structured interviews, conducted at a private research office located in a university building accessible by public transportation. Prior to each interview, the interviewer reviewed the information letter and consent form (see Appendix B) with the participant, placing particular emphases on the procedures used to ensure confidentiality and the right to withdraw without negatively affecting compensation or reimbursement. Participants were also invited to raise any concerns or ask questions. This time was also provided an opportunity for the interviewer to build rapport with the women prior to beginning the interview. Consent to participate was obtained in writing, and participants were provided with a copy of the consent form and encouraged to contact the researcher should questions or concerns arise at a later time. None of the participants requested to withdraw from the study. All interviews were conducted by the first author and recorded using a digital audio recorder with the consent of participants.

The interviews took between 39 and 110 minutes ($M = 57, SD = 18$) and were conducted with the aid of an interview guide (see Appendix C). The development of the guide was guided by the three stages in Liang et al.’s (2005) help-seeking model, as well as the existing literature on factors affecting formal service use decisions among sexual assault survivors and among members of low socioeconomic groups. At the beginning of the interviews, a structured questionnaire was orally administered to gather demographic information, such as age, employment status, education level, and income. Following this, participants were asked to talk about the sexual assault experience, providing only as much detail as they were comfortable with, and asked how they were affected by the experience.
The remainder of the interview focused on issues around help-seeking for sexual assault-related concerns from various support sources, namely community-based agencies (e.g., rape crisis centers, shelters), members of the criminal justice system (e.g., police, lawyers), mental health providers (e.g., therapists, psychologists), medical professionals (e.g., doctors, nurses), and informal support providers (e.g., family members, friends), using a combination of open- and closed-ended questions. Participants were asked about whether they had sought help from each type of support source, the reasons for their decisions, and their personal experiences of seeking assistance. An additional set of questions inquired about the women’s general views on the quality of formal supports for sexual assault survivors living in poverty, and factors that help or hinder access to these supports. These latter questions were thought to be particularly important in providing the space for women to articulate their needs, their thoughts on how factors such as class, gender, and ethnicity shaped these needs, and their recommendations for how the needs of sexual assault survivors struggling with poverty could be best met.

Consistent with a standpoint approach, the researcher maintained awareness of the potential for her biases and assumptions (e.g., anticipated findings based on existing literature) to influence the data, and actively sought to limit this influence through various measures. For example, building interviewer-participant rapport, treating the women as equals and self-disclosing appropriately, and valuing the women’s well-being and safety were maintained as priorities during the initial screenings and interviews, as these feminist interviewing principles have been found to be essential to the creation of a safe, supportive environment in which survivors feel able to speak freely and be heard (Campbell, Adams, Wasco, et al., 2009; Campbell Adams, Wasco, et al., 2010). During instances where
participants appeared hesitant to disclose their negative views of certain formal service providers or share their views on discrimination, the researcher communicated non-judgment and validated their experiences and views as a means of encouraging these women to speak freely. At the same time, women were assured of their right to decline to answer questions or to elaborate on their answers if they so wished; in the few instances where this wish was expressed implicitly or explicitly, this right was respected. The interviewer was also conscious to engage in dialogue, request clarification, and double-check the accuracy of her understanding of the participants’ experiences with the women themselves. Finally, although the questions were aimed at obtaining data relevant to Liang’s (2005) model, departures from the guide were welcome to allow women the flexibility and control to explore topics of interest and/or relevance to them, and the space to fully articulate their own narratives. These measures also served to better ensure that women felt heard, validated, and comfortable. Indeed, many of the women expressed that they had enjoyed talking about their experiences and that they had felt comfortable during the interview; three women shared that they were glad for the opportunity to talk about their experiences and to feel understood and not judged, and two women volunteered to be contacted for follow-up.

At the close of the interview, the interviewer checked in with participants on how they were feeling. Participants received a list of resources for information about sexual assault and relevant community resources and services (see Appendix D), $20 as compensation for their time and energy, and reimbursement for transportation in the form of public transportation tokens.

Ethical approval for this study was obtained from the University of Toronto Office of Research Ethics.
Data Analysis

The interviews were digitally transcribed verbatim, and the transcriptions were checked against the audio-recordings, line by line, to ensure accuracy. Braun and Clarke’s (2006) six-step model of thematic analysis was applied to the data in order to identify, analyze, and report themes around the help-seeking processes of women sexual assault victims living in poverty. Familiarity with the data was gained during the process of transcribing interviews, the initial reading of each transcript, and the jotting down of preliminary ideas in the margins. During subsequent readings, all units of text in the women’s responses pointing to potential factors that were influential in help-seeking processes were hand-coded, and data corresponding to each code were combined into separate Microsoft Word documents. Next, both inductive and deductive processes were used to conceptualize key themes and their interrelatedness; that is, the initial development of key themes was based on by both commonalities across women’s experiences, while also being guided by the research objectives (Braun & Clarke, 2006). Themes were then refined to ensure that they were inclusive, useful, and mutually exclusive (Patton, 2002) as well as both coherent and internally consistent (Braun & Clarke, 2006). Further organization and refinement of the themes occurred with the goals of checking that the data set was accurately represented and interpreted within the framework of the Liang and colleagues’ (2005) help-seeking model and existing literature on help-seeking among sexual assault survivors and low-income populations.

The results are organized into three main sections. First, background information on the characteristics and consequences of the sexual assaults experienced by the sample is provided. Next, seven themes related to factors that shaped women’s decision-making at
each of the three stages of help-seeking are presented. The final section presents three additional themes that emerged from participants’ recommendations for improving formal services.
CHAPTER 3: Results

Sexual Assault Characteristics and Consequences

Characteristics of the Sexual Assaults

Across the sample, the majority of incidents occurred between one and five years prior to the interview; two incidents took place over ten years before the interview. At the time of the assaults, nine women (60%) were homeless (i.e., living on the streets or in shelters), and six women (40%) were living in subsidized housing. Six women (40%) were raped by prostitution clients, three of whom were regular clients. Four women (26.7%) were victimized by a stranger, four (26.7%) were victimized by acquaintances (26.7%), and one woman was raped by an intimate partner.

Twelve incidents (80%) involved penetration, and ten (66.6%) involved the use of physical force or a weapon, namely knives and broken bottles. Perhaps not surprisingly, nine women described sustained physical injuries other than the rape itself (60%), and the majority of injuries were severe, involving head wounds, laceration/knife wounds, deep bruising, and sore muscles. Over half disclosed one or more past experiences of rape, sexual assault, or childhood sexual abuse.

The connection between poverty and sexual victimization, and the role this played in their own experiences, was talked about by many participants, including the following women:

People take advantage of you when you’re high and people take advantage of you when you don’t have money and you’re vulnerable. (Monica)

Men look for women who are vulnerable, for women who are poor to do that with. (Rose)
Sexual predators usually tend to focus on women that are in more vulnerable states. Like most sexual predators don’t like to take advantage of women that are independent and stronger. They look for women that are more weak (sic) to take advantage of. And at that time, I was in a weak situation. (Mara)

This greater vulnerability was often attributed to lifestyle factors that participants connected to their socioeconomic status. Many women spoke of the challenges they faced in trying to make ends meet while on social assistance, which often put them in situations where it was difficult to protect oneself. Working in the sex trade industry was a prime example of this, and was seen by participants as a choice made out of necessity by women who are “living in real poverty” (Jodie) and needed to make ends meet. Mara, who had started working in the sex trade industry when she was twelve and referred to prostitution as “my livelihood [and] my survival,” described being sexually assaulted and raped numerous times while on dates with clients. After last experience of rape, which had been particularly distressing, Mara reported that, “I just felt like I had no hope and felt like I had nowhere turn, really,” and described herself as trapped in “a cycle of despair.”

The link between financial instability and a compromised ability to protect oneself was also felt by other women not working in the sex trade. Lena believed that “most people, at least from my experience, will sense the fear or vulnerability” in women facing poverty and homelessness, which made them more likely to be targeted for sexual victimization. Monica spoke at length about the frequent sexual harassment she faced from men who lived in her apartment building and surrounding neighbourhood which left her constantly feeling fearful, and about not having the resources necessary to move into an area where she would feel safer and more comfortable. Monica also talked about how tight financial situations left
women susceptible to being “used for sex to get money,” describing her own financial struggles with trying to support herself in Toronto and her three children back home in Kenya on social assistance, and her experiences of being frequently offered financial assistance from men she believed wanted to take advantage of her sexually, and of finding it difficult to turn them down.

The Impacts of Sexual Assault

Perhaps unsurprisingly, all of the women reported being deeply affected by the incident in the immediate aftermath, and a number of women reported continuing to suffer from one or more impacts of the sexual assault even after several years had passed. The following illustrates some of the psychological, cognitive, and behavioural post-assault consequences were endured by women in this sample.

Psychological and emotional effects. Almost all of the women reported the development or worsening of symptoms of depression and anxiety after the victimization. Difficulties with concentration, increased irritability and anger, changes in appetite, and insomnia were also common. Accordingly, some began using or increased their dosage of prescribed psychotherapeutic medications to manage their distress and improve their sleep patterns.

Unsurprisingly, the incidents were “traumatizing” for many (e.g., Jodie, Maggie), and although only one woman reported developing PTSD, all of the women described one or more symptoms of psychological trauma. Nightmares and flashbacks, sometimes triggered by physical intimacy or individuals who shared physical attributes with the perpetrator, were reported by over one-third of the sample, while two women also experienced night terrors. Two women described how they had been affected by the sexual victimization:
It takes your whole life away… It took everything out of me… It destroyed everything inside of me. (Jodie, raped three years ago)

I get a lot of night terrors and a lot of nightmares, backflashes (sic), and then I get really depressed and I can’t focus on things much and all I want to do is sleep all the time. And before, I used to think about suicide. For a long time in my life, I used to think about suicide. It comes and goes. It comes and goes. (Mara, raped three years ago)

Nearly all of the women reported a loss of a sense of safety which in turn gave rise to fears associated with certain times of the day, public spaces, or groups of men. Accordingly, women frequently recalled staying home more and going out less, avoiding going out in public, or sleeping at night time. Monica developed a particularly strong fear of men who she began to see “as people who want to attack you” and “use me for sex”, which preoccupied her daily and made it difficult to form and maintain friendships. She shared multiple stories to illustrate the extent of her fear which she sometimes felt was “in [her] head”, in which being looked at or offered what she described as a favour or a compliment by any man, including gay men, male friends, and her pastor was cause for immediate suspicion and distress. Over one-third of the sample also described being hypervigilant for signs of danger, manifesting in behaviours such as continuously looking over their shoulders or changing how they carried themselves in public. For example, one woman stated:

I was scared. I was scared shitless. I’d be looking behind my back all the time, wondering if that’s them pulling over or somebody’s going to come get me now. I always thought somebody was after me all the time. (Rebecca)
Lisa described being startled easily by her children when they touched her unexpectedly, while Kate reported that she became “very violent towards men” after the rape (“I’ll stab them in a heartbeat because I’ve been hurt so I have to protect myself”) and that she had served a ten-year prison sentence for assaulting a man with a knife in reaction to him grabbing her.

Moreover, for many of these women, the depression, anxiety, and nightmares persisted for two or more years after the assault. Fear, too, was something that stayed with these women, with a feeling of being safe never being fully restored. For example, one participant, who was raped two and a half years ago, shared:

I didn’t sleep well. I didn’t want to be alone when I walked at night. I was more fearful, you know, [and] I was never fearful before... You know, even to this day, there’s [sic] places I won’t walk. Before, I would walk through the park at night. So that’s still there. (Amy)

Beth, who self-identified as a transgender woman and reported a long history of physical and sexual victimization, sustained a stab wound that she perceived as life-threatening when she was raped three years ago. The incident prompted her to start “disguising myself in a more masculine way” to deter future attacks and for her, fear was also a lasting effect that, although subsided, was still present four years later:

Even to this day, like he’s been out and I’ve changed my appearance, I still walk down the street watching my back. Every corner I turn, I’m like, ‘Okay, he’s going to be there just to finish me off this time,’ so I’m kind of messed up about that. (Beth)

Maggie, who was sexually assaulted by someone who lived in the same apartment building, reported that she remained fearful of being assaulted again until he passed away.
Changes in beliefs and attitudes. Many women also described alterations in their beliefs and attitudes towards themselves, others, and the world. In addition to the loss of feelings of safety described above, self-blame was common. Although few women held themselves responsible at the time of the interview, many recalled believing that they had done something to cause their victimization or could have done something to prevent it. For example, two women described their thoughts following the rape:

I was thinking to myself that if I wasn’t wearing this, if I wasn’t doing that, then it wouldn’t have happened. If I wasn’t a – how can I say this – if I wasn’t a trans-female, I wouldn’t have been targeted. Just all kinds of thoughts going through my head, like if I wasn’t dressed up, if I wasn’t working, if, if, if... (Jodie)

At the end of the day, I always came back to the idea that I could have made something else happen, like I could have avoided it. (Lena)

As these quotes illustrate, although some participants did identify specific behaviours that they believed contributed to the assault (e.g., being a sex worker, using drugs with a client), it was more common for women to have only a general sense that they were at fault, and to suggest any and all behaviours as possible catalysts for the assault, including “being nice” (Nicole), failing to notice “anything at all that could have acted as a flag” (Julie), or, simply, “allowing this to happen” (Monica).

In addition to self-blame, sexual victimization often had a negative impact on self-appraisals, such as self-worth and self-esteem. Words like “weak-minded,” “stupid,” “inferior,” “dirty,” “worthless,” or “a bad person” were used to describe how these women perceived themselves after the rape. Monica reported that “there are times I feel (pause) like useless and I feel like I’m just someone that is to be used by other men and women.” Self-
directed anger was a part of some women’s post-assault cognitions, as was the case for these two women:

It makes us hate ourselves. We think we’re useless, we’re broken. (Lisa)

At the time, I was angry at myself because I got into working on the street, being a sex worker and working for money and degrading myself in a lot of ways. And I had to do what I had to do to survive – and I think about it that way, the way I was brought up by my own self. I made some mistakes. I got to struggling, too, with being trans... Like a lot of that cycle that I went through, and the experience, and the knowledge of the streets, I think all that combined into hating myself because of all that. (Jodie)

As Julie put it simply, “You beat yourself up about it.”

The belief that others could be trusted was also challenged. Women often described that they were unable to trust anybody after the assault, including long-time friends, family members, and significant others, and preferred to keep others at a distance. Statements such as the following were common:

So the trust for people is definitely gone. I’m very closed and I don’t open myself up for anybody. (Lisa)

I didn’t like to be touched or couldn’t get close to anybody. I lost trust in a lot of people. I couldn’t trust. It was hard for me to trust people. (Jen)

Nearly all of the women reported losing trust in and being more cautious towards men specifically, an attitude that many women believed would help prevent future assaults. For some, discomfort with physical intimacy in romantic relationships and a loss of sexual desire after the incident were new. For others, the most recent rape only reinforced a pre-existing
distrust of men or people in general, which was described as deeply ingrained due to past experiences. Rebecca and Mara, for example, linked their longstanding issues with trust to working in the sex trade industry since they were teenagers, and having years of being “nothing but used and abused by men” (Rebecca) and needing to exercise caution with clients.

**Isolation and maladaptive coping behaviours.** Some women reported that they withdrew from social life and friends and family members for a period of time after the assault and adopted maladaptive behaviours often as a way of coping with distressing feelings and thoughts. Beth frequently observed sexual assault victims “getting stuck in a rut... of thinking and believing that it was their fault when it wasn’t” which in turn led to isolation and self-harming behaviours, a pattern that was also her experience:

> I was isolating myself a lot. I was medicating with illegal street drugs, just, just shutting myself off from the rest of the world. Didn’t want to be bothered by anybody. Really irritable, irritated. Just didn’t care. Wanted to give up, wanted to die, just the whole nine yards. (Beth)

The use of substances “to numb the pain, to escape reality” (Beth) was shared by Kate, who explained that she “beat up my own body” as way to “numb all my emotions”:

> “I went to suicide. More drugs. Because I tried to numb it with the drugs so I didn’t have to think about it and I tried to commit suicide a few times, slashed my arms, stuff like that. Tried to overdose. My self-esteem went down.” (Kate)

Jodie understood the two-year period of “isolating myself from everyone” as a result of “not know[ing] who to trust” and finding it “so hard to acknowledge the experience.” Self-blame and shame led Nicole, who was assaulted by a co-worker, to leave her job due to concerns
that co-workers knew about it and were judging her negatively, and to turn to alcohol. Indeed, alcohol and drug use and abuse were the most frequently reported maladaptive means of coping, although some women also reported self-harm, suicidal ideation and attempts, and risky sexual behaviours.

Psychological and emotional distress and negative cognitions were often at the root of the isolation and maladaptive coping behaviours that emerged and often lasted years after the sexual assault itself. At the time of the interview, the majority of women reported a continuing struggle with depression, anxiety and fear, and difficulties trusting others, with some reporting additional issues. This was reflected in statements such as the following:

I got over it, kind of. Well, I don’t think I’ll ever get over it. (Nicole, raped four years ago)

It gets better, but I’ll never forget. (Rebecca, raped four years ago)

As time goes by, as time passes, things start fading away a little. But it’s always there. It never completely goes away. (Maggie, raped four years ago)

Beth and Lisa talked about having physical scars from the injuries they sustained during the rape that served as a perpetual reminder of the event and the trauma endured. The notion of being permanently changed in some way was echoed by Jodie, who said, “I think a lot of women, myself, and other people in this world have big scars in our lives and we’ll never get rid of [them].”

**Influential Factors in the Help-Seeking Process**

This section examines the ways in which women understood their decisions around seeking formal assistance. Overall, all but two women received at least one type of formal support for a sexual assault-related issue after the incident. More specifically, six women
received assistance from the criminal justice system (e.g., police, courts; 40%), eight from a medical health professional (e.g., doctor, registered nurse; 53%), six from a mental health worker (e.g., psychiatrist, psychologist, counsellor, social worker; 40%), six from a community-based agency (e.g., rape crisis centre, victim services, refugee services; 40%), and one from a spiritual leader (i.e., an Aboriginal healer; 7%). The most commonly used services from community-based agencies were counselling services and support groups.

While for some, the help-seeking process began almost immediately after the rape, for the majority, help-seeking was delayed anywhere from two months to ten years after the sexual assault. Thematic analysis revealed seven factors that were influential in participants’ help-seeking decisions. Organization and refinement of these themes were guided by the interrelationships between them, as well as Liang et al.’s three-stage help-seeking model.

**Stage One: Appraising and Defining the Problem**

In the first stage of the help-seeking process, victims evaluate the nature of their experiences and use these understandings to make a judgement about whether help is needed (Liang et al., 2005). Two key themes emerged around how participants’ understandings of medical and mental health issues, and of sexual assault, affected their help-seeking decisions. Despite the violent and distressing nature of many of these women’s sexual assault and post-assault experiences, many participants reported that they did not perceive the need for formal assistance, particularly immediately after the assault, and, accordingly, did not reach out for help. Moreover, their assessments of the sexual assault and its consequences were often shaped by past and present life circumstances connected with their socioeconomic location.

**Conceptualization of medical and mental health issues.** As noted above, over half of participants described sustaining injuries from the perpetrator’s use of physical force (e.g.,
stab wounds, head wounds, deep bruising) and all described psychological and emotional issues resulting from the traumatic nature of the rape itself. When asked whether they had sought help from a doctor, however, many participants expressed the belief that help was not needed. For example, Amy, who described extensive injuries after being kicked repeatedly all over her body and head and dragged across the ground by the perpetrator, reported that she decided to “just let myself heal”:

I was black and blue let’s put it that way, but it was the kidneys that hurt the worst because I couldn’t lie down, I couldn’t get comfortable, you know? I was whimpering in my sleep for a couple days, you know, people were telling me… it hurt when I peed but I wasn’t peeing any blood or I would have went to the doctors, but I didn’t. (Amy)

In addition, of the six women were in contact with hospitals in the immediate aftermath of the assault, only three had actively contacted emergency services themselves, and one of these three had done so to get help for the perpetrator who had stabbed himself and was “bleeding to death on my floor.” In the remaining three cases, it was a bystander or a significant other who had called 911, and it is unknown whether these women would have elected to seek medical treatment for their injuries or testing for sexually transmitted diseases if emergency services had not been contacted on their behalf. Indeed, excepting the six women who were seen at hospitals immediately after the assault, only two women reported speaking to a doctor about the sexual assault, leaving seven women who had never talked to a doctor about the incident.

Problem definition also played a role in influencing participants’ decisions to use mental health services. As noted above, although the majority of women did eventually seek
out and receive some type of mental health treatment, many delayed doing so, in large part because the sexual assault was overshadowed by other issues. For example, Jodie, who was raped at knifepoint and physically assaulted by a client, talked about her preoccupation with survival needs rather than with treating her depression and fear:

I never thought about getting the help... My mind was like, ‘Go get that money,’ you know? Then I can go out shopping, I can pay off my bills, so whatever disability gives me, I can just save that, and with the extra money that I make, I can pay my bills. (Jodie)

In her view, her reaction was typical among sex trade workers who tended to “just block it out” and never seek help:

I know a few women who’s (sic) been sexually assaulted three or four times and they’re still working. They don’t want help... They’re thinking, ‘Okay, I’m going to go and forget that. I’m going to go to work, make money, get my drugs, get high, just kill the pain off.’ And then they’re going back to work again, and then it happens again. It happened to me. (Jodie)

Other participants also raised the issue of low-income and poor women often lacked the motivation or ability to seek help, citing addiction and isolation as common barriers to seeing the need for help. Based on their experiences, they believed that many women living in poverty “won’t bother” to get help (Nicole), “go to drugs” (Nicole), and “just bide their time [and] go on with their everyday lives” (Rebecca).

Oftentimes, this way of understanding the event and its impacts was implicitly or explicitly rooted in their present circumstances or life histories, which, as noted above, were often coloured with negative and traumatic events. Tammy, for example, was a victim of
group rape and forcible confinement. Although her boyfriend had decided to call 911, when asked whether she felt like she needed counselling, Tammy replied:

> I haven’t really dealt, like really... I’ve had some really bad things happen in my life, so I just kind of chalked this up to something else that happened. And I’m a really strong person, so I just moved forward with what happened. I’m not dwelling on it...

> It’s not that it doesn’t affect me, but I just, like I said, I don’t dwell on it.

> [Interviewer: Like, ‘It’s just another thing...’?] Yeah, yeah. It has to be. For me, that’s how I deal with stuff. (Tammy)

When asked how the rape had affected her, Julie attributed her acquired “ability to laugh it off” to having previous experiences with sexual victimization, both personally and through her friends.

> However, whereas many women did not ever perceive a need for medical assistance, the majority of women reported that they did eventually come to view their psychological and emotional distress as a problem. When asked what was going on in their lives when they began searching out help, many women described having realizations that they could not “deal with it alone,” and that professional help was needed in order to alleviate their symptoms:

> Fear and feelings of loneliness. Like feeling like I needed support because after that, it felt like there was no safety anywhere. (Lena)

> For the longest time – it lasted about two years after that happened – I was really, really, isolating myself from everyone, and I realized, I said, ‘You know, I can’t be isolating myself. I need to turn around and get the help I need.’ (Jodie)
I was alone and I was depressed and [I had] nobody to talk to, so I had to open up and tell them, ‘This is what is happening with my lawyer.’ (Monica)

I thought I was going nuts. I thought I was losing my brain mentally. Crying all the time. I couldn’t stop crying. (Tammy)

It was common for participants to describe the period of time when they began considering formal support as a “turning point” when they realized that the impacts of the sexual assault were beyond what they could manage alone. For example, Lisa described the moment she decided to access formal support three months after the last incident of physical and sexual abuse from her ex-husband:

At one point in my life, like just after we had split up, I was cutting myself. Not deep but I was. And I started to realize that I don’t want that life for my children. I don’t want them growing up, seeing this type of environment. So that’s when I started seeking help because I knew there was damage done that needed professional help.

(Lisa)

Kate reported that it was only when she began serving a 10-year sentence for assault with a weapon that she started “looking for ways to heal [and] to start getting to the roots of my problems.” Although the majority of the treatments she underwent in prison were mandatory, Kate described herself as a motivated and engaged participant, and reported continuing to seek mental health treatment after her release. For many of these women, it was when the distress was defined as something that needed to be changed and could not be changed on their own, that they began reaching out to friends and family members, as well as counsellors, social workers, support groups and doctors.
Conceptualization of sexual assault. The ways in which women interpreted their experiences of victimization also influenced their judgements regarding whether formal assistance was needed. There was a tendency among a few women, such as Julie, to normalize their experiences:

Well growing up how I did – and it happened one time a long time ago with a cab driver – it wasn’t anything really like explosive like it was maybe with the cab driver [where] I was really, really shaken up. With this one, it was more – and I had already had a little with of experience with the people that I was hanging around with – knowing that it happens. It just happens, right? So like I’ve been there for other friends when it’s happened to them. (Julie)

The idea that rape was something that “just happens” was echoed by others, such as Lena, who reflected that being homeless and frequently in unsafe situations where rape was “bound to happen” had shaped how she felt about the rape, and she recalled thinking that “because it’s so often occurring that it’s not as serious.” In a similar vein, Mara, who began working in the sex trade industry when she was thirteen, said, “[sexual assault] always played into my life and I never really looked at it as sexual assault... I just looked at it like it was fucking normal, right?” She described a history of rape beginning at age eleven, physical violence from clients, including being choked, beaten, and almost run over by a car, and intimate partner violence, including rape and physical assault, which she summed up almost casually, saying, “You know, those are just other stories about life and sexual assault.” Although women were not asked, their personal stories were often interwoven with stories of other women’s experiences of being violently physically or sexually assaulted, or murdered. As these excerpts illustrate, these women did not appear to be minimizing the seriousness of
their specific experiences of rape; rather, they appeared to be normalizing or downplaying rape in general, because of the frequency with which they personally experienced or witnessed violence in their everyday lives, which in turn, gave rise to a belief that help was not needed.

A few women did, however, interpret the events in ways that facilitated formal reporting; namely, they viewed what happened to them as serious crimes that needed to be made public. Beth, for example, explained her decision to speak out about the assault “right away,” both formally and informally, saying:

It helps me when I speak up because people get to know about who’s doing this and what they look like, and what they’re driving and stuff, you know what I’m saying? If I keep my mouth shut, I’m allowing him to do that to other women. Yeah, so I spoke out. (Beth)

As noted above, six women were in contact with emergency services almost immediately after being sexually assaulted, albeit not always voluntarily. Nevertheless, the perceived need to ensure the physical safety of women and to get justice for a crime committed emerged as strong motivators for deciding to engage with formal support, and all but one agreed to file a report with the police. For example, Tammy reflected that although she had not been the one to called 911 and had “just wanted to go home” and not talk to anybody, she ultimately agreed to engage in criminal justice process because she believed that “it was the right thing [to do]”:

I’m glad that I did [talk to the police], just to call them out [and] to not let them get away with it... It didn’t, like I don’t know if it made me feel better. I just thought I was doing the right thing, that’s all, because somebody did something that was that
horrendous to me... If I would have just went home and didn’t do anything, they would have gotten away with it. And that wasn’t gonna happen. (Tammy)

Similar beliefs were described by two women who had called 911 seeking medical attention but also agreed to get rape kits done and to provide statements to the police. That is, the perceptions that an injustice had been committed and of a threat of future harm that could be prevented prompted these women to report the sexual assault, so that the perpetrator would not “get away with it” and “do it to other people” (Maggie), and could be “punished” (Beth) and taken “off the streets” (Jodie). The conceptualization of rape as a serious crime against women was salient across the sample, perhaps because it was such a common threat and experience faced both by themselves and by other women they knew and had helped through their experiences of victimization. Indeed, many women, including those who did not file police reports for reasons described below, shared that they had made it a priority to tell friends and acquaintances about the assault so they would be aware of the perpetrator, and/or had reported the incident to the Bad Date Book, a publication circulated to sex workers containing information on individuals suspected or alleged to have committed assaults while soliciting services from sex workers.

This analysis illustrates the ways that problem appraisal and definition shapes help-seeking decisions in the first stage of the process. For the women in this sample, perceptions of whether or not their assault or post-assault experiences warranted help, influenced whether or not they delayed help-seeking or sought help at all from medical and mental health workers, as well as individuals in the criminal justice system. Moreover, socioeconomic factors often played a role in shaping how problems were assessed or understood. On the one hand, the pervasiveness of violence in their lives may have primed many women to
understand rape as a serious crime and a real threat to women’s safety, and, as a result, made them inclined to report their sexual assault experiences. On the other, there was some evidence that tendencies to minimize or normalize the incident itself, as well as its aftermath, were a reflection of both present and past stressors and traumas. For example, psychological distress was often initially downplayed relative to more pressing issues such as basic survival needs as well as addiction, and the rape itself was often normalized in relation to other instances of violence experienced themselves in the past or vicariously through others around them. Although to some extent, this reaction may be a reflection of these women’s resilience and ability to cope with frequent stressors and traumas, it also deters women from accessing the medical attention that they may need.

Stage Two: Deciding to Seek Help

The second stage of help-seeking builds upon the first, in that it begins when victims understand their experiences as a problem to be resolved, and that resolution requires the assistance of others (Liang et al., 2005). A number of common themes emerged from the interviews, as participants described their reasons for and against deciding to seek the help that they felt was needed. These encompassed individual, interpersonal, and sociocultural factors, and were intrapsychic barriers, accessibility issues, and the availability of informal support. Again, the influence of socioeconomic location was often apparent.

**Intrapsychic barriers.** Intrapsychic barriers, such as feelings of shame and self-blame, and fears of judgment and prejudice from others, played a central role in discouraging women from making the decision to seek help. Delayed disclosure was frequently attributed to feelings of shame and responsibility for the assault. As described above, many women’s self-evaluations were negatively impacted by their sexual victimization experiences, in part
due to the internalization of the stigma associated with sexual assault. This in turn led them to worry that support providers would come to share their view if they learned about what happened:

With my close friends, I was isolating myself. I wasn’t reaching out for help or talking to anybody about it. I just felt dirty, shamed. (Beth)

I know I felt, ‘I don’t think anybody will ever respect me again.’ I thought I was losing my own self-respect too, and... I just kept thinking, ‘I hope nobody knows, I hope nobody else knows.’ (Nicole)

When asked what made it difficult to seek desired assistance after a sexual assault, a number of participants talked at length about the role of negative judgements from others. For example:

I think fear of judgment that they may have been doing something wrong. Like their friends might think, ‘Oh, you were putting yourself in a bad situation,’ stuff like that. Judgement is a big one. And then in general in society, there are some stigmas around it. Sometimes guys will be like, ‘Oh, she shouldn’t dress that way,’ or stuff like that. (Lena)

Just judgement, I think. Just the attitudes, like, ‘Well, you shouldn’t have been alone, you shouldn’t have been there, you shouldn’t have been,’ kind of thing. (Amy)

If there wasn’t a lot of physical damage done to your body – say you didn’t rip or they didn’t punch you out or there’s no bruises or they used a condom, there’s no tears, there’s no semen – they’re going to look at you and think you’re just crying wolf. (Lisa)
Concerns about being blamed by others were often intertwined with participants’ own feelings of responsibility and guilt.

Not knowing what the end results will be. They don’t want to be laughed at or be told that it’s their fault, or they can’t stop blaming themselves, stuff like that. There’s (sic) a lot of things going through your head, right? ... It was hard for me. That’s why I retaliate with anger. (Kate)

They don’t want to talk about it, they don’t want people to know it happened to them, they don’t want people to think, “Well, what did she do?’ or “Why...,” you know?...

Even if it’s not true, you’re still going to feel that [way]. (Tammy)

Tammy continued, saying “People can feel like they’ve done something wrong and feel like a victim for a long, long time.” In fact, the majority of women demonstrated an awareness of the frequency at which sexual assault victims faced victim-blaming and doubting responses from others, and reported that this had played a role in their own decisions to delay reaching out, both informally and formally, when they had wanted help.

Unfortunately, these feelings were often exacerbated by the marginalized position these women occupied by virtue of poverty, gender, and ethnicity, as well as situational factors that arose from financial constraints. Maggie talked at length about the ways in which poverty affected individuals’ willingness to seek help, describing the ways in which “society likes to limit your choices,” by providing examples of discrimination in the labour and rental markets, and exclusion from mainstream activities. She went on to describe the stigma that the poor faced in society and how this was internalized:
When you’re living in poverty, you get stigmatized badly, just as you’re stigmatized if you have mental health [issues] or addiction. You really get stigmatized and people think that they can take advantage of you or exploit you. (Maggie)

They tend to have lower self-esteem, lower self-confidence, lower self-image...

Because when you’re in poverty, you feel you’re very limited in resources, and you feel like your horizons or future outlook is not positive, and you feel you can’t accomplish as much as the one who has money... What I’m saying is that you feel your possibilities [are limited] so that really tears you down. (Maggie)

The impact of stigmatization on women’s self-concepts was also described by Amy, who expressed that she was made to feel “like a lower-class citizen” by societal attitudes towards poor and homeless individuals. Relatedly, when asked about potential barriers to help-seeking faced by women living in poverty, Amy and Beth listed a myriad of factors that frequently formed the basis of prejudicial attitudes towards the poor, and could deter these women from coming forward due to fears of further exposing themselves to negative judgements, such as blame:

Maybe they have warrants for their arrest, maybe they’re wanted for something, maybe they’re a drug user or have addictions, maybe they’re in the sex trade business, maybe they’re a woman of colour where they think they’re going to be judged or ridiculed because of the colour of their skin. Right? All kinds of things... Maybe because of what they were wearing, maybe because they’re well-known. Who knows? There’s [sic] many different reasons for police to just treat them differently. (Beth)
Because they think that if you live on the street, you do this. You’re all prostitutes, you know what I mean? Or drug addicts or something... Yeah, they assume something. That it’s your fault in some way, for your condition or for your situation at the time… It’s your fault, you’ve allowed yourself to become homeless or whatever. A lot of people think that way. (Amy)

Both Nicole and Monica expressed the sentiment that by virtue of being poor and ethnic minority women, they would not be trusted or believed by others. Indeed, Monica’s concern that “people won’t trust that I say the truth because he’s in a higher position so people would rather trust somebody who’s in the higher position” led her to keep silent for months before coming forward about the sexual assaults by her lawyer.

For some women, situational factors surrounding their victimization experiences which stemmed from their socioeconomic location provided additional reasons for them to feel shame and guilt or to believe that they would be blamed by others. When asked if there was anything that made it difficult to get help, Amy and Rose talked about their concerns that they would be judged for being homeless or selling sex at the time of the rape:

I think just my circumstances, just being in a shelter. I think that if I was in my own place, and I was just taking a walk to the store or something, and that happened, I would have called the police, you know what I mean? It was different, I was out there just smoking joint, just hanging around, do you know what I mean? (Amy)

If it happened during the day, maybe [I would have sought help] because I shouldn’t be outside at night. Night time’s when most crimes happen, in the middle of the night, and that’s what made me more, ‘I put myself in that situation.’ (Rose)
While Mara had reported past incidents of physical and sexual victimization to the police, the last incident, which “affected me a lot”, was not reported due to “shame and embarrassment,” as well as self-blame surrounding the fact that she had been using drugs with a client that she did not know well, leading up to the assault. In a similar vein, although Rose was “not afraid to report rape,” she ultimately decided against going to the hospital after the rape, despite being worried about having a concussion and needing stitches for the severe head injury she sustained. She expressed concern that others would be less inclined to be sympathetic because she had been raped by a client, and stated, “I was afraid to,” elaborating that, “I don’t want to be blamed. I don’t want to be looked at like I did it, you know?” and, “There’s (sic) details that I didn’t know how to get across.” The narratives of these women illustrate the significant role that shame, self-blame, and fears of being blamed and stigmatized by others in deterring sexual assault survivors from seeking help. They also highlight the ways in which the everyday stigma and prejudice faced by poor individuals were felt to further dissuade women living in poverty from seeking post-sexual assault assistance.

**Issues of accessibility.** Contrary to expectations, the availability of appropriate resources was rarely mentioned as a barrier to help-seeking. Only one woman reported that a dearth of services for victims of violence had discouraged her from seeking help, and it was only when she moved to a different city where there were “a lot more services up here for violence against women, whether it be sexual, domestic, anything” (Lisa) that she began reaching out. It is worth noting that Lisa was also the only participant who resided outside of downtown Toronto, which may point to geographical disparities in the availability of support services. Such disparities were also noted by Maggie:
It depends on where you live. We’re lucky we live in Toronto. If you were to live in a small town up north or in the rural area, you may not get the support because it’s harder to even get access to information. They may not even have services, so it’s a lot harder. (Maggie)

For the most part, however, women appeared to be in agreement that low- or no-fee formal support providers from which low-income and poor women could access assistance after a sexual assault were widely available. As Kate expressed, “People [who are] low-income, we have a lot of programs. There’s a lot of things out there for us and people who are homeless... but you just have to be the ones who make the right steps to take on those programs.”

There were, however, other accessibility issues that emerged. One important barrier was the lack of knowledge that such supports existed. Nicole and Maggie noted that while they perceived an increasing openness in society to discussing sexual assault and disseminating information about relevant services and programs in phonebooks, on the Internet, and through physical postings, they also believed that many victims remained unaware about their existence. As Nicole stated, “A lot of them don’t even know where the resources are because these poor people, some of them don’t know who to ask or won’t ask.”

Indeed, Maggie identified the police forwarding her information to Victim Services, who in turn referred her to group counselling at a community agency, as the most supportive aspect of her help-seeking experiences. She explained that in the days following the assault prior to being called by Victim Services, she had been undecided about whether to reach out formally or not, because “I didn’t know where these programs are.” Moreover, Maggie believed that it was her role as a peer support worker at a community health clinic that enabled her to gain
knowledge about available services, and that access to information remained an issue for individuals living in poverty, many of whom were not similarly actively involved in the community or did not have access to phones or computers.

This issue of awareness was believed to be exacerbated by the fact that poverty places restrictions on the range of services that could be used due to limited financial resources. A few women spoke to the idea that low-income and poor women not only had to know that support services were available, but they also had to be aware that low- and no-fee options based on financial need were available in order to be sufficiently motivated to actively seek out more information. Lisa, for example, described how the assumption that mental health treatments cost money could discourage women from explore and learning about potential affordable options:

A lot of women think, ‘Oh I’m going to need a shrink, I’m going to need a psychiatrist, or a psychologist,’ or anything like that which cost a lot of money... It’s a lot of women going, ‘Okay I’m broke, I have no money, how am I going to afford help? I might as well just go to the hospital, say, I’m having panic attacks, don’t mention anything, they’ll prescribe me something for the panic attacks and I’ll walk out.’ (Lisa)

A similar scenario was described by Maggie who noted that survival for those living in poverty necessitated becoming “very resourceful” compared to those in more affluent situations. This was echoed by Mara, who expressed that the fact that a poor woman would be “always worried about money” heightened the importance of “knowing the right connections and reaching out to the right hands” for support.
It is worth noting that for the most part, all of services used by participants were free of charge, and that the cost of services was never mentioned as a barrier to help-seeking both for themselves and for women living in poverty in general. However, one woman (Nicole) did attribute her decision not to pursue counselling and psychotherapy services at two organizations to the need to pay bus fare, and articulated a preference for health services that were located within walking distance. Nicole also noted that a lack of access to phones or outlets, which was common among women living in poverty, could create logistical challenges for help-seeking.

**The absence of informal support.** The receipt of negative responses or the absence of support from informal support providers also seemed to deter help-seeking. This occurred as women’s beliefs about themselves, the sexual assault, or how others would respond were validated. For example, Lisa endured five years of physical and sexual abuse from her ex-husband and only decided to start seeking formal help three months after the last experience of abuse. Her reasons for deciding to “keep it all hidden” centered around a fear of being blamed and disbelieved by formal supports which had been reinforced by her ex-in-laws’ disclosure reactions:

> When it was happening, I always told myself that I was going to call the police. I was going to talk to somebody. I never did. I always thought, “Who’s going to believe that someone’s husband is raping you?” His parents always took his side. Because I went to his mom a couple times and she just said, “Well, maybe you should be more of a wife, and maybe it wouldn’t happen.”... I reached out to his family to see if maybe they could help him one way or another and when I got rejected from them, I figured, well if they don’t believe me, why would anyone else? (Lisa)
Similarly, Lena, who had been criticized by friends for being in the wrong area or hanging out with the wrong people when she disclosed prior sexual assaults, explained, “I learned to keep to myself because I felt people judged sometimes,” and neither reached out to informal or formal supports for the most recent rape.

The connection between informal support and formal help-seeking was also observed among three women (Tammy, Rebecca, Rose) who described themselves as having no close family members or friends upon whom they could call. Moreover, all three reported being hurt by the lack of support they received when they disclosed the rapes to their mothers, who were described to be emotionally and physically unavailable. In addition, two described receiving blaming responses from their significant others:

My boyfriend actually a couple of times said it was my fault, so that is an extremely brutal thing to say to anybody. Yeah, so that just hurt more than anything. (Tammy)

When we fight and argue, [my husband] says just stuff like, ‘No wonder that happened to you because you’re a bitch and you’re a whore.’ (Rebecca)

Tammy, Rebecca, and Rose were three of the four participants in the sample who never actively sought formal assistance after the assault, although in two cases, others had called 911 on their behalf. Moreover, although Rebecca sought help from a doctor for psychotherapeutic medications, she opted not to disclose the assault. The influential role of informal support providers was affirmed by a number of women, who expressed the belief that the absence of a strong social support network would make it more challenging for victims to access the support that they needed after a sexual assault. Indeed, when asked what would make it easier to get formal help, Tammy stated that “support from your family is huge,” while Beth expressed her belief that that it was important for women to first reach
out and make sure they have the support of a friend, which would make it easier for them to report to the police.

Positive responses from friends and family members were frequently described to facilitate formal help-seeking in two ways. First, receiving emotional support from individuals within their social network helped alleviate the negative beliefs held by the women themselves and also helped ease their worries about the negative reactions they might receive from formal supports. This was the case for Beth who had positive, supportive experiences reaching out to friends and family:

By speaking out, talking, and asking for help, it builds a bond between you and your supports... I feel it helps to build a strong bond with your supports and stuff, and it kind of makes it easier to go forward and charge the person and call the police. (Beth)

Nicole reported that disclosing to her friend and daughter was helpful in that she became motivated to report the sexual assault by her co-worker to her bosses who then fired him:

Maybe I needed that encouragement, someone to say, ‘Yes, go talk to the bosses,’ because I didn’t want to at first. But I did, so they did encourage me to do that instead of just trying to deal with it alone.

Second, friends were often a valuable source of knowledge regarding existing and helpful formal services. For example, many of the women who had attended group counselling at a rape crisis centre had learned about this service from friends whom they disclosed to:

I didn’t even know about [the rape crisis centre]. A friend told me about it and took me there... She seen what I looked like, and I told her what happened, and she’s like, ‘Come over here,’ and it was good. (Amy)
I was at a drop-in for lunch and a friend of mine came in and said, ‘They have this place where you can go to. I’ll take you there.’ She says, ‘I go there.’ And ever since she took me, I’ve been going every two weeks for over a year. (Jodie)

Nicole also ended contacting both the rape crisis centre and psychologist at the recommendation of two friends. From the women’s perspectives, the value of these exchanges was not only in learning that certain services existed, but also that others had positive experiences, and it was these two pieces of information that encouraged them to also reach out.

This section examined the factors that impacted these women’s decision-making processes at the second stage of the help-seeking process. Central barriers included feelings of self-blame, shame, and the fear of negative judgments and prejudice from formal support providers, which were frequently made worse by the marginalized position these women faced as a result of their socioeconomic status. Moreover, across the interviews, these individual and interpersonal barriers appeared far more salient than did issues of accessibility, although a lack of awareness of existing services among poor women was felt to be a real and significant challenge to help-seeking. Finally, negative experiences of disclosing to friends and family members also served to discourage formal help-seeking.

While previous studies have noted the importance of informal support providers, the emotional support and tangible aid that friends and family members can provide may have particular significance for women living in poverty as they can aid in overcoming the challenges faced at this stage of the process.
Stage Three: Selecting a Support Source

After recognizing that a problem exists and making the decision to seek help, victims enter the third stage of help-seeking in which they decide what type of or which support provider they will reach out to. Of course, these decisions are based in part on the appraisals made in stage one regarding the nature of the problem and the help needed. At the same time, the women in this study did make choices regarding support source, taking into account their perceptions of, past experiences with, and the anticipated consequences of seeking assistance from specific formal support providers. Here, too, the influence of socioeconomic status on each of these factors was evident.

Perceptions of and past experiences with specific support sources. As noted above, fears of negative reactions factored largely into decisions about whether or not to seek formal help in general. It was, however, often the case that women distinguished among support sources, with some being perceived as more likely to judge them negatively than others, with these evaluations frequently rooted in past experiences. For example, both Julie and Lena attributed their decisions not to report in part to their first experiences of talking with the police after being sexually assaulted as teenagers. In both cases, women recalled being dissuaded from or being asked outright not to press charges and feeling like the police were more interested in protecting the perpetrators, who were a pair of adolescent boys in one case and a police officer’s son in the other, than themselves.

Moreover, it was common for past negative experiences to be understood as the manifestation of the prejudicial and discriminatory attitudes against their socioeconomic status and lifestyle choices. Many of the women who did not report the sexual assault, along with some who did, expressed strongly held beliefs that they would be poorly treated by the
police because of their poverty, which were supported by numerous examples of past negative experiences. Amy’s conviction that “the cops, when you’re in the shelters, they treat you differently” was rooted in her personal experiences, described below, as well as the experiences of others, such as a scene she had witnessed a few weeks prior to being raped, where police officers were called to the shelter to take care of a women who was intoxicated and suicidal, and proceeded to “beat the hell out her”:

One time, [the police] checked my purse. I was just standing outside and they said, ‘Somebody robbed somebody,’ and looked. And just like, you know, like you’re second class citizens because you’re outside a shelter. Yeah, I wasn’t going to bother [talking to the police]. (Amy)

Feelings of distrust and the sense that “they don’t really care” were also expressed by other women, who similarly based them on personal experiences, as well as those of friends and acquaintances, of mistreatment by the police, including being dismissed and physically assaulted. For example:

With the police, it’s like they do their jobs, but in certain situation, they banish you because of your financial status, or your gender, or what you do for... Like if I tell them I’m a sex trade worker or a prostitute, they just look at you and think you’re a piece of garbage anyways, the cops. It happens every day, right? You know they’re not there to protect us. (Mara)

I have friends or people I know who work on the street, and they live in poverty, or I have friends who live in housing so they are poor. And when something [happens], if they need a police officer, what they have to say really is not heard by them a lot of
times because they look at the situation, ‘Oh well, they’re in housing,’ or ‘Oh, she works on the street,’ or ‘Oh, she uses drugs.’ (Tammy)

These experiences were strongly believed to be reflective of police officers’ prejudices against people who were disadvantaged and marginalized because of involvement in the sex trade industry, poverty, mental health issues, and ethnicity.

Julie also linked police attitudes towards her, which she characterized as “dirty and degrading,” to her socioeconomic status, recalling an incident where she had approached two police officers for assistance and “as soon as I said I was staying in the shelter, their whole attitude changed.” When asked if she ever felt like she needed help from the police, Julie described the victim-blaming attitudes she would expose herself to, had she gone to the police:

Let’s just say he beat me up. No sexual assault. He just beat me up. It’s like, ‘Okay, he’s bad, I know it, he came up to me, he hit me, fine.’ You go to the cop shop [and] they’re the ones that make you feel dirty. They’re the ones that make you feel like you deserved it. They’re the ones that look at you and look at what you’re wearing. Or they’re the ones that look at your rap sheet and go, ‘Oh, okay, you were in for this, you did blah, blah, blah. Were you drinking tonight, blah, blah, blah.’ I’d rather just get beat up the once and keep walking, you know what I mean? I don’t need to feel small. (Julie)

Similar conclusions were drawn by other participants:

I didn’t think too much would happen. I just thought they’d be judgmental, and like, ‘You shouldn’t have been there,’ You should have been’ whatever. But I didn’t
bother. It crossed my mind for a minute, and I didn’t even really think about it.

(Amy)

If I didn’t really feel that way about the police, I would have called them maybe and said, ‘This is what happened. Can you come over and talk to me?’... I didn’t do that, but I would have done it maybe if I didn’t have that negative... I have this negative thing about the police because of the way they treat my people. I thought, ‘Oh, they won’t believe me. They won’t care.’ (Nicole)

Unfortunately, but unsurprisingly, these negative experiences stayed with these women and were often drawn upon to support these women’s conclusion that no positive results would come of reporting, as they would only be judged and blamed as they or others had been in the past.

While experiences of discrimination were often focused on interactions with police officers, they did unfortunately sometimes extend to other service providers. A few women described the negative treatment they had received or saw others receive from staff at various agencies serving low-income populations, such as shelters and employment agencies. Beth expressed irritation over the way her friend, who had an intellectual disability and had been raped earlier in the week, was talked down to by a staff member at their shelter during the morning of the interview. Frustration over “the lack of sympathy” demonstrated by individuals whose jobs it was to provide support was also felt by Julie and Beth:

It’s amazing how people keep their jobs and… or even choose jobs that require sympathy or empathy or something like that, and they don’t care one little bit about you. ‘Oh yeah, it’s the middle of winter, get out!’ ‘You looked at me sideways, get out!’… So I don’t understand how most people, why most people choose to work –
and half of them get off on it. Oh, if I can make your life miserable, I’m going to and you can’t do anything about it. It’s not just me. It’s like everybody in each one of these [support] groups is like, ‘What did your landlord do to you today?’ ‘What did blah blah blah?’ (Julie)

[Support] is key in order to get better. You need the support and what, am I going to talk to a staff member and she’s judging me because I’m trans? She’s judging me because of the way I dress? Because of the way I look? You think I’m going to go out and talk to her? No. (Beth)

There was no doubt in these women’s minds that their past experiences of being dismissed, treated without compassion or empathy, controlled, and disrespected were tied to their socioeconomic, gender, and ethnic background, and the perceptions that these service providers would be similarly judgmental in future interactions were a strong influence on choices of support source.

Accordingly, some women seeking justice and protection opted to fulfill these needs through informal avenues, rather than by going to the police. That is, women disclosed the assault and described the perpetrator to their male friends to “get my own justice” (Amy) and to their female friends to prevent a similar victimization:

I know a lot of big friends in that drop-in and plus, too, if I did see him and I’m in that drop in, I got a lot of women friends in that drop-in, so I’d be like (yells). And if he decided to run, that would be his problem, but at least they’d be safe. (Julie)

Amy explained her decision to tell her “all the guys I knew and everybody that hung around there,” saying, “because if I was going to see him again, I wanted to kind of get back at him.
I didn’t want to call the police. I’ve had some bad experiences with the police just being homeless, right? So I didn’t really want to go to the police.”

Also unfortunate was the impact distrust of police had on decisions to seek help from other support sources. When asked whether they had sought medical and mental health services post-assault, Julie and Nicole reported that they were ultimately deterred from following through on their desire to desired seek assistance by concerns that support providers would be obligated to report the assault on their behalf or would pressure them to report. This meant that some women who had felt they needed help never disclosed or delayed disclosing to staff members at shelters, doctors, counsellors, and for one participant, her mother who “would have been assertive in pressing charges” (Rose).

Positive perceptions of and experiences with support sources were equally strongly influential when women did decide to reach out to informal and formal supports. In fact, the majority of participants’ first disclosures were made to individuals in their informal social network. Seeking support from close friends was often talked about as natural response that did not require much consideration, as “they were the first ones that I thought to call for support” (Mara) or “it was really easy for me to just go to them” (Julie). Many women described having confidence that their close friends would understand and could relate and feeling at ease to open up, and attributed this to having gone through similar experiences or “walked down the same type of path” (Lisa) of abuse, sexual assault or rape (Beth, Kate, Nicole, Lisa), involvement in the sex trade industry, living in poverty (Beth) and being transgender women (Beth). These considerations were at play in Nicole’s decision to speak with one of her friends about the sexual assault:
People used to ask me, ‘What really happened?’ I don’t want to talk about it! It’s not like they care you know? (Nicole)

I didn’t really tell many people about it, just the one, just the one. Well, my daughter I told, but that was a little while later. Before that, I did tell a male friend I know... I felt comfortable talking about it because he’s talked to me about his problems when he went to school in a residential school, and what teachers and nuns and a priest used to do, stuff like that. So we understand... I didn’t worry about telling him.

(Nicole)

Similar life experiences, along with having known a person for a long time (Amy, Julie, Lisa) and having received support from them in the past (Beth, Kate, Lisa) were what often gave women confidence and trust that the informal supports that they did reach out to would understand and be “very supportive,” prior to actually doing so.

Confidence and trust often similarly shaped women’s decisions to engage with the formal support that they did. For example, Beth described how she navigated the dismissive and disrespectful attitudes that she often received at the shelter by consciously engaging only with staff members that conveyed respect or with whom she had built up trust from past experiences

You get some good staff and you get some bad staff, right? If I’m talking to a staff member at the shelter and I feel like I’m getting a negative feedback, I will go to the next one until I feel comfortable and I can actually talk to her and she’s looking in my eyes when I’m talking to her and not at the ground going, “Oh really, okay. Mm-hmm. Are you done?” There’s a lot of ignorant staff at shelters. It’s just, wow, I just had a few encounters yesterday with a couple of the staff at the shelter... So yeah, it
depends on who the person is at the shelter. Some of them can be [disrespectful].

They look down on people who are vulnerable, in poverty. (Beth)

When she did decide to talk about the assault, Beth disclosed only to a specific staff member who she felt she could talk to “about any issue that I have. She’s just very supportive and understanding, not judgmental. She’s there for me.” Nicole had debated between pursuing counselling at a rape crisis centre, a psychologist, and a healer, and ultimately decided on a healer at a Native health clinic because “usually, that’s where I go when I have certain problems, anything. They are there for me. It helps a lot.” Other women also spoke about their decisions to speak with family doctors or counsellors as “natural” given the pre-existing trust that had been built up over several years of receiving support:

It’s a doctor that I really trust... She’s a woman doctor and I’ve had her since the mid-1990s... If you have a really good rapport and a great trust in your doctor, you will be able to tell her anything. (Maggie)

Indeed, Monica, who had talked to her doctor about her issues with depression and trouble sleeping was prescribed psychological drugs, had not mentioned the sexual assault. She spoke about her decision not to talk about the assault, saying, “I’ve never had trust with men really, so I was not comfortable with the doctor,” but added that she have disclosed to another doctor who she had more trust in, if she had the chance.

**Fear of retaliation.** In line with the literature on non-reporting, fear of reprisal from the perpetrator was a strong deterrent to reporting the sexual assault. One-third of the women described fears that the perpetrator would bring additional harm to them or their loved ones if he found out she was behind the allegations to explain why they had decided not to speak with the police. Again, factors that emerged from their socioeconomic position sometimes
added an additional dimension to this barrier. Indeed, the majority of women for whom retaliation was a concern had been violently victimized by a client, as in the case of Rebecca:

I just didn’t want to because I had to live with myself and I knew that I was just gonna have to bite my tongue and go back and prostitute again, and I just didn’t want no problems with anybody. Like, he could have sent somebody to really hurt me, you know, if I pressed charges. I knew his name and everything though. He was a regular client... [and] he knew where I lived and everything. (Rebecca)

Moreover, according to Rebecca, had the very real possibility of future harm from the perpetrator not existed, she “most definitely” would have spoken with the police. Jodie believed that many women in the sex trade industry feared going to the police because “they think their lives are going to be in danger, because they think these people are going to come after them or something, you know, in the back of their mind.” While Jodie did overcome her fears of being physically harmed or killed by her attacker and report her own experience, she believed that the police “can only do so much. But even if they do, still the chance is 50-50 – chances that this person may come after you are 50 percent, the same chances that they won’t come after you. You have to think, what’s your safety at?” For Beth, the promise of additional support and protection offered by police was integral to her decision to testify, as she “didn’t want to testify because I was scared for my life”:

I’m thinking, ‘What if he gets out and he recognizes me and then he’s going to kill me.’ And then [detective’s name], the head detective from the sexual assault unit told me that she’s going to come to my hospital room every day until I testify, so I said, ‘Okay, I’ll testify.’ (Beth)
These women’s stories illustrate the ways in which lack of economic security and security of the person are often intertwined. For individuals living in poverty, limited financial and social resources can not only increase their likelihood of being sexually victimized, but it can also give rise to significant challenges to post-assault help-seeking. Unique factors such as the normalization of sexual assault, the stigmatization of poverty, and past experiences of prejudice and discrimination compounded the impact of barriers identified in past research, which were also at play here.

**Recommendations for Improving Utilization and Quality of Formal Services**

This final section presents participants’ recommendations on how service use could be encouraged and services made more helpful for sexual assault survivors. In spite of these varied experiences, there was a strong consensus across the sample that it was important for women to seek assistance after a sexual assault. This viewpoint was expressed by both those women who had and those who had not reached out themselves; in fact, experiences of nondisclosure, delayed disclosure, and disclosure all factored into women’s reasons for advising other survivors’ to seek formal help. Many women pointed to the strong possibility for nondisclosure or delayed disclosure to prolong or even exacerbate the impacts of sexual victimization, as had been their own experiences. In their words, “bottling everything up” (Rebecca) or “sitting home and burying it all under anger or guilt” (Mara) could lead to greater feelings of shame, self-blame, self-directed anger, and overall emotional distress, which could then be detrimental to their interpersonal relationships. As Lisa put it, “Living with it is one of the hardest things you can do, and not opening up about it is one of the worst decisions you can make.” Moreover, the potential benefits of disclosing and receiving support were often framed as integral to post-assault adjustment, with many women
expressing that they had “felt better” after talking with a counsellor or doctor, noting a
decrease in feelings of fear, inadequacy, anger at one self, and self-blame. Reaching out was
believed to be a necessary step for survivors to come to the realization that “you’re not alone,
it’s not your fault” (Beth), “you’re not that bad,” (Nicole) and “it doesn’t only happen to you,
it happens to other people” (Monica).

Accordingly, over half of the women said that they would encourage a survivor to
seek formal assistance, and would support them in their decisions to do so. Beth shared the advice she often gave to survivors, including one of her friends just a few days before the interview:

I just think that if any woman has been sexually assaulted or raped, go get help. Go get support. Whether that be from a doctor, a counsellor, a friend, a police you may know even, whatever. Go get some help. Don’t wait. You need to talk to somebody right away. (Beth)

This was echoed by other participants, who expressed that they would tell a survivor to “put a little bit of trust out there again” (Rebecca), “ask for help and reach out,” (Beth), and “get help as soon as you can” (Lisa). While for the most part, the importance of “finding somebody you really think you can trust” (Nicole) was emphasized over reaching out to a specific support provider, a number of women did note the advantages of seeking “professional help,” including a guarantee of confidentiality, greater emotional support, and formal justice and protection.

At the same time, as indicated above, the women were acutely aware of the reality that there were many sound reasons why survivors may not take this step. Participants were asked about their thoughts on how formal service providers could increase help-seeking and
improve the quality of services for sexual assault survivors. Although responses varied, three common themes emerged around ideas of increased emotional support, availability of information, and opportunities for empowerment. Often, the significance of these ideas was illustrated by personal help-seeking experiences, both positive and negative.

**Changes to Service Provider Attitudes and Behaviours**

One set of recommendations centered on the need for support providers to respond in more emotionally supportive ways and, concomitantly, changes in dominant attitudes towards sexual assault survivors and marginalized groups. When asked what would be helpful after a sexual assault, participants frequently talked about specific responses to disclosures that would be important to hear, and provided examples from their own “caring,” “supportive,” and “nurturing” help-seeking experiences, often with counsellors, rape crisis centres and friends.

Many women spoke about the value of conveying to survivors that they were not to blame for the assault. For Amy and Beth, being told that rape was a violent, rather than a sexual act, and that perpetrators “try to prey on the most vulnerable and it doesn’t matter what you were wearing or what you look like” (Beth) were among the most supportive responses they received, as they helped to make sense of the brutality of the attacks and reassured them that they were not at fault. Having support providers communicate understanding, belief in their stories, and an absence of judgement to survivors was also important in the view of many participants, who had found comfort and confidence in such responses, and were able to contrast them with the victim-blaming and doubting reactions that they had also heard. Monica, for example, described how having her story validated by
staff members at two community agencies motivated her to begin the process of filing a formal complaint to the Law Society of Canada against her lawyer:

They responded well, and they said, ‘It’s wrong. It’s wrong. You should report him immediately.’ It made me feel better. Like it opened up my head and it made me start thinking like, okay, you know, why are you even afraid? Your story is credible.

(Monica)

Monica contrasted this reaction to the blame and limited emotional support she had received from informal support providers, which had led her to stop disclosing for three months.

In addition, some women spoke to the significance of having being provided with a safe space in which they could express themselves freely, and feel heard and understood. Two women described their experiences with counsellors and friends as being allowed to “talk at your own pace” (Lisa) with supports who are “not trying to guide me anywhere or guide the conversation anywhere. They’re listening and they’re understanding, and they give you space (Julie). These experiences were juxtaposed against their experiences of disclosing to shelter staff, doctors, or the police, where they were felt to have little control over the process, due to their “imposing” attitudes (Julie), tendency to ask too many questions (Nicole, Lisa), and sole interest in prescribing medication or obtaining a statement (Lisa). In fact, for a few women, having support providers make themselves available to be physically present with them, listen and communicate understanding, and reassure them that it would get better not only enough, but was identified as the most helpful response they had received.

In the view of many participants, training formal support providers to be more emotionally supportive and avoid re-victimizing language and behaviours would not only lead to more positive help-seeking experiences, but also encourage survivors to reach out for
help. Beth, for example, spoke of confidence in support sources’ abilities to be supportive and non-judgmental, and “to actually listen to them, to be there for them [and] not to judge,” as “key” because “they’re very vulnerable at that time.” The need for improved attitudes was especially salient when women talked about the reporting process. Indeed, a number of women who had reported the assault described the experience as “negative,” “upsetting” (Jodie) and “traumatizing” (Lisa). This was often attributed to the nature of the reporting process itself, which required victims to answer numerous questions about the sexual assault, often repeatedly and in much detail, a process that was described as “re-living it all over again” (Lisa). Indeed, it is important to note that all of the women described the police officers who took their statements in positive terms, such as “very helpful,” “really supportive,” (Beth, Jodie) and “very nice” (Lisa, Jodie, Maggie). One woman reflected on this lack of emotional support inherent in the reporting process, saying:

She was comforting in a way, but it felt like it was just a meaningless process. They just wanted the information so they could charge him. There was no actually support there. ‘These people will contact you tomorrow. You need to come into the station to make a thing.’ Like to get help for it all? I did that all on my own. Like there’s no support system within [police services], once you report it. (Lisa)

Lisa was one of three women to advocate for emotional support to be integrated into the reporting process, either through enhanced police training or the presence of an ‘external’ support source, such as an on-site counsellor.

Also noted was the need for real changes in dominant attitudes in order for more sexual assault victims to come forward, especially those living in poverty. Negative perceptions of and past experiences of discrimination and prejudice with support providers
were seen as contributors to survivors’ general disinclination to report sexual assaults, and, as described above, had frequently played a role in participants’ own decisions not to seek help, particularly with the police. Many participants were keenly aware of recent public criticisms of the police force’s ability to manage and communicate effectively in crisis situations, particularly with individuals of minority backgrounds and with mental illnesses, and victim-blaming attitudes and re-victimizing treatments of sexual assault survivors. Indeed, five of the six women who had spoken with the police, noted that their positive interactions with the officers had been somewhat surprising or unexpected. For example, Tammy reflected on her experience, saying:

Nobody was making me feel like I did something wrong. And I just expected people to like (pause) … I thought that they might say, ‘Well, why were you standing there or sitting there or…’” I mean, they asked all the questions cuz that’s part of their job but… they were nice about that too. They weren’t like [blaming me]. Not at all. (Tammy)

She added, “If you have go through [reporting], it’s how it should be done, but I know it doesn’t go like that a lot of the time,” referring to the stories she had heard through her peer outreach work with women who were homeless or working as sex workers. Similarly, Beth contrasted her positive impressions of the police officers to whom she reported the sexual assault, to a number of previous “really bad, negative run-ins” with the police, some involving violence:

I was kind of surprised because I’ve had a lot of bad experiences with the police, but these police – and because they were from the sexual assault unit, right? So that’s why I had such a supportive, and had such a good feeling with them helping me.
They’re trained in how to work with people who’ve been raped or sexually assaulted.

(Beth)

Much like Tammy, Beth also believed that an experience like she had “doesn’t happen that often, I’m sure (laughs).” Moreover, many women, like Beth, made sense of this disparity between their expected and real interactions with police, by pointing to the fact that the detectives they had spoken to were women (Lisa) or had been from the Sexual Assault Squad (Beth). In other words, these experiences did little to alter their deeply ingrained beliefs about the attitudes of law enforcement officials, rooted in numerous personal and vicarious experiences with the police for non-sexual assault-related issues. Accordingly, the need for a broader shift in police attitudes towards sexual assault survivors as well as marginalized groups, and for the police to regain trust with the community was viewed as an important factor for facilitating help-seeking.

**Increased Accessibility of Information**

Increased access to information was the theme of the second set of recommendations that emerged. Information regarding sexual assault-related issues, often received through formal support providers such as counsellors and support groups, was highly valued (e.g., Maggie, Lena, Jodie). This included information about the nature of sexual assault, skills for coping with the emotional and psychological aftermath of the assault, and protective strategies against future assaults. For Monica, information and guidance related to the process of filing a complaint against the lawyer who had assaulted her was identified as the most helpful response she had received. Monica, who was a recent refugee claimant, spoke about the significance of hearing from staff members at community agencies that “apparently, in this part of the world, you’re support to report such things,” as it was
uncommon to report sexual assault in her country of origin, as “back home, no one would ever believe you.” She also described feeling relieved upon learning that it was typical for survivors not to have “tangible evidence” of the sexual assault, as this had been a significant deterrent to her taking action against the perpetrator:

They really helped me a lot. They made me realize that sexual harassment or rape or anything, it’s not something you can have evidence for... I can just tell [them], ‘This is what happened,’ and if they decide to believe it... Because I was also afraid if I say it [and] I don’t have any evidence, who will believe that this guy did all these things to me? (Monica)

Many women reported that the coping and safety strategies that they had learned after the assault (e.g., mindfulness skills, staying near bright lights when working) had been integral in helping them deal with the debilitating fear and flashbacks they had experienced post-assault, and believed that these would be important for any woman, sexual assault survivor or not, to know.

Information was understood not only as a valuable form of assistance, but a meaningful way of encouraging survivors to reach out to formal services. As described above, the ways in which sexual assault was conceptualized had prevented some women from seeing the incident as a problem for which help was needed. This had especially been the case among women who reported a history of sexual abuse beginning in childhood or adolescence, and often recalled difficulties recognizing their experiences as sexual abuse or sexual assault, and/or as serious (e.g., Lena, Mara, Monica). As Lena explained, at the time of her first sexual assault at age fourteen, she had little knowledge about sexual violence and struggled with labelling it as sexual assault, rape, or “something serious” because she “didn’t
know what really constituted that.” Many women saw this lack of knowledge as an ongoing societal issue that was due in part to the reluctance of schools and parents to talk about sexual assault with young kids, something that a few women mentioned they had begun doing with their own kids since the incident. Accordingly, some women recommended that services begin reaching out, potentially in the form of support groups or information sessions, to make available to young girls and women information about what sexual assault was, common consequences of victimization, how to protect oneself, and available services and programs for victims, (Lena, Mara, Monica) to complement the sexual education that should be, but often wasn’t taking place at home (Monica).

Women also highlighted the importance of increased availability of information regarding sexual assault-related resources in the community. As illustrated above, participants were largely in agreement that rather than limited availability of appropriate services, it was a lack of knowledge that that these services existed and/or how to look for them that prevented help-seeking among sexual assault survivors living in poverty. Indeed, this had been the case for Maggie, who talked about her indecision about whether to seek formal assistance immediately after the assault because “I didn’t know where these programs were.” For Maggie, the most helpful response she received was having the police refer her to the victim support hotline, which called her a few days later and informed her about the women’s support group that she ended up attending. Consequently, when asked what would make help-seeking easier, many suggestions centred on the need for organizations to “find ways to reach out to women” (Lena) and ensure that “people get the information somehow, to get access” (Maggie). Some suggested that agencies “get their word out” about services for sexual assault survivors, especially those that were low- or no-fee, through the
distribution of advertisements in public community spaces, such as libraries (Lisa, Lena). Others, such as Jodie and Julie, suggested that police services and hospitals agencies could make information about and enrolment in various programs and services available at police stations and hospitals so victims had it “right from the get-go.” As Lisa pointed out, this would reduce the burden on potential service users, by making information “readily available” so that they did not have to “physically look for them”. Indeed, these strategies had facilitated service use for Tammy and Monica, both of whom had taken up counselling services only after approached and informed about them by staff members, one at a hospital, and one at a church.

Although hospitals and police officers did sometimes provide referral information, some women noted that victims were often unable or unwilling to contact agencies from a list that they knew nothing about (e.g. Jodie). This was believed to be particularly common among survivors living in poverty, many of whom had a lack of trust in formal service providers, due to past negative experiences. Accordingly, many women stressed the importance of having survivors hear about services from other women who had also experienced sexual assault and had used the services. For example, Jodie, who began attending group counselling at a rape crisis center after being told about it by a friend, stated:

Referral sources are good, but [the agencies] have to have someone come to the hospital who has been experiencing the groups for the last two, three years [and] has experience what they (the victims) have gone through.

This idea that having somebody make personal recommendations would greatly facilitate help-seeking among low-income and poor women was echoed by other participants, such as Tammy:
They need to be told of these places. You can’t make someone go, but they need... just somebody to tell them that it’s a non-judgemental place and it’s a safe place.

And those two things are what’s gonna get somebody out the door. (Tammy)

Accordingly, many of those women who did peer outreach work for marginalized persons saw as an important part of their work, not only referring women to appropriate resources, programs, and services, but also recommending specific agencies that were known for having staff members who were supportive and non-judgemental.

**Opportunities for Empowerment**

The final set of recommendations that women made around improving services for sexual assault survivors was creating more opportunities for empowerment, often in the form of consciousness-raising activities and social action. For many women, one of the most valuable factors in their recovery had been the mutual sharing of experiences with other women. This often took place within a women’s support group, such as the ones offered through a rape crisis centre, but also occurred in informal settings, such as between friends at coffee shops. Women spoke passionately about the value of having a safe and confidential environment in which women could share similar experiences of not only sexual assault, but also of poverty, other forms of violence, and incarceration. Among the benefits that these women experienced was an opportunity to “express their feelings about their lives” (Jodie), to know that “your voice has been heard,” to offer and receive “just support and understanding” (Julie), and to “be sort of a family [and] share in everybody’s triumphs” (Amy). In addition, a number of participants identified other women’s stories and experiences as sources of hope for recovery and of knowledge on how to mobilize one’s own personal strength.
This mutual sharing of experiences had a healing effect in two ways. First, the knowledge that sexual assault was a shared experience rather than an individual one helped de-stigmatize their own experience while also alleviating feelings of shame and self-blame:

It’s comforting to know that you’re not alone. That there’s (sic) other women who have experienced some kind of sexual assault or rape in one form or another. (Beth)

Monica described how learning that sexual assault “doesn’t only happen to you, it happens to other people” counteracted her self-blame, saying “I didn’t feel dirty anymore and I didn’t feel bad about myself anymore because he was doing this with other people.” Jodie stated:

I think the biggest healing power is hearing from another woman who’s been through it, learning the knowledge of those women who’s been powerless and then came to be powerful, you know? I think that’s key. (Jodie)

Jodie spoke ardently about the ways in which showing respect and love to other women and witnessing “the value of their lives” allowed her to see herself and her own experiences as worthy of the same positive regard, which was reinforced by the support of other women. Indeed, for some women, there was evidence of a reframing of the narrative of their lives that stood in stark contrast to the devaluing cognitions that many described having immediately after being sexually victimized. These women spoke of themselves as “survivors” who had experienced a series of negative and traumatic life events and “battled through it,” only to “come out stronger” in many ways. Underlying these shifts in their beliefs was a heightened consciousness of the fact that sexual assault was not only an individual problem, but a societal issue of oppression and exploitation that was faced by many marginalized groups.

Second, the process of gaining hope and strength from the experiences of others enabled women to see their own experiences as sources of those same benefits, which could
be used to help other women in similar positions. Kate, for example, saw the involvement of women with experiences in the sex trade industry, such as herself, in outreach and advocacy work as “very important,” because “we can understand and relate to [sex workers] more than someone who just has book knowledge.” In a similar vein, Monica talked about her newfound passion for “humanitarian work” that allowed her to “be there for women who have gone through sexual assault,” which she explained was “very important to me because I’ve gone through things so I know what to talk about.” The notion that their experiences of enduring and overcoming significant challenges over the course of their lives rendered them invaluable sources of knowledge that could be passed onto other women was echoed by other women, such as Jodie, who spoke of a desire to focus her energy on using her experiences to help other women who were going through similar challenges, which she felt was her purpose at this stage in her life.

Indeed, this realization, coupled with changes in consciousness that shifted the blame from themselves and onto the perpetrator or societal forces, often served as catalysts for women to engage in social action. Across the sample, the range of accomplishments that was talked about was varied and remarkable, and included providing sexual education in schools, facilitating groups and workshops (e.g., related to arts or health issues) for women, helping to organize and put on a fashion show for sex workers, and doing peer outreach and advocacy work for marginalized groups. The latter was the most common form of social action, engaged in by over half of the sample, and involved providing support, information, and tools to individuals living in poverty, victims of violence, and/or sex workers, to promote improved health and safety practices, use of community supports, and harm reduction. More
importantly, these ongoing commitments, sometimes spanning over a decade, were spoken about with pride. As Kate stated:

I’m glad I went through what I did in life because it’s given me the experience and the backbone behind it and it’s made me street smart. And it’s given me ways to try to help out other people. Like I’ve been able to reach out to other people because when I do my outreach, people come up to me. They’ll approach me before they approach someone who’s working from the government type thing. (Kate)

Often, women’s engagements in these activities began after utilizing services from community agencies and being approached by staff members about opportunities for participating in various projects. The ability to “give back” to the community that had helped them through difficult periods in their lives was often referred to as important and empowering. Many women reported that the achievements they had made had been instrumental in building their confidence and self-esteem, by showing them that they were “somebody who can make a difference” (Monica). Other activities that were also described as empowering were self-defence classes and participation in Take Back the Night, an annual march or rally intended to protest against rape and other forms of sexual violence.

Accordingly, many women emphasized the need for more programs and services that would facilitate the empowerment of survivors of sexual assault. A few women suggested the creation of more workshops or events that not only provided women a space to talk, but also offered them opportunities to “participate in something where their minds aren’t always on [the sexual assault]” (Kate) such as arts and crafts, or volunteer work for a cause in the community that they were passionate about. Not surprisingly, the creation of more volunteer or paid peer outreach worker positions through community organizations was also advocated,
both to provide survivors with a sense of empowerment, as well as to ensure that more survivors, particularly those without a support network, had access to a source of support “to help them get through it.” Finally, Mara identified more structural changes as necessary for helping survivors, including changing the current Canadian prostitution laws to offer women better protection, and providing funding towards the creation of programs or grants to help sex workers enrol in education or training programs and get out of the sex trade industry.
CHAPTER 4: Discussion

Discussion

The current study examined the help-seeking processes of women sexual assault survivors who are living in poverty. The purpose was to 1) explore individual, interpersonal, and sociocultural factors that impact decision-making at each of the three stages of the help-seeking process; and 2) to identify recommendations for formal service providers that can encourage service use decisions and improve help-seeking experiences among this population. The results indicate that help-seeking decisions for sexual assault survivors living in poverty hinge on many factors that are influential for survivors in general. At the same time, past and present circumstances associated with socioeconomic status create added dimensions to these barriers as well as unique barriers for women living in poverty. The recommendations put forth by survivors in this sample reflect these challenges as well as highlight the importance of taking socioeconomic considerations into account when thinking about ways to improve help-seeking among sexual assault survivors.

A number of important findings emerged from interviews. Overall, the characteristics of the sexual assaults and assault histories described by participants confirm the strong link between poverty and violent victimization which has been identified in past research. Two-thirds of the incidents involved the use of physical force or a weapon, and 60 percent resulted in physical injuries other than the rape itself, the majority of which were severe. In contrast, in national studies, fewer than one in three rapes resulted in physical injuries (31.5%), and only 26% of those were serious types of injuries similar to those described in this sample (Tjaden & Thoennes, 2006). Moreover, although women were not asked about past experiences of sexual victimization, over half disclosed one or more past
experiences of rape, sexual assault, or childhood sexual abuse; it is possible that other participants also had such experiences but did not bring it up. Their experiences are in line with past studies indicating that histories of sexual and physical victimization are common among poor women (e.g., Bassuk et al., 1996; Breton & Bunston, 1992), and that poor women frequently endure rapes that involve greater violence and physical coercion compared to their more affluent counterparts (Stermac & Paradis, 2001). These women’s experiences also illustrated the ways in which poverty-related circumstances not only presented barriers to help-seeking, as will be discussed later, but also increased their vulnerability to sexual victimization. Although struggles with self-blaming cognitions in the aftermath of the assault were commonly reported, the link between limited socioeconomic resources and sexual victimization was also articulated by many participants during the interview.

It is notable that while six women had contact with emergency services immediately after the incident, in three cases, someone other than the victim had made this decision often because the victim was found in a significantly incapacitated state. Nevertheless, despite some initial uncertainty, all of these women agreed to medical treatment at the hospital and all but one agreed to provide an official statement to the police. It is possible that while medical assistance and police reporting may not be activities that many survivors are interested in pursuing in the immediate aftermath of a sexual assault, they may nonetheless view these services as worthwhile, and may be willing to engage with them with sufficient encouragement and support from others. This finding also affirms the importance of being mindful of the distinction between whether a victim sought assistance or received assistance
when constructing surveys on help-seeking decisions (Kilpatrick et al., 2007), as responses to the latter would not indicate whether the victims themselves were active in reaching out.

**Influential Factors in Help-Seeking Processes**

Regarding the first purpose of the study, seven key themes emerged from the analysis, each representing an influential factor in one of Liang et al.’s three stages of help-seeking. As mentioned above, many of these mirrored the barriers identified in past studies on disclosure and help-seeking among sexual assault survivors. Yet, it was clear that the challenges the women in this sample faced were shaped by socioeconomic factors.

For example, in the first stage of problem definition, similar to past findings on the role of survivors’ understanding of the sexual assault, some women in this study demonstrated a remarkable ability to downplay the significance of post-assault physical and mental health consequences and the rape itself. However, in contrast to other studies, it was uncommon for these women to articulate beliefs that their rape was “not a rape” or a crime, a private matter, or not that serious (e.g., Koss et al., 1988; Walsh et al., 2010), or to attribute their decisions not to formally report the sexual assault to these beliefs (e.g., Bachman, 1998; Kilpatrick et al., 2007). Rather, tendencies to minimize or normalize either the incident itself or the impacts of it appeared to be a consequence of the need to address more pressing issues such as making ends meet, or of the prevalence of violence in lives and the lives of those around them which made rape a somewhat expected occurrence. This finding is consistent with prior research with poor populations (e.g., Anderson et al., 2006; Dupéré et al., 2012) and indicates that a more holistic and integrated approach to service delivery, that addresses not only psychological and physical health issues but also external conditions that are the
source of ongoing and unexpected negative stressors and life events, is crucial for these populations.

At the second and third stages, the themes of intrapsychic barriers (Starzynski et al., 2005; Tjaden & Thoennes, 2006) and perceptions of and past experiences with service providers (Campbell et al., 2001; Golding et al., 1989) provide additional examples of factors that have also been identified in past research to affect the help-seeking decisions of all survivors. However, in this study, it was clear that the significance of barriers of shame, self-blame, and fear of judgment, along with distrust in support providers’ ability to be emotionally supportive and nonjudgmental was amplified by the stigma and prejudicial attitudes that these women experienced daily as a result of their socioeconomic and ethnic minority status, and their past and ongoing experiences of prejudice. For many of the women, factors such as living in poverty, working in the sex trade industry, and being Aboriginal gave rise to concerns that they would not be perceived as “real” victims, and treated accordingly. Unfortunately, the fact that the circumstances of the rapes they experienced often shared many of the features of “the classic rape” scenario (e.g., perpetrator is a stranger, and the rape is violent and results in physical injuries) (Williams, 1984) was not perceived to be enough to overcome the power of rape myths to invalidate their victimization experiences in the eyes of formal support providers on the basis of their personal characteristics.

This was especially apparent in regards to police reporting. Whereas fear of reprisal, embarrassment, and uncertainty whether a crime has been committed have topped lists of reasons for not reporting in national studies (Kilpatrick et al., 2007; Tjaden & Thoennes, 2006), in this sample, only a few women reported fear of retaliation from the perpetrator as a
reason for nonreporting. Instead, many participants were strongly opposed to filing a report out of a fear or distrust of the police because of past abuses, a conviction that nothing would be done for them, or concerns that they would be treated differently due to their criminal record, homelessness, sex trade work, or ethnicity. These beliefs were also present among those who had reported the rape, as their positive interactions with a few police officers did little to erase the long string of oppressive and sometimes violent encounters with police that they had personally experienced or witnessed.

A lack of informal support and accessibility issues were two barriers in the second stage that have received relatively little attention in the help-seeking literature on sexual assault survivors. Participants emphasized the facilitating role that informal support providers could play in survivors’ help-seeking decisions, and, conversely, the potential for the absence of a strong social support network to discourage survivors from reaching out. More specifically, some women alluded to the negative impact that receiving victim-blaming responses had on future disclosures, while others described the ways friends and family members had provided the emotional support and tangible aid that were essential for them to take the next steps and access formal help. It is encouraging that many women in this sample reported positive experiences of disclosure to informal support providers, who frequently provided emotional support as well as resources. This may be due in part to the fact that sexual assault was so prevalent in participants’ social networks, such that many had the support of a friend who had also been sexually assaulted and thus had knowledge of appropriate emotional and informational support. It should be noted that while the majority of participants in this sample did appear to have strong informal supports in their lives, one
woman believed that limited social resources was a significant and common issue among individuals living in poverty.

In regards to accessibility, it was interesting that although participants were not asked directly about whether costs were a barrier to help-seeking, a number of women talked about the widespread availability of programs and services targeted towards low-income users that were low- or no-fee, at least in the city of Toronto. However, many women brought up that a lack of access to information about such resources was an issue among women living in poverty, particularly those without social supports or connections to the community. This barrier has also been identified in other studies of help-seeking among low-income populations (e.g., Anderson et al., 1993), and was attributed in part to inadequate information dissemination on the part of community organizations, and in part to a lack of willingness or ability to seek out such information on the part of survivors. In regards to the latter point, many women highlighted the fact that help-seeking could require a significant amount of effort on the part of poor individuals, due to a lack of access to phones, transportation, as well as the need to deal with more pressing life stressors, factors which have been identified in other studies (Dupéré et al., 2012; Miranda & Green, 1999). Moreover, it was frequently noted that awareness that services existed alone was rarely enough to prompt individuals from marginalized groups to seek help, as past negative experiences with formal service providers often left individuals disinclined to put forth the effort required.

**Recommendations for Improving Utilization and Quality of Formal Services**

The second aim of the study was to formulate recommendations for improved services for low-income and poor women survivors of sexual assault, by synthesizing participants’ suggestions with a contextualized understanding of their help-seeking processes
and existing literature. The majority of participants were in agreement that it was important for sexual assault survivors to seek assistance, noting both the potential for non-disclosure to exacerbate the emotional and psychological distress resulting from the assault, as well as the potential for disclosure to lead to improved post-assault functioning. These beliefs were often rooted in their own experiences, which is in line with previous literature indicating that withdrawal from social life and maladaptive coping strategies can exacerbate the psychological distress associated with an experience of assault (Frazier & Burnett, 1994). Participants made several program and policy recommendations for encouraging service use and improving the quality of services for sexual assault survivors, which largely clustered around three themes. These complemented their own experiences of help-seeking and also echoed recommendations that have come out of past studies on service use among low-income populations.

First, women emphasized the need for organizations to provide the education and training needed to improve attitudes and behaviours among service providers. These recommendations were grounded in their own experiences of the healing benefits of receiving respect, empathy, and emotional support, the harmful effects of being blamed, judged, or controlled, blame, and the central role these experiences played in influencing future help-seeking decisions. Indeed, the differential impacts of positive responses, such as being believed or listened to, and negative responses, such as blaming and dismissing the victim, on post-assault adjustment are well-documented (e.g., Campbell et al., 2001; Ullman, 1996). Education and training programs that enhance service providers’ knowledge of the realities of sexual victimization, ability to critically debunk rape myths, and skills in providing helpful and not harmful responses to sexual assault disclosure can increase the
likelihoods that survivors will not be dissuaded from coming forward by the fear of being judged and blamed for the assault, and that survivors will have positive experiences when they do. As the nature of the reporting process may have a high potential of re-traumatizing victims during a time when they are most vulnerable, adoption of such changes within police services is especially important, to facilitate the creation of a safe environment in which victims feel as comfortable as possible.

Moreover, broadening the scope of these initiatives is critical if they are to have the desired impacts on low-income sexual assault survivors. As discussed above, participants’ negative experiences with service providers in the past were often believed to reflect widely held prejudicial attitudes towards marginalized communities, such as the poor and Aboriginal community. What is needed, then, is a more comprehensive shift in attitudes and behaviours, whereby service providers approach all consumers with compassion and respect, regardless of income, ethnicity and culture, gender, etc. (e.g., Stewart et al., 2005). Such a shift may require commitments at the organizational-level to diversity training that fosters critical perspectives of poverty and its structural causes; awareness and evaluation of one’s own assumptions about poverty; and skills to tailor services and interventions to be more responsive to the unique circumstances and needs of individuals living in poverty (Stewart et al., 2005; Williamson et al., 2006). These changes would allow survivors experiencing poverty to make the decision to reach out without fear of being stigmatized, discriminated against, and blamed, and to actually receive the support they need rather than be re-victimized.

Second, women called for organizations providing services to sexual assault survivors to devote more resources into outreach activities that would provide the
information and education needed to encourage help-seeking. While few participants in this sample identified financial accessibility or availability of appropriate services as barriers, some noted that the real issue was a lack of awareness about existing low-cost or free services and how to find them. Formal service providers, particularly those serving low-income and poor populations, need to become more proactive in disseminating information about affordable services and programs and how to access them. As those living in poverty may not have phone or Internet access, advertisements using traditional media (e.g., flyers, brochures), posted in public spaces that are regularly frequented by low-income individuals (e.g., community health centres, public libraries) are likely to be more effective strategies than posting in an online directory or phone book.

Many women also suggested that organizations employ outreach workers and advocates to reach out to individuals face-to-face and guide them through the process of getting help. This would reduce the level of effort required of potential low-income consumers to access information, as well as allow them to receive recommendations about services from peers who had undergone similar experiences and had also used the services. This latter benefit is significant given the potential for marginalized groups to be distrusting of formal services due to commonplace experiences of being dismissed, ignored, and patronized. The finding that affordability and availability do not constitute access issues for low-income communities should be interpreted with caution as it contrasts findings of past studies (Stewart et al., 2005; Williamson & Fast 1998), and may reflect the sample rather than the state of affairs for this population, which is discussed further below.

A few women also recommended that organizations increase their public education efforts, to disseminate knowledge about a range of sexual assault-related issues, from the
causes and characteristics of sexual assault, to strategies for coping with the consequences of victimization, to protective strategies. Moreover, these women noted the need to reach younger populations given that first experiences of sexual victimization frequently occur before the victim is eighteen, and that a history of victimization is a consistent predictor of future victimization (Kilpatrick et al., 1997; Tjaden & Thoennes, 2006). Educational efforts could include workshops or information sessions that raise awareness of what constitutes sexual assault, potential impacts of victimization and how to cope with them, and available resources and how to access them, but must include interventions tailored for and targeted at children and early adolescents. These are critical in order for sexual assault survivors and potential informal support providers to more readily identify incidents of sexual victimization as sexual assault and as serious crimes, and for victims to access the support they may need.

Finally, many women also spoke to the importance of creating opportunities for empowerment. A number of participants had experienced the positive impacts of consciousness-raising activities and social action on their recovery, from enabling them to reframe the narrative of the victimization in a way that alleviated feelings of self-blame and shame and shifted responsibility to the perpetrator and wider society, to allowing them to give new meaning to their victimization experiences. As experiences of victimization can lead to feelings of worthlessness, helplessness, and vulnerability (Simon et al., 1989), programs and services such as women’s support groups and peer outreach and advocacy positions can play important roles in facilitating a greater awareness of the social forces at play and the development of a social consciousness, while also helping victims regain a sense of self-esteem, agency and control, and meaning in their lives (Stewart et al., 2005).
There are lessons here for support providers who can contribute to these goals, by listening to victims’ experiences rather than imposing their own worldviews; giving victims power to direct or control the disclosure experience rather than giving them advice or asking many questions; and acknowledging and highlighting structural causes of sexual violence rather than scrutinizing the victims’ choices.

Empowerment opportunities may particular resonance among women living in poverty for whom the disempowering effects of sexual victimization are exacerbated by virtue of their social location at the intersection of multiple oppressions. The daily realities of violence, traumatic and negative life experiences, and the stresses of homelessness and poverty can compound the consequences of later victimizations (Follette et al., 1996; Goodman et al., 1991), while experiences of exclusion and exploitation from a multitude of social and cultural institutions can contribute to feelings of powerlessness, hopelessness, and low self-esteem, and low-self-efficacy (Miranda & Green, 1999). Given that sexual violence is often targeted at vulnerable, marginalized groups and functions to further their oppression, a greater focus on empowerment could be part and parcel of the move to make services more relevant to marginalized populations. It would be remiss to ignore the need for broader policy and program changes that reduce poverty, thereby decreasing low-income women’s reliance on dangerous survival strategies and lack of physical protection, both of which are associated with risk of victimization (Padgett & Struening, 1992; Wenzel, et al., 2000; Whitbeck & Simons, 1993), and exposure to negative life events and daily stressors which impede their ability to prioritize help-seeking (Dupéré et al., 2012; Miranda & Green, 1999).

While many community organizations serving marginalized populations certainly can and do contribute to the empowerment of individuals, government-level changes to the way poverty
is understood and addressed are also needed to shift priorities to the creation of safe and affordable housing, interventions to address mental and substance use disorders, and increasing access to educational and employment opportunities.

**Conclusion**

At a time when sexual assault continues to be a crime that is all too pervasive, and too many victims continue to opt not to seek formal assistance, continued efforts to understand why victims decide against seeking formal assistance and what changes are necessary to encourage them to do so, are needed. This study was aimed at this effort, with a focus on a marginalized group of sexual assault survivors that has not yet received significant attention. The results highlight the importance of examining and understanding socioeconomic barriers to help-seeking, and also illustrate how that the impacts of poverty extend far beyond limited financial resources. As the voices of these women illustrated, the lived experiences of poverty give rise to a range of individual, interpersonal, and sociocultural factors that influence help-seeking decisions, many of which are not yet well-understood in the literature. Knowledge of the barriers survivors face and recommendations they believe in informs meaningful changes that can be implemented by formal support providers to ensure that services are accessible and meet the needs of sexual assault survivors living in poverty.

As with all studies, a few limitations should be noted. First, the findings of this qualitative study provide a rich description of the help-seeking processes of fifteen women sexual assault survivors living in poverty, recruited from a large, metropolitan Canadian city. However, as is the case with most qualitative research, the degree to which these exploratory results are generalizable to poor survivors of sexual assault in other Canadian cities is uncertain. Toronto is one of Canada’s largest cities and is known for having a diverse
population. As a result, it may feature more culturally-appropriate programs and services and more norms accepting and valuing of diversity compared to cities that are smaller, located in suburban or rural areas, or are more demographically homogenous.

Second, caution should be taken in assuming that the views and experiences described here are representative even of sexual assault survivors living in poverty in Toronto. Participants were recruited through community agencies, a decision that facilitated recruitment but decreased the probability of reaching women living in poverty who were not currently using services of some kind. This recruitment decision likely contributed to the levels of formal help-seeking reported in this sample which were relatively high compared to those found in national and random samples (e.g., Golding et al., 1989; Walby & Allen, 2004), although similar rates have been found in non-random samples (e.g., Campbell et al., 2001; Filipas & Ullman, 2001). This is unlikely to be typical of this marginalized population as a whole, and almost certainly reflects the fact that this sample consisted of women who were seeking help of some kind and who self-identified as having experienced a sexual assault.

Along these same lines, it would be appropriate to elaborate here on the difficulties that were encountered when attempting to reach potential participants to conduct a screening interview or schedule an interview. Attempts to reach fifteen of the thirty-seven individuals who contacted the interviewer about the study were unsuccessful because no contact information had been left, phone lines had become disconnected, or messages that were left with a community agency as requested were not responded to. This may suggest that, to some extent, the women interviewed in this study may have been experiencing a relative degree of stability in their lives compared to those who were unable to participate. Future
research would benefit from utilizing more varied recruitment methods, to ensure a more diverse cross-section of the poor population.

Perhaps a more substantive limitation of this study is that more attention could have been paid to the role of other influences such as ethnicity, age, and sexual orientation. As noted above, the sample was diverse, and the interviewer was mindful to probe for potential barriers related to ethnicity and gender when these factors were self-acknowledged as relevant aspects of a woman’s identity. At the same time, the limited data available for analysis on these intersecting identities is undoubtedly a reflection, at least in part, of the fact that questions directed toward exploring these issues were not included in the interview guide.

These limitations notwithstanding, the present study highlights the need for continued research on this issue. Future studies should continue to examine influential factors on low-income and poor women’s help-seeking processes, with a focus on exploring the multiple identities within this heterogeneous group, including ethnicity, gender, sexual orientation, and disability. It is important to understand how effective formal support providers are at not only reaching out to marginalized communities of sexual assault survivors and encouraging service use, but also at providing services and programs that adequately meet their diverse needs. Qualitative components to research design may be useful in these endeavours, as the use of close-ended response formats can prevent the development of in-depth and accurate understandings of the barriers to and experiences of help-seeking among women living in poverty. The results are also suggestive of the utility of Liang’s help-seeking model for IPV victims in conceptualizing the decision-making processes of sexual assault survivors around seeking formal assistance. While additional research is needed to validate the applicability
of this theoretical model, this and other studies (e.g., Walsh et al., 2010) provide some preliminary support for using this framework in research with sexual assault survivors. Insofar as formal service providers do not adapt to bring their services more in line with the needs and goals of women living in poverty themselves, rates of help-seeking are likely to remain low, and sexual assault victims will continue to be restricted from accessing the physical, psychological, and social assistance that they may need.
References


doi:10.1353/hpu.2007.0011


doi:10.1016/j.ijlp.2008.11.003


PARTICIPANTS NEEDED!

We are conducting a study about decisions to seek help or not to seek help after a sexual assault

You may be eligible to participate if you:
- Are female and 18 years of age or older
- Self-identify as living poverty
- Experienced a sexual assault within the past five years
- Experienced psychological or emotional distress as a result of the sexual assault

Participants will take part in an interview lasting approximately one hour.

All information will be treated as confidential.
You will be compensated $20 for your time.

To learn more about this study, please contact us at:
(416) 978-0686 or victoria.sit@mail.utoronto.ca

This study has been approved by the University of Toronto’s Office of Research Ethics
Appendix B

Information Letter and Consent Form

Counselling & Clinical Psychology Program
Ontario Institute for Studies in Education at the University of Toronto
252 Bloor Street West, Toronto, Ontario, Canada  M5S 1V6

CONSENT INFORMATION

My name is Victoria Sit. I am a Masters student in the Counselling & Clinical Psychology Program at the University of Toronto (Ontario Institute for Studies in Education), working under the supervision of Dr. Lana Stermac. We are currently conducting a study about decisions to seek help or not to seek help after a sexual assault.

What is this study about?
This study aims to learn about how women come to decide whether or not to seek help after an experience of sexual victimization. We are interested in speaking with women, who are living in poverty and who have experienced a sexual assault, about their reasons for choosing to get help or not to get help. The purpose of this study is to improve our understanding of the factors involved in shaping women’s decisions around seeking help, including factors that make it easier or harder to seek help when women themselves believe that help is needed.

What does participation involve?
During this interview, you will be asked some questions about your background, the nature of the sexual assault you experienced and its impact on you, and your reasons for deciding to seek help or not from various support sources (e.g., counselors, friends, crisis centres). You will also be asked about your general thoughts on seeking help after a sexual assault. The interview will be audio-taped using a digital voice recorder, and should take approximately one hour.

Can you withdraw from the study?
Your participation in this study is completely voluntary. You have the right to refuse to answer any question(s), or to stop participating at any time during the study, without negative consequences. If you do decide to withdraw, you will still receive compensation and reimbursement, and any data you provided will be destroyed.

Are there possible risks of participation?
Some of the questions may ask you to talk about things that are uncomfortable or upsetting for you. If this happens, please do feel free to let me know, as I hope to make your experience participating in this study as safe and supportive as possible. As your participation is voluntary, you may refuse to answer any question(s) or choose to stop participating at any time without negative consequences. A list of available resources for support and counseling services will be provided to you.

Are there possible benefits of participation?
There are no personal benefits to you for participating in this study. However, your participation will help us gain a better understanding of the reasons why women living in poverty decide to seek help or not after experiencing sexual victimization. This knowledge can inform changes that can be made to increase the willingness of sexual assault survivors to seek help when they feel they need it. You will be compensated $20.00 for your time. If travel to the University of Toronto was required, you will be provided with TTC tokens as reimbursement for travel costs.

**What happens to the information you provide?**

All of the information collected during this interview, including the consent form, the interview notes, the audio recording, and transcriptions of the audio recording, will remain confidential. This means that only my supervisor and I will have access to your information. There are exceptions defined by law or regulatory statutes, however, where the researcher may be required to disclose confidential information. These are circumstances in which the researcher: a) gains knowledge of child abuse or suspected child abuse, b) believes the participant may be a danger to self or others, c) gains knowledge of sexual abuse, assault or harassment by a regulated health professional (e.g., a psychologist, physician, nurse), or d) receives notice that the data is subpoenaed by a court of law.

During the process of digitally transcribing interview notes and audio recordings of the interviews, any and all identifying information will be removed. Audio recordings will be destroyed and consent forms will not be linked to any participant data. You will not be identified in any way in any publications or presentations made on the basis of the information collected for this study. All collected materials will be stored on a password-protected computer or in a locked filing cabinet, located in a locked and secure research office at the University of Toronto, and will be destroyed after five years.

**Questions?**

Your involvement in this research is appreciated. If you agree to participate, please continue with the consent instructions below.

If you have any questions, please feel free to contact me, Victoria Sit, at (416) 978-0686 or at victoria.sit@mail.utoronto.ca, or my supervisor, Dr. Lana Stermac, at (416) 978-0722 or at l.stermac@utoronto.ca.

This research has been reviewed by the Office of Research Ethics at the University of Toronto and conforms to the standards of the Canadian Tri-Council Research Ethics Guidelines. If you have any further questions pertaining to your rights as a participant in this study, please contact the Office of Research Ethics at (416) 946-3273 or at ethics.review@utoronto.ca.

A copy of this consent information sheet will be provided to you.
CONSENT
By signing below, I am indicating that I have read and understood the conditions under which I agree to participate in this study voluntarily. My signature does not constitute a waiver of any legal rights. I am free to decline to answer any question(s) and to end my participation in the study at any time. I have also had the opportunity to ask questions of the researcher.

I, _____________________________________________ agree to take part in the study outlined above.

Signature: ________________________________________
Date: ____________________________________________

Thank you for your participation,

Victoria Sit
MA student, Counselling & Clinical Psychology Program
Ontario Institute for Studies in Education, University of Toronto

Request to Receive Results of Study
If you would like a general summary of the results of this study, please contact me at (416) 978-0686 or victoria.sit@mail.utoronto.ca and the information will be provided to you. Your name, email and/or mailing address will remain confidential and will not be associated with the answers you have provided.
Appendix C

Interview Guide

Demographic Information

I would like to begin by getting some background information about you.

1. What is your age? ___

2. What is the highest level of education you completed?
   Some high school ___   Some college/university ___
   High school ___   College/university ___

3. People sometimes identify themselves by “ethnicity,” such as French, Chinese, or Indian. Do you identify with any ethnic groups?
   Yes____   No ___
   a. If yes, describe. __________

4. Do you identify as a visible minority?
   Yes ____   No ___

5. What is your relationship status?
   Never married ___   Married/cohabitating ___
   In a relationship ___   Divorced/separating ___

6. Do you have any children under 18?
   Yes ____   No ___
   a. If yes, how what are their ages? __________

7. What type of residence do you live in?
   House (own/rent) ___   Apartment/room/condo (own/rent) ___
   Subsidized housing ___   No fixed address ___

8. What is your current living situation (e.g., live alone, with family, roommate)?
   __________

9. What is your current employment status?
   Unemployed ___   Employed full-time ___
   Temporary work ___   Employed part-time ___
   a. If working, what is your personal income (per year or month)? __________
   b. If working, what is your household income (per year or month)? __________

10. Are you receiving social assistance from the government?
    Yes ____   No ___
    a. If yes, which type(s)? __________
Nature of the Sexual Victimization Experienced

This interview will focus on your experiences of seeking help after you were sexually victimized, but I would like to get a sense of what you went through. I know that this is quite personal, and I want to emphasize that your information is completely confidential, and hope that this helps you feel comfortable talking about it honestly.

1. Can you tell me a bit about the unwanted sexual experience you had? You can provide as much or as little detail as you like. (If more than one, ask about the most significant/recent experience. **Provide reminder that perpetrator(s) should not be named/identified**).

Prompts (to be asked if not covered above)

1. How long ago did the incident take place? __________
2. What was your relationship to the perpetrator at the time (e.g., romantic partner, friend, relative, acquaintance, stranger)? __________
3. Was there sexual contact, sexual intercourse, or both? __________

2. Can you describe how this experience of sexual victimization affected you or your life?

Prompts (to be asked if not covered above)

1. Were there any changes in how you felt (e.g., about yourself, others, the world)?
   2. Were there any changes in your health (physical and/or mental)?
2. Were there any changes in your behaviours (e.g., eating or sleeping patterns, use of alcohol/drugs, socializing habits)?
3. Were there any changes in your relationships with people around you (e.g., friends, significant other, family members)?
Defining the Problem and Deciding to Seek Help

We have talked about the unwanted sexual experience that you had. Now I would like to talk about your experiences of seeking help from others after the incident. While some people decide to seek help after they have been sexually victimized, others decide not to. I am interested in whether you sought help after what happened, and your reasons for making that decision.

1. Did you ever seek help from anyone or talk to anyone about the assault, or issues related to the assault or its impact on you?
   Yes____   No ___
   If yes,
   a. What made you decide you needed help? How did you know you needed help?

   Prompts (to be asked if not covered above)
   1. What did you think about what happened to you?
   2. What did others around you (e.g., friends, relatives) think about what happened to you?
   3. Did any beliefs or values related to your culture or your financial situation influence how you thought about the assault?

   b. What made you decide to seek help from others?

   Prompts (to be asked if not covered above)
   1. Was there a specific event(s) that happened? What were you experiencing (in your life) at the time you decided to get help?
   2. Did anyone around you (e.g., friends, relatives) influence your decision to seek help?
   3. Did any beliefs or values related to your culture or your financial situation influence your decision to seek help?

   Probes: Past experiences of help-seeking, perceived availability/accessibility and quality of help

   If no,
   a. Was there ever a time that you felt like you needed help from others?
   Yes____   No ___
   If yes,
   i. What made you decide you needed help? How did you know you needed help?

   Prompts (to be asked if not covered above)
   1. What did you think about what happened to you?
   2. What did others around you (e.g., friends, relatives) think about what happened to you?
   3. Did any beliefs or values related to your culture or your financial situation influence how you understood the assault?
If no,
i. What made you decide you did not need help? How did you know you did not need help?

Prompts (to be asked if not covered above)
1. How did you think about what happened to you?
2. How did others around you (e.g., friends, relatives) think about what happened to you?
3. Did any beliefs or values related to your culture or your financial situation influence how you thought about the assault?

b. What made you decide to not seek help from others?

Prompts (to be asked if not covered above)
1. Was there a specific event(s) that happened that made you know you did not need help from others? What were you experiencing (in your life) at the time you decided not to get help?
2. Did anyone around you (e.g., friends, relatives) influence your decision to not seek help?
3. Did any beliefs or values related to your culture or your financial situation influence your decision to not seek help?

Probes: Past experiences of help-seeking, perceived availability/accessibility and quality of help

2. Did you ever seek help for the assault or issues related to the assault or its impact from:

a. Any community-based agencies, such as rape crisis centers, crisis hotlines, victim services, social services, shelters, or support or self-help groups?
   Yes____ No ___

b. Any mental health workers, such as counselors, social workers, psychologists, psychiatrics or religious leaders?
   Yes____ No ___

c. Any medical health workers, such as doctors or nurses at a clinic or a hospital?
   Yes____ No ___

d. Any police or a legal professional?
   Yes____ No ___

e. Anyone in your social network, such as a friend, family member, or romantic partner?
   Yes____ No ___
Selecting a Specific Support Provider

(The following questions are to be asked regarding each type of service that help was reportedly sought from)

3. Which agency/person did you seek help from? __________

4. What made you decide to seek help from this agency/person?

Prompts (to be asked if not covered above)
1. What kind of help or support were you looking for? What did you expect would happen if you sought help from this agency/person?
2. Did anyone around you (e.g., friends, relatives) influence your decision to seek help from this agency/person?
3. Did any beliefs or values related to your culture or your financial situation influence your decision to seek help from this agency/person?
   Probes: Past experiences of help-seeking, perceived availability/accessibility and quality of help

5. What was that experience was like?
   Probes: What kind of help did you receive from this service? Did you receive the help you were looking for? How did the person respond? Did you find the experience helpful or unhelpful, or both? Overall, was it a positive or a negative experience?

(The following questions are to be asked regarding each type of service/person that help was reportedly not sought from)

6. Was there ever a time that you felt like you needed help from this service/person?
   Yes_____ No ___

If yes,
   a. Which service/person (if applicable)? __________
   b. What made you decide not to seek help from this agency/person?

Prompts (to be asked if not covered above)
1. What kind of help or support were you looking for? What did you expect would happen if you sought help from this agency/person?
2. Did anyone around you (e.g., friends, relatives) influence your decision to not seek help from this agency/person?
3. Did any beliefs or values related to your culture or your financial situation influence your decision to not seek help from this agency/person?
   Probes: Past experiences of help-seeking, perceived availability/accessibility and quality of help
If no,
a. What made you decide you did not need help from this service/person? How did you know you did not need help from this service/person?

Prompts (to be asked if not covered above)
1. What kind of help or support were you looking for? What did you expect would happen if you sought help from this agency/person?
2. Did anyone around you (e.g., friends, relatives) influence your decision to not seek help from this agency/person?
3. Did any beliefs or values related to your culture or your financial situation influence your decision to not seek help from this agency/person?
   Probe: Past experiences of help-seeking, perceived availability/accessibility and quality of help
LIST OF RESOURCES

The following is a list of resources that you may find helpful if you would like to receive further information or counselling and support services.

INFORMATION

Canadian Association of Sexual Assault Centres (CASAC)
The CASAC is a Canadian group of sexual assault centres that work together towards the prevention and, ultimately, eradication of rape and sexual assault. Their website provides information on issues and debates related to sexual assault, and contact information for rape crisis centres and women’s centres across Canada.

Website: http://casac.ca/?q=en/home

Canadian Mental Health Association (CMHA)
The CMHA aims to promote mental health and recovery from mental illness. This site provides information about various mental health concerns, including Post Traumatic Stress Disorder (PTSD).

Website: http://www.cmha.ca/mental-health/

Ontario Coalition of Rape Crisis Centres (OCRCC)
The OCRCC is a coalition of Rape Crisis/Sexual Assault Centres across Ontario that works toward the prevention and eradication of sexual assault. The site provides information and resources about sexual violence and its impacts, and about sexual assault centres in your local community.

Website: http://www.sexualassaultsupport.ca

Ontario Network of Sexual Assault/Domestic Violence Treatment Centres
The site provides information about sexual assault and its impact, as well as what to expect from counseling services or sexual assault/domestic violence emergency services.

Rape, Abuse, and Incest National Network (RAINN)
RAINN is an anti-sexual violence organization that aims to prevent sexual violence and offer support to survivors. This website provides information about various issues related to sexual violence, including the effects and aftermath of sexual assault, and what to expect when recovering from sexual assault.

Website: [http://www.rainn.org/](http://www.rainn.org/)

SUPPORT SERVICES AND RESOURCES

Assaulted Women’s Helpline
The Assaulted Women’s Helpline provides a 24-hour telephone crisis line offering emotional support, crisis counselling, safety planning and referrals for women who have experienced violence. All services are free, anonymous and confidential.

Website: [www.awhl.org](http://www.awhl.org)
Crisis Line: 416-863-0511 | 1-866-863-0511 (toll-free)

Barbra Schlifer Commemorative Clinic
This clinic provides a range of legal services (e.g., counseling and advocacy), individual and group counselling services, information and referrals, and interpretation services in over 90 languages, to women who have experienced violence. Services are free of charge.

Website: [www.schliferclinic.com](http://www.schliferclinic.com)
Tel: (416) 323-9149

Canadian Mental Health Association (CMHA) – Local Branches
The CMHA aims to promote mental health and recovery from mental illness. Local branches of the CMHA provide a range of support services and programs, including support for depression and suicide prevention workshops. Consult local branches for more information.

CMHA – Toronto
Website: [http://toronto.cmha.ca/](http://toronto.cmha.ca/)
Email: info@cmha-toronto.net
Tel: (416) 789-7957 (Lawrence Ave. West site); 416-289-6285 (Markham Road site)

CMHA – York Region
Website: [http://www.cmha-yr.on.ca](http://www.cmha-yr.on.ca)
Email: yorkregion@cmha-yr.on.ca
Tel: (905) 853-8477 | 1-866-208-5509

Distress Centres of Toronto
Distress Centres of Toronto offers a 24-hour telephone crisis line which provides emotional support, crisis intervention and suicide prevention to callers in need. Interpreter services are provided in 151 languages.

Website: www.torontodistresscentre.com
Crisis Line: (416) 408-4357

**Family Services Ontario**

Family Services Ontario offers a range of programs and services, including individual, family and child, and couple counseling; group therapy and support groups; and workshops, with expertise in abuse and trauma-related issues. Services are provided in a number of languages and fees are on a sliding scale based on income. They have a number of locations in downtown Toronto, Scarborough, York Region, South Etobicoke, and Rexdale.

Family Services York Region (FSYR)
Website: [http://www.fsyr.ca](http://www.fsyr.ca)
Tel: 1-888-820-9986 (Richmond Hill); 1-888-223-3999 (Newmarket); 1-866-415-9723 (Markham)

Family Services Toronto (FST)
Website: [www.familyservicetoronto.org](http://www.familyservicetoronto.org)
Email: sau@familyservicetoronto.org
Tel: (416) 595-9618

**Mood Disorders Association of Ontario**

The Mood Disorders Association of Ontario offers support and recovery programs to individuals who are living with depression, anxiety, or bipolar disorders. Services are offered free of charge, and include peer support groups and recovery programs. The website contains information and links to further resources.

Website: [http://www.mooddisorders.ca/](http://www.mooddisorders.ca/)
Tel: (416) 486-8046 | 1-888-486-8236 (toll-free)

**Sexual Assault Centres**

The Sexual Assault Centres provide counselling, information, and support services to survivors of various forms of sexual violence, including sexual assault or rape, sexual harassment, childhood sexual abuse, and incest. All services are free and confidential, and include: individual and group counseling; a 24-hour crisis line; hospital, police reporting and court accompaniment; information on the legal system and other community resources; and information and support for partners, families, and friends of survivors.

Toronto Rape Crisis Centre / Multicultural Women Against Rape
Website: [www.trccmwar.ca](http://www.trccmwar.ca)
Email: trcc@web.net
Sexual Assault / Domestic Violence Care Centres
Sexual Assault / Domestic Violence Care Centres operate out of hospitals located across the GTA, and offer services to male and female survivors of sexual assault or intimate partner abuse, and children who have been sexually abused. Services offered include 24-hour emergency medical care 7 days a week, as well as counselling and referral services.

Domestic Abuse and Sexual Assault Care Centre of York Region
(Operates out of Mackenzie Health Hospital in Richmond Hill)
Website: http://mackenziehealth.ca/patient_services_emergency_page.php?id=404
Tel: (905) 832-1406 ext. 2 | 1-800-521-6004 ext. 3

Sexual Assault / Domestic Violence Care Centre
(Operates out of The Scarborough Hospital in Scarborough)
Website: http://www.sacc.to
Tel: (416) 495-2555

Sexual Assault / Domestic Violence Care Centre
(Operates out of Women’s College Hospital in Toronto)
Tel: (416) 323-6040

The Gerstein Centre
The Gerstein Centre provides support to adults, living in Toronto, who are experiencing mental health problems. Services are free of charge, and include counseling and crisis intervention for immediate, crisis issues, and referrals to other services on on-going, non-crisis issues.

Website: http://www.gersteincentre.org
Email: admin@gersteincentre.org
Tel: (416) 929-0149
Crisis Line: (416) 929-5200

Victim Services of York Region
Victim Services of York Region aims to help victims of crime or tragic circumstances, including sexual assault, to cope with the impact or trauma of the incident, access
support services in the community, and feel supported by the police and justice system. All services are free of charge to victims and confidential, and include providing emotional support, information, referrals, and other practical assistance.

Website: http://www.victimservices-york.org/
Tel: (905) 953-5363 | 1-866-876-5423 ext. 6790

**Victim Services Toronto**
Victim Services Toronto aims to support victims of crime or tragic circumstances, including sexual assault, to cope with the impact or trauma of the incident and access support services in the community. Through the Victim Crisis Response Program, Victim Services Toronto provides emotional support, information, referrals, and other practical assistance.

Website: http://www.victimservicestoronto.com/
Email: info@victimservicestoronto.com
Crisis Line: (416) 808-7066

**Women's Counselling, Referral and Education Centre (WCREC)**
WCREC is a community-based mental health agency serving the GTA and surrounding areas that aims to promote the psychological and emotional well-being of women. A wide range of free services are available, including crisis counseling, counselling, and information and referrals.

Website: http://www.plasmalife.com/WCRECsite/involved/involved.html
Email: generalmail@wcrec.org
Tel: (416) 534-8458
Phone Line Service: (416) 534-7501