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Briefing Paper Working Group Members

Heather Littleton, Ph.D.

East Carolina University, United States

Naaemah Abrahams, Ph.D.

University of the Western Cape,
South Africa

Mindy Bergman, Ph.D.

Texas A & M University, United States

Lucy Berliner, M.S.W.

University of Washington, United States

Margaret Blaustein, Ph.D.

Center for Trauma Training, United States

Judith Cohen, M.D.

Drexel University, United States

Emily Dworkin, Ph.D.

University of Washington, United States

Barbara Krahé, Ph.D.

University of Potsdam, Germany

Noemí Pereda, Ph.D.

University of Barcelona, Spain

Zoë Peterson, Ph.D.

Indiana University, United States

Afroditi Pina, Ph.D.

University of Kent, United Kingdom

Shireen Rizvi, Ph.D.

Rutgers University, United States

Terri Weaver, Ph.D.

Saint Louis University, United States

Michele Ybarra, Ph.D.

Center for Innovative Public Health
Research, United States

Heidi Zinzow, Ph.D.

Clemson University, United States

Additional Contributors

Brittany Goss, M.A., M.S.

East Carolina University, United States

Kayla Sall, B.A.

East Carolina University, United States

Rose L. Siuta, M.A.

Texas A & M University, United States

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Key Points

Sexual assault and abuse

- Sexual assault occurs worldwide. Although all individuals are vulnerable, sexual assault is gendered in that girls and women are more frequently victims than boys and men.
- Members of a number of marginalized groups including individuals with disabilities, sexual and gender minorities, individuals who are sexually trafficked or engaging in sex work, individuals who are runaways or homeless, and aboriginal and indigenous groups face substantially elevated rates of sexual assault.
- Survivors of childhood sexual abuse, unwanted sexual contact, and rape experience elevated risk for multiple psychological disorders, including posttraumatic stress disorder (PTSD), depression, anxiety disorders, dissociative disorders, disorders of sexual functioning, eating disorders, sleep disorders, and substance use disorders.
- Sexual assault victimization is associated with elevated risk for a host of health risk behaviors, including substance misuse, sexual risk behavior, smoking, unhealthy eating patterns, avoidance of preventative healthcare, and a sedentary lifestyle, as well as physical health problems including gastrointestinal symptoms and disorders, headaches, obesity, reproductive health problems, and sexually transmitted infections.
- Survivors of sexual assault and abuse face substantial barriers to disclosure and help seeking. Survivors in certain cultural contexts may face stigma, shunning, and other social sanctions if they disclose or engage in help seeking.
- Trauma-focused psychotherapeutic interventions have the strongest evidence base for the treatment of psychological distress associated with sexual assault and abuse, including PTSD and depression, experienced by child and adult survivors.
- Sexual assault survivors often experience multiple forms of violence and may be embedded in contexts of poverty, few resources, and community violence. Survivors with multiple experiences of violence and who are embedded in these contexts may have no or minimal access to appropriate medical and mental health care, and may face extreme difficulties in accessing care that is available.

Sexual harassment in work and educational settings

- Sexual harassment is frequent in educational and occupational settings, with women more likely to experience sexual harassment than men. Institutional tolerance for sexual harassment is strongly associated with the incidence of sexual harassment within educational and occupational settings.
- Sexual harassment is frequent in educational and occupational settings, with women more likely to experience sexual harassment than men. Institutional tolerance for sexual harassment is strongly associated with the incidence of sexual harassment within educational and occupational settings.
- Survivors of sexual harassment in educational and occupational settings rarely engage in formal reporting within their organizations. Of those who do report, many experience negative outcomes, including minimization, retaliation, and lack of pursuit of appropriate remedial actions.
- Experiencing sexual harassment is associated with negative affect, including anger, anxiety, fear, sadness, and depression. Harassment survivors also often report stress-related psychosomatic symptoms, including headaches, muscle pains, nausea and gastrointestinal disorders, respiratory problems, weight changes, fatigue, heart palpitations, and insomnia. Some sexual harassment survivors who experienced sexual assault as part of a pattern of sexual harassment, may develop PTSD symptomology.

Executive Summary

Recent events including revelations of the systematic cover-up of widespread childhood sexual abuse in the Catholic Church, sexual assault and harassment accusations involving many prominent individuals in the entertainment and other industries in the U.S., Canada, Europe, Australia, and Japan, global coverage of cases of violent rape and rape-murder of girls and young women in India, and the #metoo movement, have served to increase public consciousness internationally regarding the pervasiveness of various forms of sexual victimization worldwide. In response, the International Society for Traumatic Stress Studies (ISTSS) commissioned this briefing paper to inform its membership, policymakers, and global stakeholders about the prevalence, impact, and barriers faced by survivors of various forms of sexual victimization including attempted and completed rape, sexual abuse in childhood, and sexual harassment in workplace and educational settings. This paper outlines the research evidence regarding (1) the prevalence of different forms of sexual victimization worldwide including childhood sexual abuse, various forms of sexual assault in adulthood, and sexual harassment in workplace and educational settings, (2) the prevalence of various forms of sexual victimization among several marginalized groups, (3) the psychological, behavioral, and physical health impacts of sexual victimization in childhood and adulthood, (4) evidence-based interventions for survivors of sexual victimization, and (5) barriers to treatment seeking commonly faced by survivors of different forms of sexual victimization. Recommendations are also made in the areas of policy, practice, research, and for professional organizations.

Research conducted throughout the world continues to document the alarmingly high prevalence of various forms of sexual victimization throughout the lifespan, including the sexual abuse of children, sexual assault of adults, and sexual harassment within individuals' place of employment and in educational settings. Although all individuals are vulnerable to experiences of sexual victimization, sexual assault, abuse, and harassment are gendered crimes, such that women and girls are more likely to be victims of these forms of sexual violence. In addition, members of a number of marginalized groups face substantially increased vulnerability to sexual victimization. These include individuals with disabilities, sexual and gender minorities, homeless individuals, individuals engaging in various kinds of sex work, and members of indigenous populations. Further, the impact of sexual victimization is both broad and targeted, with various forms of sexual victimization, including experiences of childhood sexual abuse and sexual assault in adulthood, associated with a host of negative outcomes including the development of posttraumatic stress disorder, depression, anxiety, substance use disorders, eating disordered pathology, suicidality, dissociation, and high risk sexual behaviors. Further, sexual victimization is associated with risk for a number of negative physical health outcomes including obesity, gastrointestinal disorders, chronic pelvic pain, and reproductive health issues.

There exists a robust evidence base supporting the efficacy of psychological treatment for PTSD symptomology among adult survivors of childhood sexual abuse and sexual assault. Of extant treatments, cognitive-behavioral based treatments have the strongest evidence for their efficacy. Similarly, cognitive-behavioral treatments, such as trauma-focused CBT, have demonstrated efficacy in treating PTSD and depressive symptomology among children and adolescents who have experienced sexual abuse. There is also some evidence supporting the efficacy of psychopharmacological treatment in reducing PTSD symptomology among adult survivors of sexual abuse or assault. Conversely, there is far more limited research examining the efficacy of psychological treatments for PTSD in other cultural contexts, with the vast majority of research involving United States samples. There is also much less evidence regarding the impact of trauma-focused treatments on other outcomes besides PTSD symptomology and depression, or examining how to treat additional behavioral and mental health issues among survivors of sexual victimization. Finally, almost no research has evaluated the efficacy of psychological treatments for individuals who have experienced sexual harassment in their workplace.

Further, research documents that survivors of various forms of sexual victimization often face substantial barriers to disclosing their experience or seeking formal help. These barriers include issues related to defining the experience as a victimization, concerns about not being believed or taken seriously, and feelings of stigma, shame, or embarrassment. Other barriers include concerns about whether the experience will be reported to authorities, mistrust of formal support systems, and prior negative experiences following disclosure of a sexual victimization experience. Many survivors also may be unaware of services that are available to them, may believe that available services are not appropriate for them, and may also face substantial barriers to accessing the care that is available, and available care may be inadequate for addressing their needs in many parts of the world. Finally, it is important to note that many individuals who experience sexual victimization face ongoing issues related to poverty, socioeconomic disadvantage, ongoing personal and community violence, and belong to marginalized groups.

Given the prevalence, impact, and substantial barriers to care faced by individuals who experience sexual victimization, including childhood sexual abuse, sexual assault, and sexual harassment, it is clear that concerted, international, and collaborative efforts involving policymakers, researchers, clinicians, professional organizations, and other global stakeholders is imperative.

Types of Sexual Assault, Abuse, and Harassment

Sexual assault is an umbrella term that encompasses a broad range of nonconsensual sexual behaviors. The World Health Organization defines sexual assault as “any sexual act, attempt to obtain a sexual act, or other act directed against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work” (World Health Organization, 2017). Similarly, the Centers for Disease Control and Prevention in the United States defines sexual assault as any sexual act committed against someone without that person’s freely given consent, including sexual acts obtained by force, coercion, and perpetrated against an individual unable to give consent due to age (e.g., minor), disability, or impairment following voluntary or involuntary substance use (Basile, Smith, Breiding, Black, & Mahendra, 2014). Both definitions are neutral with regard to the gender of victim and perpetrator, reflecting the recognition that men and boys can be victims, and that women can perpetrate sexual assault. However, sexual assault is gendered in the sense that across the globe more women and girls are victims as compared to men and boys. Additionally, men are more likely to be perpetrators of sexual assault than women. This briefing paper will focus on the following: childhood sexual abuse, unwanted sexual contact, attempted and completed rape, and sexual harassment. It is important to acknowledge that this does not represent a comprehensive review of all forms of sexual victimization that individuals can experience, but instead focuses on several of the most serious and common forms of sexual victimizing events that affect individuals throughout the lifespan. The definitions of each of these forms of sexual violence utilized in the current briefing paper are listed below.

Childhood sexual abuse

Childhood sexual abuse comprises any sexual activities with a child below the age of consent. As children are considered unable to freely agree to sexual activities, any sex with a child by an adult is nonconsensual by definition. It is important to note that from a legal standpoint, the age of consent, that is the age in which individuals are seen as legally competent to consent to sexual contact, varies across countries. For example, the majority of countries in Europe set the age of consent between 14 and 16 years, although there are some notable exceptions, such as France, which has no legally defined age of consent (Doezema, 2018; Farand, 2018). The United States has no nationwide legally recognized age of consent, with individual states’ age of consent varying from 16 to 18 (Survivor Alliance, 2017). In contrast, Canada’s nationally recognized age of consent is 16 years (Department of Justice, Canada, 2017). The age of consent varies widely amongst Asian, Middle Eastern, and African countries, ranging from 12 to 21, with some primarily Middle Eastern and North African countries having no set age of consent, but instead legally restricting consensual sexual activity to that which occurs between married couples, regardless of age (Age of Consent, 2018).

Finally, the age of consent ranges from 14 to 18 years in Central and South American countries (Age of Consent, 2018). Regardless of the legal standard in a particular jurisdiction, from a research and clinical perspective, it is recognized that children are unable to fully consent to sexual activity, even if that sexual activity is legally sanctioned within a particular cultural setting (e.g., marriage involving a minor child). Further, children and adolescents generally lack sufficient power in the settings in which sexual abuse occurs to freely refuse sexual activity.

Sexual abuse of children can be differentiated into contact abuse and noncontact abuse. *Contact abuse* comprises any sexual acts that involve direct physical contact with the child, such as touching the child's genitalia, penetration of the body, or making the child sexually touch the perpetrator. *Noncontact abuse* comprises acts that do not involve direct physical contact, such as exposing the private parts of one's body to the child, exposing the child to sexual materials, or filming or photographing the child in sexualized poses (Leeb, Paulozzi, Melanson, Simon, & Arias, 2008).

Unwanted sexual contact

Unwanted sexual contact is a type of sexual assault and refers to non-consensual kissing or touching of the private parts of the body (e.g., breasts, genital area, buttocks) of a person via the threat or use of physical force, or exploitation of the other person's inability to give consent or show active resistance, for instance due to alcohol intoxication or other substance use (Koss et al., 2007).

Attempted and completed rape

Attempted and completed rape are generally considered to be two of the most serious forms of sexual assault. Attempted rape involves a non-successful attempt to engage in vaginal, anal, or oral penetrative sex, whereas completed rape involves vaginal, anal, or oral penetrative sex, including penetration with fingers, objects, or a penis. In both cases, these sexual acts are perpetrated using the threat or use of physical force and/or exploitation of the other person's inability to give consent or show active resistance, for instance, due to alcohol intoxication or other substance use (Koss et al., 2007). For anatomic male victims, attempted and completed rape also includes instances in which the victim is forced to penetrate or attempt to penetrate the perpetrator (Stemple & Meyer, 2014). Finally, any instance of attempted or completed penetrative sex against someone who is constitutionally not capable of consenting (e.g., an individual with insufficient cognitive capacity to consent) would also be classified as attempted or completed rape.

Sexual harassment

Sexual harassment is defined as "any deliberate or repeated sexual behavior that is unwelcome to the recipient, as well as other sex-related behaviors that create an environment that is hostile, offensive, or degrading" (Fitzgerald, 1993). It can include various forms of sexual assault among individuals in these settings (e.g., unwanted

sexual contact, attempted or completed rape) as well as unwanted sexual behaviors not involving sexual assault (e.g., lewd gestures, cyber-harassment, unsolicited propositions, and unwanted sexual comments/jokes/discussions). In this briefing paper, we will focus on sexual harassment that occurs within work and educational settings, while acknowledging that sexual harassment occurs in other settings as well. Within such settings, two types of sexual harassment are legally recognized. The first of these is quid pro quo harassment, where employment (e.g., being hired, receiving a promotion) or educational (e.g., receiving a passing grade) decisions are made on the basis of, or implied to be contingent upon, the individual providing sexual favors to an individual in a position of authority (e.g., work supervisor, teacher or professor). The second type is hostile environment harassment which refers to deliberate and repeated sexual behavior within a work or educational setting that is pervasive enough to create an environment that is intimidating or demeaning to individuals within that environment (Society for Human Resource Management, 2018).

Prevalence of Sexual Assault, Abuse, and Harassment

Childhood sexual abuse (CSA)

The widespread prevalence of childhood sexual abuse, including contact and non-contact abuse, has been confirmed in studies of adults' retrospective reports of experiences of CSA. Although studies vary in the specific definition of CSA provided (e.g., whether they include contact and non-contact abuse), these studies generally find reported rates of CSA ranging from 15.0 to 19.7% for girls and from 7.6 to 8.0% for boys (Barth, Bermetz, Heim, Trelle, & Tonia, 2013; Pereda, Guilera, Forns, & Gómez-Benito, 2009; Stoltenborgh, Van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011; Tanaka, Suzuki, Aaoyoma, Takoka, & MacMillan, 2017). However, as these studies rely on retrospective reports of events that happened many years ago, there is some concern that these prevalence estimates represent an underestimation of the true prevalence of sexual abuse, as some adults may not recall experiences of childhood abuse (Becker-Blease & Freyd, 2006). More recent work has therefore sought to examine direct reports of sexual abuse experiences among children in North America (Cyr et al., 2013 in Canada; Finkelhor, Turner, Shattuck, & Hamby, 2015 in the United States), Central America (Pineda-Lucatero, Trujillo-Hernández, Millán-Guerrero, & Vásquez, 2009 in Mexico), Europe (Radford, Corral, Bradley, & Fisher, 2013 in the United Kingdom; Edgardh & Ormstad, 2000 in Sweden; Pereda, Abad, & Guilera, 2015 in Spain; Mohler-Kuo and colleagues, 2014 in Switzerland), Asia (Al-Fayez, Ohaeri, & Gado, 2012 in Kuwait; Chen, Dunne, & Han, 2004 in China; Lin, Li, Fan, & Fang, 2011 in rural China), Australia (Moore et al., 2010), and Africa (Moore, Awusabo-Asare, Madise, John-Langba, & Kumi-Kyereme, 2007; Reza et al., 2009). Studies of child reports tend to find somewhat higher rates of CSA as compared to those relying on retrospective reports of adults. In North America, studies involving child reports have found a prevalence of CSA ranging from 11.2 to 26.6% for girls and between 5.1 to 17.3% for boys. Similarly, in Europe, the CSA prevalence has ranged from 11.2 to 20.8% for girls, and from 3.1 to 12.5% for boys. An Australian study similarly found a CSA prevalence of 11.7% of girls and 5.7% of boys. In contrast, in Asia, a higher prevalence of CSA has been documented among boys than girls, with the prevalence ranging from 8.9 to 16.7% for girls and from 10.5 to 22.5% for boys. The highest prevalence of CSA among girls has been found in Africa, ranging from 15.0 to 38.0%. To date, there is no study directly assessing CSA among male children and adolescents in Africa.

Sexual assault victimization in adulthood

It is difficult to summarize the prevalence of specific forms of sexual assault victimization among adults because definitions and measurement approaches vary substantially across studies. Although prevalence rates are inconsistent, one consistent finding is that adult women experience sexual assault victimization at higher rates than adult men. Additionally, research strongly supports that sexual assault is a universal problem worldwide.

Generally, epidemiological research has taken one of two approaches to evaluate the prevalence of sexual assault. The first is to utilize one or several broad screening questions to determine if an individual has experienced one or more of several forms of sexual assault during their lifetime. Research taking this approach has documented the high prevalence of lifetime sexual assault victimization among women. For example, in the United States, a national study of women found that approximately 36% had experienced some form of sexual assault, including nonconsensual penetration, unwanted sexual contact, and/or sex obtained through verbal pressure or manipulation (Smith et al., 2017). In a study conducted in ten European countries (Krahé et al., 2015), the prevalence of any nonconsensual sexual contact obtained through force or threat of force since age 14 varied across countries from 12 to 36% among women, with an overall prevalence of sexual assault of 19.5%. In this same study, prevalence of nonconsensual sexual contact obtained through exploitation of a woman's incapacitation due to drugs or alcohol since age 14 ranged from 8 to nearly 36% across countries, with an overall prevalence of 17%. Similarly, a national survey of over 17,000 individuals residing in Australia found a lifetime prevalence of sexual assault of 17.1% among women, where sexual assault was defined as any incident of completed or attempted rape or sexual touching perpetrated by use of threat, violence, or intimidation (Cox, 2016). Although research is much more limited in these regions, overall estimates of the lifetime prevalence of sexual assault among women have ranged from 4.5 to 21% in Africa, from 6 to 12% in Central and South America, and from 3 to 12% in Asia (Abrahams et al., 2014).

Other studies have focused on the lifetime prevalence of rape specifically. Although research definitions of "rape" (i.e., penetrative sex obtained through force, threat of force, or incapacitation) are somewhat more consistent across studies, variations do exist (e.g., some include both attempted and completed rape and some exclude rape through incapacitation from drugs or alcohol, and some focus exclusively on rape by an intimate partner). Despite these differences in operational definitions, based on national samples in the United States, researchers consistently find that 18-19% of women have experienced attempted or completed rape by at least one perpetrator (inclusive of intimate partners and other individuals) in their lifetime (Black et al., 2011; Kilpatrick, Resnick, Ruggiero, Conoscenti, & McCauley, 2007; Smith et al., 2017; Tjaden & Thoennes, 2000). A similar prevalence of attempted rape (19.4%) and completed rape (9.8%) among women was recently found in a large epidemiological survey of individuals residing in Britain (Macdowall et al., 2013). Additionally, the European Union Agency for Fundamental Rights (FRA) recently completed the first epidemiological survey of violence against women across all 28 European Union member countries. They found a lifetime prevalence of rape obtained by force ranging from 4 to 17% of women across the countries surveyed (FRA, 2015).

Much less epidemiological research has examined the prevalence of rape victimization in Africa, Asia, and Central and South America. Additionally, extant studies in these geographic regions vary much more in the estimates obtained, likely in part due to methodological differences across studies, and in some cases, issues related to

underreporting of victimization experiences. Regarding the prevalence of rape in Africa, estimates obtained via epidemiological research in South Africa range from 4.5 to 12% of women (Jewkes & Abrahams, 2002). Similarly, a recent epidemiologic study of women in Kenya found a lifetime prevalence of forcible rape of 13% (Adudans et al., 2011). In contrast, an epidemiological study of rural women in Uganda found that 24% reported experiencing forcible rape by their current intimate partner (Koenig et al., 2004). Regarding Central and South America, a summary report of epidemiological studies involving nationally representative samples of adult women residing in eleven Caribbean, Central American, and South American countries found the lifetime prevalence of rape obtained by force by an intimate partner to range from 4.6 to 15.2%, with only two countries reporting a lifetime prevalence of forcible rape of less than 7.6% (Bott, Guedes, Goodwin, & Mendoza, 2012). Finally, a recent epidemiological study of women residing in four Asian and Pacific countries (Cambodia, China, Sri Lanka, and Papua New Guinea) found the lifetime prevalence of rape obtained by force or incapacitation by a non-intimate partner ranged from 1.7 and 15.9% across countries. Similarly, the prevalence of rape obtained by force or threat by an intimate partner ranged from 3.2 to 16.0% of women across countries (Jewkes et al., 2017).

Although rates of reported sexual assault are lower among men than women, men worldwide experience sexual assault, including rape, perpetrated by both men and women (see Peterson, Voller, Polusny, & Murdoch, 2011, for a review). In a nationally-representative sample of United States men, approximately 17% reported they had experienced one or more instance of sexual assault, including nonconsensual penetration, unwanted sexual contact, being forced to penetrate someone else, and sex obtained through verbal pressure or manipulation (Smith et al., 2017). In ten European countries, the prevalence of forced nonconsensual sexual contact since age 14 for men varied from less than 6 to almost 42% of men across countries, with an overall prevalence of 16% (Krahé et al., 2015). In Australia, an epidemiological study found that 4.5% of men reported having experienced some form of sexual assault obtained by force, threat, or intimidation during their lifetime (Cox, 2016). Additionally, a study of over 1,700 adult men in South Africa found that 9.5% reported a history of some form of sexual assault perpetrated by a man, including sexual acts obtained via use of force or verbal coercion (Dunkle, Jewkes, Murdoch, Sikweyiya, & Morrell, 2013).

Among studies of the prevalence of attempted and completed rape among men specifically, the obtained prevalence is similarly lower among men than among women. Across several national studies of men in the United States, researchers have found that between 1.4 and 3.0% of men report having experienced attempted or completed rape in their lifetime (Black et al., 2011; Smith et al., 2017; Tjaden & Thoennes, 2000). Among a community sample of South African men, 3.3% reported a history of completed rape by a male perpetrator (Dunkle et al., 2013). A study of men in Kenya found a somewhat higher prevalence of completed rape of 4.5% (Adudans et al., 2011). Finally, among men residing in Britain, 4.7% reported a history of attempted rape and 1.4% a history of completed rape (Maddowall et al., 2013).

Sexual harassment in workplace and educational settings

The prevalence of sexual harassment varies across nations/cultures, settings and contexts (e.g., workplace, education), and demographic factors (e.g., race, economic class, education levels). Further, specific organizational contexts are associated with a higher prevalence of sexual harassment within these settings (e.g., organizations with defined hierarchical power structures, organizations with high institutional tolerance for harassment; Fitzgerald et al., 1997; Ilies, Hauserman, Schwochau, & Stibal, 2003). Much of the research on sexual harassment prevalence comes from the U.S., Europe, and Australia, with this research supporting a high prevalence of sexual harassment in the workplace. For example, the 1992 U.S. National Health and Social Life Survey found a prevalence of workplace sexual harassment of 41% of women and 32% of men (Das, 2009). Similarly, a recent meta-analytic review found that, using probability samples, approximately 58% of women had experienced sexual harassment (Ilies et al., 2003). In Australia, a survey by the Australian Human Rights Commission (AHRC) found the lifetime prevalence of sexual harassment to be 33% for women and 9% for men (AHRC, 2012). Similar sexual harassment prevalence has been found in European samples. Across the 28 European Union Member States, 45 to 55% of women had been targets of sexual harassment at least once, and 21% had experienced sexual harassment in the past year (Latcheva, 2017). There was variation across countries, with 71-81% of women in Denmark, Finland, France, the Netherlands, and Sweden indicating that they had experienced sexual harassment, but only 24-32% of women in Bulgaria, Poland, Portugal, and Romania indicating the same (Latcheva, 2017).

There has been far less research on sexual harassment incidence and prevalence in other countries. One extant epidemiological survey in China found that 12.5% of women overall had experienced sexual harassment within the past year (Parish, Das, & Laumann, 2006). In Japan, a study of psychiatric hospital employees found that 9.5% of workers had experienced sexual harassment within the past year (Chen, Hwu, Kung, Chiu, & Wang, 2008). Conversely, a study of college employees in Ethiopia found a much higher prevalence of sexual harassment, with 47% of women faculty and staff reporting they experienced sexual harassment in the workplace (Marsh et al., 2009). Differences in prevalence and incidence rates of sexual harassment across cultures likely reflect cultural differences in the frequency of harassment, as well as differences in the likelihood of labeling specific behaviors as harassment (particularly among studies that do not use behaviorally specific descriptions of sexual harassment behaviors). Further, methodological differences across studies make direct comparisons in incidence and prevalence more difficult, including use of different definitions of harassment, different survey methods, use of convenience versus representative samples, and studies of employees in different types of organizations (Ilies et al., 2003).

Finally, it should be noted that studies conducted in the United States support that members of minority groups face elevated rates of sexual harassment in work and educational settings. Therefore, not only are women more likely to experience sexual

harassment than men, but women who have additional minority identities are even more likely to experience harassment. Overall, racial and sexual minorities, individuals with lower levels of education and of lower socioeconomic status, individuals with lower status within an organization, and younger and unmarried individuals face increased risk of sexual harassment (Bergman & Drasgow, 2003; Fain & Anderton, 1987; Harned, Ormerod, Palmieri, Collinsworth, & Reed, 2002; Ryan & Wessel, 2012; Settles, Buchanan, & Colar, 2012).

Sexual assault victimization among marginalized groups

Although a focus on the prevalence of sexual victimization in the overall population is imperative to document the scope of the problem of sexual violence, it is important to note that members of a number of marginalized populations may face substantially elevated rates of sexual assault. Although not an exhaustive list, examples of such marginalized groups with documented elevated victimization risk include individuals with disabilities, sexual and gender minorities, individuals who engage in sex work, homeless individuals, and members of indigenous populations.

Individuals with disabilities. A large epidemiological study of children in the United States found that 21% of those with an intellectual disability had experienced childhood sexual abuse, which was four times higher as compared to children without disabilities (Sullivan & Knutson, 2000). These findings were replicated in a systematic review and meta-analysis conducted by Jones and colleagues (2012) who concluded that the risk for sexual abuse among children with disabilities was 2.9 times higher than among their peers without disabilities. Research further supports that sexual abuse is the most common form of maltreatment experienced by children with disabilities (Hershkovitz, Lamb, & Horowitz, 2007), particularly those with an intellectual disability (Horner-Johnson & Drum, 2006). Research with adults with disabilities similarly supports that they are at substantially increased risk for sexual assault, including completed rape. For example, a study of U.S. women found that women with disabilities faced a nearly five-times increased risk of experiencing some form of sexual assault in the past year relative to women who do not have a disability (Martin et al., 2006). Similarly, an epidemiological study of U.S. men found that those with disabilities were nearly seven times more likely than men without a disability to have experienced completed rape, and were five times more likely than men without disabilities to have experienced some form of sexual assault in the past year (Mittra, Mouradian, & Diamond, 2011).

Sexual and gender minorities. Sexual and gender minorities, including those who identify as gay, lesbian, bisexual, and transgender, are another group at substantially elevated risk. In U.S. studies, even though all sexual minority groups are at increased risk, bisexual women appear to be at particularly elevated risk of experiencing different forms of sexual assault, including rape (Balsam, Rothblum, & Beauchine, 2005; Ford & Soto-Marquez, 2016; Hequembourg, Livingston, & Parks, 2013). As an example, one study found that 46% of bisexual women reported a history of completed rape as compared to 17% of heterosexual women and 13% of lesbian women (Walters,

Chen, & Breiding, 2013). Gay and bisexual men also are at elevated risk, with 47% of bisexual men and 40% of gay men reporting a history of some form of unwanted or nonconsensual sex, as compared to 21% of heterosexual men (Walters et al., 2013). In another U.S. study, bisexual men were more likely to report a completed rape history (13.2%) than gay men (11.6%) or heterosexual men (1.6%; Balsam et al., 2005). This same study found that sexual minority men (21.5-29.4%) and women (24.2-28.3%) were more likely to report a childhood sexual abuse history as compared to heterosexual men (5.6%) and women (17.1%; Balsam et al., 2005). Notably, studies of hate crime-related sexual assaults in the U.S. have found the prevalence of this form of sexual assault to range from 3 to 19.8% of sexual minority individuals (Rothman, Exner, & Baughman, 2011). Outside the U.S., a study in South Africa of men who have sex with men (MSM) found a completed rape prevalence of 11%, and a study of MSM in Malawi found a completed rape prevalence of 7% (Baral et al., 2011; Wirtz et al., 2013). In cultures where there exist strong cultural prohibitions against homosexuality, sexual minority individuals may face elevated risk of being targeted for sexual assault motivated by homophobia. For example, researchers and human rights groups have documented the existence of so-called “corrective rapes” of lesbian women in South Africa and other countries, where women who are lesbians are targeted for highly violent rape, gang rape, or rape-murder as a way to “cure” them or punish them for their sexuality (Mwambene & Wheal, 2015). The prevalence of such assaults is difficult to fully document, given that many victims may fear retaliation for reporting, and legal authorities may do little to protect victims or apprehend perpetrators (Mwambene & Wheal, 2015).

Gender minorities, including transgender and gender non-binary-identified individuals, also experience disproportionately high rates of different forms of sexual assault including rape. Although rates vary widely depending on methodology, summarizing across studies, approximately 50% of trans-identified individuals in the U.S. have experienced unwanted or nonconsensual sexual activity, with male-to-female transgender individuals at higher risk than female-to-male transgender individuals (Stotzer, 2009). Research conducted in other countries similarly documents extremely high rates of sexual assault among transgender individuals. For example, a study of Dutch transgender individuals found a lifetime prevalence of some form of sexual assault of 41% for transwomen and 21% for transmen (Cense, de Haas, & Doorduyn, 2017). Similarly, a study of transwomen in Jamaica found that 46% had experienced rape (Logie et al., 2017). Finally, a recent study of transwomen from eight African countries found an overall rape prevalence of 28% (Poteat et al., 2017).

Homeless individuals. Homelessness encompasses various categories of inadequate or unstable shelter among youth and adults, including lacking any sort of home/dwelling, lacking a home which provides shelter from the elements (e.g., rooflessness), having an unstable living situation (e.g., “couch surfing”), and living in substandard or inadequate housing (Olufemi, 2000). Research on homeless women, particularly those who live on the streets, consistently supports that women who are homeless

have extensive and ongoing trauma histories, with some describing their experiences as a “traumatic lifestyle” (Goodman, Fels, & Glenn, 2006). Studies have documented rates of CSA of up to 68% among homeless women (Buhrich, Hodder, & Teesson, 2000; Goodman et al., 2006). Additionally, two-thirds or more of U.S. homeless women report having experienced violence by an intimate partner (Fisher, Hovell, Hofstetter, & Hough 1995; Goodman et al., 2006; Koehlmoos, Uddin, Ashraf, & Rashid, 2009). Indeed, fleeing partner violence appears to be a common pathway to homelessness for women in a number of countries. The prevalence of rape in adulthood among homeless women often exceeds 30%, with some studies finding a prevalence of up to 50% (Buhrich et al., 2000; Hudson et al., 2010). Homeless men also are vulnerable. For example, one study found that 1% of homeless men in the U.S. had experienced sexual violence in the last month, and a study of men in Australia found a lifetime rape prevalence of 10% among homeless men (Buhrich et al., 2000; Wenzel et al., 2000). Homeless/runaway youth also are highly vulnerable to sexual exploitation and violence. Indeed, studies in the U.S. and Canada find that between 11 and 43% of homeless youth have experienced rape (Heerde & Hemphill, 2016).

Individuals engaging in sex work. Research conducted in multiple countries has documented the high prevalence of violence, including various forms of sexual assault, experienced by individuals engaging in sex work. First, the majority of individuals engaging in sex work report past histories of childhood abuse, with most studies finding that at least 75% report a history of childhood sexual abuse prior to initiating sex work (Farley, Baral, Kiremire, & Sezgin, 1998; Farley, Lynne, & Cotton, 2005; Lankenau, Clatts, Welle, Goldsamt, & Gwadz, 2005). Indeed, many individuals who engage in sex work report an extensive history of childhood adversity, including poverty, homelessness, instability of caregivers, childhood abuse and neglect, and removal from their homes due to abuse/neglect (Dalla, Zia, & Kennedy, 2003; Lankenau et al., 2005). Individuals with childhood abuse histories may initiate sex work as a way to survive on the street following running away or leaving home, may be trafficked or sold into prostitution by their caregivers, or may be forced into sex work by pimps who take them in off the street (Dalla et al., 2003; Lankenau et al., 2005; Sarkar et al., 2008). Studies of women and girls engaging in sex work support that physical and sexual violence is ubiquitous, particularly among homeless individuals, individuals who are dependent on substances, and those who are sexually trafficked (Sarkar et al., 2008; Shannon et al., 2009). Further, women and girls engaging in sex work often experience severe and chronic violence, including severe beatings, gang rapes, threats with a weapon, rape using objects, and multiple rapes (Decker et al., 2010; Farley et al., 2005; Raphael & Shapiro, 2004).

Much less is known about the sexual assault risk faced by men and boys engaging in sex work, with extant studies supporting that sexual assault is not uncommon among cisgender men and boys (individuals whose gender identity matches their sex assigned at birth; Chemnasiri et al., 2010), and research on homeless men and boys engaging in sex work supporting that they often experienced severe childhood abuse, including

sexual abuse (Lankenau et al., 2005). Finally, individuals assigned male at birth who identify as transgender or who have a feminine gender presentation (e.g., transvestites, drag queens) who engage in sex work appear to be a highly vulnerable population as they are at substantial risk for being targeted for physical and sexual violence due to their gender identity or presentation (Infante-Sosa et al., 2009; Nemoto, Bödeker, & Iwamoto, 2011; Nichols, 2010; Sausa, Keatley, & Operario, 2007).

Members of indigenous populations. Sexual assault among indigenous populations has primarily been studied within Native American/Alaska Native individuals in the United States, Aboriginal peoples in Australia, and Aboriginal peoples in Canada. High rates of violence have been posited to occur among all of these indigenous populations, although epidemiological research is limited. Among extant research conducted with Aboriginal Canadians, it is estimated that between 25 and 50% of individuals experience sexual abuse in childhood (Collin-Vézina, Dion, & Trocmé, 2009). Additionally, a national survey of Native American/Alaska Native women found that 34% reported a history of attempted or completed rape, nearly double that of other U.S. women (Bachman, Zaykowski, Lanier, Poteyeva, & Kallmyer, 2010). Native American/Alaska Native women appear to be more likely than women of other ethnic/racial groups in the U.S. to have experienced a violent sexual assault, such as one involving a weapon or physical injury. Further, Native U.S. women were more likely than other women to report that the perpetrator was using alcohol or drugs during the assault (Bachman et al., 2010). Elevated rates of intimate partner violence, including sexual assault by intimate partners, have also been documented in indigenous communities (Keel, 2004). Multiple factors contribute to the high rates of violence experienced by indigenous peoples, including severe poverty and lack of infrastructure in their communities, lack of education and employment opportunities, high rates of substance use, distrust of the government and law enforcement agencies based on historical experiences, and the long-term effects of cultural trauma associated with colonization (Gebhardt & Woody, 2012; Stanley, Cadd, & Pocock 2003).

Trauma-Related Behavioral and Physical Health Problems among Survivors of Sexual Assault

Survivors of sexual abuse

Child survivors of CSA. Sexual abuse against children often co-occurs with other types of child maltreatment and trauma. Childhood trauma experiences, including sexual abuse, involve variable degrees of perceived or actual threat. The impact of these experiences on individual children is also highly variable, and depends on many factors including genetic vulnerability, pre-existing mental disorders, cumulative trauma history, the child's cognitions related to the sexual abuse, parental support, and the responses of others and systems with whom they come in contact following disclosure or discovery of the abuse (Pine & Cohen, 2002). There is also growing evidence that sexual abuse has variable impact depending on the developmental stage at which it first occurred (De Bellis & Zisk, 2014).

Overall, childhood sexual abuse is associated with significantly heightened risk for developing posttraumatic stress disorder (PTSD; Maniglio, 2009; McLaughlin et al., 2012). Studies of school age children and adolescents who were sexually abused find that between one-third to one-half of youth exhibit clinically significant PTSD symptoms (Collin-Vézina, Daigneault, & Hébert, 2013). Experiencing sexual abuse is also associated with elevated risk for a host of other forms of psychopathology and negative outcomes in childhood and adolescence including anxiety and depressive disorders, substance abuse and externalizing behavioral disorders, bulimic and other eating disorder symptomology, bipolar disorder, suicidality, dissociation, and psychotic disorders (Ackard & Neumark-Sztainer, 2002; Brent et al., 2002; Collin-Vézina et al., 2013; Cutajar et al., 2010; Daruy-Filho, Brietzke, Lafer, & Grassi-Oliveira, 2011; Maniglio, 2009; McLaughlin et al., 2012; Ng, Yong, Ho, Lim, & Yeo, 2018; Wonderlich et al., 2000). Sexual abuse is also clearly associated with sleep disturbances which can persist for a number of years following CSA, likely in part because the bedroom and nighttime become associated with abuse experiences (Charuvastra & Cloitre, 2009; Noll, Trickett, Susman, & Putnam, 2006). Psychiatric comorbidity is common among survivors of CSA, with many children and adolescents developing multiple psychiatric disorders or alternatively, presenting with symptoms consistent with a diagnosis of complex PTSD (Cloitre, Garvert, Brewin, Bryant, & Maercker, 2013). Thus, sexual abuse should be considered a general risk factor for multiple forms of psychopathology and negative outcomes, as opposed to being associated with risk for specific forms of psychopathology.

It also should be noted that many children brought to sexual abuse specific services because the sexual abuse has been recently reported or discovered do not exhibit significant levels of trauma-related behavioral and physical health problems, with an estimated one-third of children demonstrating no symptoms at the time of abuse disclosure (Collin-Vézina et al., 2013). Initially asymptomatic children likely represent

a diverse group. Their lack of evident acute symptomology may be due to multiple factors including earlier identification of the abuse and consistent family and social support, but may also reflect a reliance by the child on avoidant coping strategies which could mask or delay symptom expression, and incomplete or inaccurate clinical assessments of symptomology among some practitioners (Collin-Vézina et al., 2013).

Adult survivors of CSA. Experiencing sexual abuse in childhood can lead to mental and physical health effects that extend into adulthood. These prolonged effects can encompass a diffuse swath of disruptions in emotion regulation, personality structure, behavior, and interpersonal functioning (Manigilio, 2009). Overall, research supports a relationship between having a history of CSA and increased risk for emotional and behavioral dysregulation including depression, anxiety, dissociation, PTSD, and sexual dysfunction symptoms, as well as hostility and anger. Additionally, adult CSA survivors are more likely to engage in a number of health risk behaviors, including substance misuse and dependence, cigarette smoking, and a host of high risk sexual behaviors. Further, CSA survivors are at increased risk for experiencing sexual re-victimization and intimate partner violence, as well as are more likely to perpetrate violent behavior. Finally, CSA survivors are vulnerable to low self-worth and a number of interpersonal difficulties, including difficulties with trust, sensitivity to perceived interpersonal threat, as well as maladaptive personality styles (Maniglio, 2009). As far as the association of CSA with mental health problems, longitudinal research supports that exposure to CSA is associated with increased risk for depression (OR: 1.8-2.6), anxiety (OR: 1.4-3.9), and PTSD (OR: 2.3-10.2; Chen et al., 2010; Cogle, Timpano, Sachs-Ericsson, Keough, & Riccardi, 2010; Molnar, Buka, & Kessler, 2001). Further, CSA survivors are over four times more likely to attempt suicide (Chen et al., 2010; Kaukinen & DeMaris, 2005; McCarthy-Jones & McCarthy-Jones, 2014; Tomasula, Anderson, Littleton, & Riley-Tillman, 2012; Wadsworth & Records, 2013). In U.S. samples, CSA survivors are 1.5 to 4 times more likely to have alcohol dependence and 2 to 5 times more likely to be dependent on another drug (McCarthy-Jones & McCarthy-Jones, 2014; Molnar et al., 2001). The documented long term physical health effects of childhood sexual abuse include increased risk for reproductive health issues, general somatic symptoms, functional gastrointestinal disorders, chronic pelvic pain, cardiopulmonary problems, headaches, and obesity (Hemmingsson, Jahansson, & Reynisdottir, 2014; Irish, Kobuyashi, & Delahanty, 2010; Maniglio, 2009; McCarthy-Jones & McCarthy-Jones, 2014).

It is important to note that drawing definitive conclusions regarding the long-term impacts of CSA is very challenging, due to the need for prospective, longitudinal research with representative samples. This complexity is deepened by the fact that child sexual abuse is often embedded within dysfunctional family (Higgins & McCabe, 2003) and community environments (Liebschutz et al., 2018) and co-occurs with other forms of abuse or neglect (Dong et al., 2004). Further, many CSA survivors experience additional sexual and interpersonal violence in adulthood.

Adult survivors of sexual assault

Experiencing various forms of sexual assault, including attempted and completed rape, is uniquely pathogenic and is associated with greater risk for negative impact on mental health when compared with many other potentially traumatic events (Dworkin, Menon, Bystrynski, & Allen, 2017). A recent meta-analysis affirmed that the mental health impact of sexual assault is both broad and targeted (Dworkin et al., 2017). Generally, this meta-analytic review found that sexual assault increased risk for most domains of psychopathology, including trauma and stressor-related disorders, anxiety, depression, bipolar conditions, disordered eating, suicidality, substance use/dependence and obsessive compulsive conditions (Dworkin et al., 2017). Further, this meta-analysis supported that both PTSD and suicidality were the negative mental health outcomes most strongly associated with sexual assault. However, the mental and physical health impact of different forms of sexual assault and at different points in the lifespan are somewhat unique, supporting a need to discuss them separately. Further, it should be noted that multiple individual, assault-related and contextual/cultural factors are related to adjustment outcomes following sexual assault (Campbell, Dworkin & Cabral, 2009; Neville & Heppner, 1999).

The majority of research on the mental health consequences of sexual assault has focused on the impact of completed rape. This research overwhelmingly supports that rape is strongly associated with increased risk for the development of PTSD, with nearly half of men and women who experience rape meeting diagnostic criteria for PTSD at some point post-assault (Kessler et al., 1999). In addition to the elevated conditional risk for PTSD, rape is associated with more severe PTSD symptom profiles as compared to other forms of trauma (Kelley, Weathers, McDevitt-Murphy, Eakin, & Flood, 2009), as well as a chronic trajectory of symptomology, particularly when symptoms persist beyond three months post-assault (Darves-Bornoz et al., 1998; Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992). Many individuals also experience comorbid mental health conditions following rape, with the most frequent comorbid mental health condition being depression (Ullman & Brecklin, 2003; WHO, 2013; Zinzow et al., 2012). Growing evidence also supports a clear link between experiencing rape and risk for suicide (Chang et al., 2015; Cogle, Resnick, & Kilpatrick, 2009; Ullman & Brecklin, 2003). Finally, rape has been associated with elevated risk for the development of anxiety disorders, including agoraphobia and social anxiety disorder (Boudreaux, Kilpatrick, Resnick, Best, & Saunders, 1998; WHO, 2013).

The link between having a rape history and risk for substance use disorders (SUDs) is also clearly established, and likely reflects bidirectional influences. Specifically, SUDs are associated with increased risk of rape victimization, particularly substance-facilitated and incapacitated assaults (the high risk hypothesis; McCauley, Ruggiero, Resnick, Conoscenti, & Kilpatrick, 2009; Testa & Parks, 1996; Zinzow et al., 2012). Additionally, rape survivors may develop SUDs as a result of using substances to cope with assault-related, and general negative affect (the self-medication hypothesis; Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997; Read, Colder, Merrill, Ouimette,

White, & Swartout, 2012; Rhew, Stappenbeck, Bedard-Gilligan, Hughes, & Kaysen, 2017). However, it is important to note that the association of rape history with SUDs is likely to vary substantially cross culturally, likely in part related to differences in the availability of substances as well as cultural taboos and religious prohibitions regarding substance use that exist more broadly within a culture or for certain groups (e.g., prohibitions against women using alcohol and other substances).

In addition to mental health outcomes, sexual assault, including rape, is also associated with a plethora of negative physical health outcomes. Experiencing rape is clearly linked to a number of negative reproductive health outcomes among women, including sexually transmitted infections, dyspareunia, endometriosis, menstrual irregularities and chronic pelvic pain (Weaver, 2009). In settings with high HIV prevalence, rape survivors are also at elevated risk of HIV infection (Abrahams et al., 2017; Shannon et al., 2012). Rape survivors also experience elevated rates of general somatic complaints (Jozkowski & Sanders, 2012), headaches (Golding, 1999) and gastrointestinal distress and disorders (Creed et al., 2005).

Survivors of sexual harassment in workplace and educational settings

The psychological impact of sexual harassment experienced in workplace and educational settings on survivors is multidimensional (Barling, Rogers, & Kelloway, 2001; Chan, Chow, Lam, & Cheung, 2008; Fitzgerald, Drasgow, Hulin, Gelfand, & Magley, 1997; Gutek & Koss, 1993; Lapierre, Spector, & Leck, 2005; Munson, Hulin, & Drasgow, 2000; Pryor, 1995; Ragins & Scandura, 1995; Richman et al., 1999; Schneider, Swan, & Fitzgerald, 1997; Thacker & Gohman, 1996; Timmerman & Bajema, 1999; Willness, Steel, & Lee, 2007). Although sexual harassment can happen to people of all genders, the majority of the literature has focused on the experiences of harassed cisgender women. However, it should be noted that a meta-analytic review found no statistically significant differences in the impact of sexually harassing experiences on the well-being of men and women (Chan et al., 2008); and thus it is presumed that the consequences of sexual harassment identified likely apply to individuals of all genders.

Sexual harassment experiences have been extensively documented as having an overall negative and lasting impact on the occupational and psychological well-being of victims (Chan et al., 2008; Fitzgerald et al., 1997; Magley, Hulin, Fitzgerald & DeNardo, 1999; Munson et al., 2000; Pryor, 1995; Wasti, Bergman, Glomb, & Drasgow, 2000; Willness et al., 2007). In general, more than half of harassment survivors describe that they experienced negative consequences for their personal well-being as a direct result of sexual harassment (European Commission, 1998). Harassment survivors frequently report experiencing multiple forms of negative affect, including anger, anxiety, fear, sadness, and depression, as well as report difficulties with trust and engaging in problematic self-medicating behaviors, including substance use and smoking (Crocker & Kalemba, 1999; Loy & Stewart, 1984; Pryor, 1995; Richman et al., 1999). Experiencing harassment is also associated with elevated stress-

related psychosomatic symptoms, including headaches, muscle pains, nausea and gastrointestinal disorders, respiratory problems, weight changes, fatigue, heart palpitations, and insomnia (Barling et al., 2001; Chan et al., 2008; European Commission, 1998; Gutek & Koss, 1993; Magley et al., 1999; Willness et al., 2007). The negative effects of sexual harassment also appear to have a lasting impact on survivors' life satisfaction and usually persist over time (Munson et al., 2000; Pryor, 1995; Willness et al., 2007).

The psychological impact of sexual harassment is related to the type of harassment experienced. Hostile environment and gender-based harassment have been characterized as chronic stressors due to their often-undecipherable onset and protracted duration (Lim, Cortina, & Magley, 2008). Some of the behaviors constituting these types of harassment (e.g., offensive comments or insults) may be singularly minor but cumulatively stressful (Schneider et al., 1997). Additionally, severe forms of sexual harassment (such as quid-pro-quo harassment where an individual in authority either demands sexual favors or implies that such favors are required to avoid negative, or receive positive, educational or occupational outcomes) can involve actual bodily and sexual threat and injury. Thus, some survivors of sexual harassment experience one or more traumas as defined in the DSM-5, whereas other survivors' experiences involve highly distressing and upsetting events, but do not include traumas. Given this variability in the types of events that encompass sexual harassment, it is not surprising that a meta-analytic review supported that experiencing more severe sexual harassment was associated with greater PTSD symptomology (Willness et al., 2007). Similarly, a study of U.S. military personnel found that experiencing more frequent physical sexual harassment in the military (e.g. unwanted sexual touching, fondling, cornering) was associated with more severe PTSD symptomology (Wolfe et al., 1998). However, research has also found that survivors of hostile environment harassment may report PTSD symptomology as a result of these experiences, even if they do not involve traumas as defined in the DSM-5 (Avina & O'Donohue, 2002; Barling et al., 2001; Gutek & Koss, 1993; Willness et al., 2007). Thus, overall both subjective appraisal of the harassment experience, as well as objective differences in the type of harassment experienced likely affect psychological outcomes (Avina & O'Donohue, 2002; Pina & Gannon, 2012).

Treatment for Trauma-related Distress among Survivors of Sexual Assault, Abuse, and Harassment

Child survivors of sexual abuse

Treatment for children and adolescents who have experienced CSA addresses the specific impacts exhibited by the survivor. Posttraumatic stress symptoms, depression and anxiety are the most common trauma-specific impacts that have been addressed in extant treatments, with PTSD symptomology being the most frequently targeted symptomology. However, it is apparent that even if children do not meet full diagnostic criteria for PTSD, clinically significant levels of trauma-specific distress warrants intervention. Cognitive-behavioral therapy (CBT) based trauma-specific treatments have the strongest evidence for effectively reducing PTSD symptoms, depression and anxiety (Leenarts et al., 2013). The most extensively studied of these is trauma-focused cognitive behavioral therapy (TF-CBT), which has been tested in eight randomized controlled psychotherapy trials for children who experienced sexual abuse, and has been found to reduce PTSD symptoms, as well as depression, anxiety, and behavior problems (Cohen, Mannarino, & Deblinger, 2017). TF-CBT treatment utilizes both individual child sessions as well as conjoint therapy sessions with caregivers, and includes a focus on anxiety management/coping skill development, as well as construction and processing of trauma narrative(s). Supporting the potential transportability of this treatment to novel cultural contexts, a study of sexually abused children in Zambia supported the efficacy of an adapted version of TF-CBT in reducing symptoms of PTSD (Murray et al., 2013). The efficacy of the adapted TF-CBT was also supported in a second RCT among children in Zambia who had experienced multiple forms of interpersonal violence and abuse (Murray et al., 2015). An adolescent-specific adaption of prolonged exposure therapy (PE) has also been shown to be effective for adolescents with sexual assault-related PTSD (Foa, McLean, Capaldi, & Rosenfeld, 2013). PE utilizes imaginal exposure to trauma memories as well as in vivo exposure to cues which are avoided due to their association with a trauma to promote emotional processing of trauma-related memories and reduce avoidance of both trauma memories and objectively safe situations associated with the trauma. Finally, while not specifically evaluated among survivors of sexual abuse, a version of narrative exposure therapy adapted for children (KIDNET) has been shown to be efficacious in reducing symptoms of PTSD among refugee children and children living in conflict settings across multiple cultural contexts (Mørkved et al., 2014; Robjant & Fazel, 2010). Narrative exposure therapy (NET) was developed specifically to be delivered by lay clinicians in refugee and conflict settings and involves construction of a consistent autobiographical narrative in which traumatic events are processed and appropriately contextualized within autobiographic memory (Robjant & Fazel, 2010).

Experiences of childhood adversity frequently overlap, and cumulative experiences of trauma in childhood strongly predict symptom complexity across the lifespan (Cloitre et al., 2009). There is ongoing debate about how best to treat the complex

clinical presentations in children and adolescents who experience sexual trauma, particularly when coupled with other forms of victimization and adversities embedded in ongoing highly compromised family and community environments. Several phase-based models have been developed specifically to address so-labeled complex PTSD symptomology, including severe and pervasive difficulties in affect regulation and in sustaining relationships (Sachser, Keller, & Goldbeck, 2017). Although none of these interventions have been evaluated specifically for youth who have experienced sexual abuse, a number have promising evidence for populations characterized by multiple childhood exposures including sexual trauma (Lawson & Quinn, 2013). These interventions typically integrate a focus on trauma-specific symptoms with additional emphases on development of the broader developmental capacities associated with complex PTSD, such as emotion identification and regulation, as well as a focus on building safe attachments to caregivers (Lawson & Quinn, 2013).

Despite the widespread use of medication for children and adolescents who experience sexual abuse, particularly in child welfare and juvenile justice populations, there is currently no evidence from placebo-controlled randomized controlled treatment trials that would support the efficacy of using pharmacotherapy for treating PTSD, or for supplementing trauma-focused psychotherapies with pharmacotherapy (Wilkinson & Carrion, 2012). Therefore, trauma-focused psychotherapy should be used in preference to pharmacotherapy unless there is a comorbid disorder for which pharmacotherapy is clearly indicated.

Adult survivors of sexual assault and childhood sexual abuse

It is important to make treatments available to survivors that are able to address the range of symptoms they may experience. Psychotherapy can reduce symptoms of both PTSD and related conditions in adult survivors of childhood sexual abuse and various forms of sexual assault (Regehr, Alaggia, Dennis, Pitts, & Saini, 2013; Taylor & Harvey, 2009; Vickerman & Margolin, 2009). Several evidence-based psychotherapies are effective in treating symptoms related to sexual victimization experiences with the majority of extant treatments focused on addressing PTSD symptomology. Specifically, trauma-focused CBT-based therapies, like prolonged exposure (PE) and cognitive processing therapy (CPT), have been associated with reductions in PTSD, depression, guilt, anxiety, and dissociation in survivors of adult sexual assault, and these benefits are maintained even 5 to 10 years after the end of treatment (Foa, Rothbaum, Riggs, & Murdock, 1991; Resick, Nishith, Weaver, Astin, & Feuer, 2002; Resick, Williams, Suvak, Monson, & Gradus, 2012). CPT, which focuses primarily on use of various cognitive strategies to assist individuals in altering maladaptive trauma-related thoughts and beliefs, has also been specifically adapted for survivors of childhood sexual abuse, and was found to reduce PTSD, depression, and dissociation symptoms (Chard, 2005). CBT-based treatments generally outperform supportive psychotherapies in clinical trials (Foa et al., 1991; Resick, Jordan, Girelli, Hutter, & Marhoefer-Dvorak, 1988). Other therapies may also be effective for adult survivors of sexual assault. For example, eye

movement desensitization and reprocessing (EMDR), which utilizes external stimuli (e.g., lateral eye movements) to facilitate trauma processing during imaginal exposure, was found to reduce PTSD, depression, anxiety, and dissociation in adult sexual assault survivors (Rothbaum, Astin, & Marsteller, 2005; Rothbaum, 1997). Although present-focused therapy (a non-trauma focused treatment that focuses on psychoeducation about PTSD and teaching of problem solving skills to address current problems), can reduce PTSD symptoms in survivors of adult sexual assault and childhood sexual abuse, trauma-focused CBT appears to be more effective in reducing symptoms of PTSD and anger (Classen et al., 2011; McDonagh et al., 2005). Lastly, some therapies have had success in treating specific symptoms common in sexual assault survivors. For example, imagery rehearsal therapy, which seeks to reduce distressing nightmares by engaging in repeated rehearsal of an alternate, non-distressing nightmare narrative, appears to reduce nightmares and improve sleep (Krakow et al., 2001).

Supporting the potential transportability of CPT to novel cultural contexts, an adapted version of CPT was found effective in reducing symptoms of PTSD, anxiety, and depression, as well as in improving overall daily functioning among survivors of sexual assault in the Democratic Republic of Congo (Bass et al., 2013). Additionally, while not examined specifically for its efficacy in treating sexual assault-related symptomology, narrative exposure therapy (NET) has been found to be efficacious in reducing symptoms of PTSD and depression in multiple studies involving refugees and individuals living in conflict areas who report exposure to multiple traumatic events (Gwozdziwycz & Mehl-Madrone, 2013; Mørkved et al., 2014; Robjant & Fazel, 2010). However, overall it should be noted that research examining the efficacy of psychosocial and psychotherapeutic interventions for sexual assault survivors outside of the U.S. is extremely limited (e.g., Tol et al., 2013).

Pharmacotherapy is also commonly used to treat traumatic stress; at present, there is limited evidence for the efficacy of pharmacotherapy for PTSD symptomology. In head-to-head studies, psychotherapy outperforms medication as a standalone treatment for PTSD (Lee et al., 2016). Among pharmacotherapy options, extant research most strongly supports the use of sertraline, venlafaxine, and fluoxetine as treatments for PTSD symptomology, although concerns about bias (findings primarily from industry sponsored trials) and diminished response to medication over time remain (Brady et al., 2000; Davidson et al., 2006; Hoskins et al., 2015; Lee et al. 2016). Overall, placebo-controlled studies support improvements in PTSD symptomology with pharmacotherapy treatment as compared to placebo, with PTSD remission rates ranging from 30 to 40% in the majority of trials, and never exceeding 60% (Brady et al., 2000; Davidson et al., 2006; Hoskins et al., 2015; Ipser & Stein, 2012; Kelmendi et al., 2016). Less research has evaluated the benefit of pharmacotherapy in combination with psychotherapy for PTSD or has focused on the efficacy of pharmacotherapy for survivors of sexual assault. An open trial of sertraline as a standalone treatment for adult survivors of sexual assault with chronic PTSD found reductions in PTSD symptoms, but the absence of a control group and small sample size were limitations

(Rothbaum, Ninan, & Thomas, 1996). A trial testing paroxetine in adults who remained symptomatic despite treatment with PE, most of whom had an index trauma of physical or sexual abuse, failed to find treatment effects (Simon et al., 2008). There is at least one trial supporting the use of paroxetine, a selective serotonin reuptake inhibitor (SSRI), for depression among women with comorbid depression and PTSD; however, this study found that individuals with comorbid depression and PTSD demonstrated more severe symptomology following treatment than individuals with depression alone (Green et al., 2006). Further, there is some mixed evidence that individuals with comorbid depression and PTSD were less likely to experience reductions in PTSD symptomology following treatment with an SSRI than those with PTSD alone (Bernardy & Friedman, 2015).

Survivors of sexual harassment in workplace and educational settings

There is an overall absence of empirical evaluation of treatments for survivors of sexual harassment in workplace and educational settings. A handful of extant treatment trials have been conducted among survivors of severe forms of sexual harassment that included sexual assault as part of the harassment experience. For example, one randomized clinical trial examined the efficacy of CPT and present centered therapy among United States military members who experienced sexual harassment which included attempted or completed rape. Results supported the efficacy of both treatments at reducing sexual trauma-related PTSD symptoms and depressive symptoms, with some evidence for the superiority of CPT at reducing PTSD symptoms, as well as reducing negative trauma-related cognitions (Holliday, Link-Malcolm, Morris, & Surís, 2014; Surís, Link-Malcolm, Chard, Ahn, & North, 2013). Additionally, one study examined the efficacy of Warrior Renew, a cognitive-experiential trauma-focused treatment, for female military veterans in the U.S. who experienced at least one sexual trauma during their service, some of which occurred within the context of sexual harassment in the military. Results of this study supported the efficacy of the treatment at reducing PTSD symptoms and negative trauma-related cognitions, both at post-treatment and a 12 month follow-up, although findings are limited by the pre- post-treatment study design and reliance on self-reported symptom change (Katz, 2016; Katz et al., 2015). Additionally, the exact nature of the military sexual trauma/harassment experienced by participants is not described.

Treatment barriers for survivors of sexual assault, abuse, and harassment

Adult survivors of sexual assault and childhood sexual abuse

Given the prevalence of mental health needs in adults who have experienced various forms of sexual assault, it is important to facilitate access to appropriate treatment. However, the majority of sexual assault survivors rely solely on informal sources of support (McCart, Smith, & Sawyer, 2010; Ullman, 2007). Adult survivors of child sexual abuse and adult sexual assault face a number of substantial barriers to receiving care, including criminal justice and reporting concerns, experiences of stigma and negative reactions to disclosure, limited or no access to appropriate care, and issues related to belonging to disadvantaged or marginalized groups.

First, survivors may not disclose their assaults to health care providers and other formal sources of support because they are concerned that the incident will be reported to police or other legal authorities, or that they will be compelled to make a formal report. Survivors have endorsed multiple concerns regarding reporting to police, including fear of reprisal from the perpetrator, financial and psychological strain of court involvement, shame or embarrassment, fear of being blamed or not believed, and concerns regarding negative impacts of reporting on the perpetrator, family, friends, and/or the community (Cohn, Zinzow, Resnick, & Kilpatrick, 2013; Jones, Alexander, Wynn, Rossman, & Dunnuck, 2009; Sable, Danis, Mauzy, & Gallagher, 2006; Zinzow & Thompson, 2011). Survivors may also have prior negative experiences with the legal, medical, or mental health systems, making them hesitant to seek further treatment and formal support (Campbell, 2008). Indeed, survivors frequently describe experiences with formal systems when seeking help as dehumanizing, frustrating, embarrassing, and distressing (Campbell, 2008; Konradi, 2007). Therefore, it is not surprising that many sexual assault and child sexual abuse survivors indicate fear of being disbelieved, mistrust that formal support systems can help them, and concerns about being further harmed as barriers to service use (Logan, Evans, Stevenson, & Jordan, 2005; Patterson, Greeson, & Campbell, 2009).

Similarly, sexual assault and abuse survivors may have experienced negative reactions when disclosing their experience to informal support sources, which could hinder attempts to seek further formal support. These reactions can include blaming the survivor, disbelief or minimizing responses, stigmatizing responses, and controlling behaviors (Ullman, 2000). Experiencing these negative reactions to disclosure is associated with increased mental health symptoms, self-blame, and poor self-esteem (Littleton, 2010; Orchowski, Untied, & Gidycz, 2013; Ullman, 1996). Experiencing self-blame, in particular, is associated with reduced likelihood of formal help-seeking (Beaulaurier, Seff, Newman, & Dunlop, 2005; Starzynski, Ullman, Filipas, & Townsend, 2005). Furthermore, lack of social support for help-seeking has been associated with lower rates of service utilization in sexual assault victims (Norris, Kaniasty, & Scheer, 1990; Ullman & Brecklin, 2002).

The nature of sexual assault and abuse engenders high levels of stigma among survivors, with many reporting shame and embarrassment as barriers to service use (Guerrete & Caron, 2007; Nasta et al., 2005; Walsh, Banyard, Moynihan, Ward, & Cohn, 2010). Other related barriers include confidentiality concerns, fear, and feeling that sexual experiences are private matters (Guerrete & Caron, 2007; Nasta et al., 2005; Walsh et al., 2010). Some sexual assault and abuse survivors also indicate that they feel unworthy of services (Logan et al., 2005; Patterson et al., 2009). Barriers related to stigma and shame may be even more pronounced for male survivors, who are less likely than women to disclose or seek services (Allen, Ridgeway, & Swan, 2015; Sable et al., 2006; Walsh et al., 2010). Similarly, individuals who are sexually assaulted or abused by authority figures and/or have low power status in society (e.g., women in patriarchal societies, members of marginalized groups), may experience high levels of stigma and shame, as well as concerns about not being believed (Smith et al., 2010). Another related factor that serves as a barrier to disclosing the assault to formal support sources involves lack of acknowledgment of the incident(s) as sexual assault or abuse. Lack of acknowledgment has been associated with lower likelihood of disclosing and seeking services (Littleton, Breitung, & Berenson, 2008; Patterson et al., 2009; Zinzow & Thompson, 2011). Acknowledgment of the incident as a type of sexual assault or abuse may be particularly difficult in contexts in which cultural norms consider certain forms of sexual assault and abuse as normative, acceptable, or consistent with gender roles (Jewkes & Abrahams, 2002; Smith et al., 2010). Stigma and shame may serve as prominent barriers to acknowledgment and service-seeking in these contexts as well (Krug, Mercy, Dahlberg, & Zwi, 2002; Smith et al., 2010). This may be particularly the case if survivors are likely to be shunned or rejected by their families and spouses or viewed as not suitable for marriage as a result of experiencing sexual assault or abuse (Kohli et al., 2012; Smith et al., 2010).

Limited awareness of and lack of access to care also serve as significant barriers to mental health service use. Studies have repeatedly shown that even individuals who reside where sexual assault services, such as rape crisis centers, are available report a lack of awareness of these resources or believe that these resources are not appropriate for them (Banyard, Ward, Cohn, & Plante, 2007; Hayes-Smith & Levett, 2010; Walsh et al., 2010; Weist et al., 2014). Survivors also frequently report issues related to lack of affordability of care (Logan et al., 2005). Indeed, in one study, survivors without medical insurance were far less likely to seek mental health services than those who were insured (Ullman & Brecklin, 2002). The problem of limited access to resources may be substantially magnified in countries that have a dearth of mental health service providers and few dedicated resources for sexual assault survivors (Kohli et al., 2012; Smith et al., 2010; Sumner et al., 2015; World Health Organization, 2014).

Finally, it is critical to note that many survivors belong to marginalized groups and may face ongoing issues related to poverty, socioeconomic disadvantage, and ongoing personal and community violence, all of which can interfere with formal treatment-seeking. For one, individuals from marginalized groups may have a wealth of both direct and indirect prior experiences that suggest that they cannot trust formal service

providers or law enforcement (Washington, 2001; Willis, 2011). Further, there may be a lack of providers from marginalized cultural groups available to provide services, and formal support providers may lack knowledge regarding the cultural values and practices of individuals who belong to marginalized groups, and indeed may hold negative stereotyped beliefs about members of these groups (Washington, 2001; Willis, 2011). Members of immigrant and indigenous groups and refugees may also face issues related to language barriers and, for immigrants and refugees, fears of deportation (Lee & Hadeed, 2009; Rodriguez, Valentine, Son, & Muhammad, 2009). Among indigenous groups, and other closely knit and isolated cultural groups, there may also be concerns related to experiencing violence in retribution for reporting sexual assault or abuse, or that reporting the assault or abuse might initiate violence between the family of the survivor and the family of the perpetrator (Willis, 2011). Overall, sexual assault and abuse survivors may experience multiple mental health concerns, substance use issues, as well as multiple experiences of sexual and other forms of violence over their lifetime, all of which may interfere with their ability to access care (Zweig, Schlicter, & Burt, 2002). Survivors who are engaging in sex work or who are homeless may be particularly likely to have multiple lifetime experiences of sexual assault and abuse, as well as be deeply distrustful of formal support services (Zweig et al., 2002). Finally, many survivors have little formal education, live in poverty, and/or live in environments of socioeconomic deprivation, severely limiting resource knowledge, availability, and accessibility (Smith et al., 2010; Zweig et al., 2002).

Barriers faced by child survivors of CSA

In addition to the barriers delineated above regarding adult survivors, youth face additional barriers to receiving trauma-focused treatment. For one, many children who experience sexual abuse either substantially delay or never disclose the abuse (Fontes & Plummer, 2010). The most frequent barriers to disclosure are concerns that the individual to whom they disclose will either not believe their account or will be non-supportive (Hershkowitz, Lanes, & Lamb, 2007; Lemaigre, Taylor, & Gittoes, 2017). Further, many children fear being punished, shamed, losing family support, or experiencing other negative consequences if they disclose (Lemaigre et al., 2017). In cases where the child has a loving or dependent relationship with the perpetrator, he or she may also be concerned that the perpetrator will face social or legal sanctions for his or her actions (Lemaigre et al., 2017).

Additionally, children very frequently experience self-blame and shame for the abuse, both of which substantially inhibit disclosure (Lemaigre et al., 2017). Feelings of shame may be particularly pervasive among children from cultures with strong cultural or religious taboos regarding sex, or among children and adolescents where the perpetrator coerced them to engage in culturally/religiously unacceptable behavior (e.g., using substances, drinking alcohol, watching or participating in pornography; Fontes & Plummer, 2010). Relatedly, those from cultures where girls and young women are viewed as responsible for preserving their virginity and dressing and behaving

modestly to prevent men from being sexually aroused may experience strong feelings of self-blame and fear blame from others. Conversely, as these cultures typically regard men as highly sexually motivated and unable to control their sexual arousal and urges, boys in these cultures may reframe sexual abuse from women as consensual sexual experiences and conceal sexual abuse from men due to fears of being labeled homosexual (Fontes & Plummer, 2010). Additionally, broader cultural taboos against speaking about sex or sexual behavior serve to substantially inhibit disclosure (Fontes & Plummer, 2010; Haboush & Alyan, 2013). As a result of all of these barriers, when children do disclose their abuse experiences, they may do so in an indirect manner that could be missed or dismissed by the disclosure recipient, such as expressing reluctance to be around the perpetrator, running away from home, or displaying negative affect to their caregivers after abuse episodes (Alaggia, 2004).

If a caregiver becomes aware that sexual abuse has occurred, he or she may not report the abuse to authorities or seek services for the abused child, with extant data supporting that the vast majority of caregivers do not report (Matthews & Bross, 2008). Concerns about losing custody of the child, concerns regarding the implications of the disclosure with regards to the perpetrator, and beliefs that such matters should be resolved within the family or community may be among the primary reasons for not reporting abuse (Haboush & Alyan, 2013). Certain cultural beliefs and practices may also inhibit abuse reporting and help seeking. These can include concerns regarding the impact of discovery of the abuse on the youth's value and marriageability for abused girls, as well as broader concerns regarding familial shame related to discovery of the abuse, particularly if the perpetrator is a family member (Fontes & Plummer, 2010). Seeking help and acknowledging mental health problems may also be regarded as signs of weakness and a source of shame for the family (Futa, Hsu, & Hansen, 2001). As a result, instead of seeking formal mental health treatment or notifying the legal system, families may turn to local religious practices or rituals for managing the abuse (e.g., engaging in an exorcism or ritual to cast out demons presumed to inhabit the abused child, urging the child to seek forgiveness or salvation for the abuse, urging the child to accept the abuse as his or her fate or view it as Karmic retribution for past transgressions; Fontes & Plummer, 2010). Alternatively, the family patriarch may be tasked with seeking retribution against the family of the abuser (Fontes & Plummer, 2010; Haboush & Alyan, 2013). Overall, caregivers may strongly prefer to resolve the abuse issue within the family and community without involving external systems.

Given that the majority of caregivers do not seek formal help or report abuse, it generally falls on members of other systems, such as educators and health care providers, to report suspected or disclosed child sexual abuse (Matthews & Bross, 2008). Indeed, in countries in which such individuals are designated as "mandatory reporters" of childhood sexual abuse, reports from members of these systems make up the vast majority of sexual abuse cases reported to formal authorities (Matthews & Bross, 2008). Conversely, reporting rates are much lower in countries without mandatory reporting laws (Matthews & Bross, 2008; Mathews, Lee, & Norman, 2016).

However, even when mandatory reporting laws exist, individuals may be reluctant to report child sexual abuse for a variety of reasons including lack of training in responding to sexual abuse, inaccurate knowledge about sexual abuse and its impact, indecision regarding whether they have sufficient evidence to suspect abuse, and confusion regarding who should make a report (e.g., administrators/supervisors/principals versus teachers/medical staff; Eisbach & Driessnak, 2010; Lynne, Gifford, Evans, & Rosch, 2015; Márquez-Flores, Márquez-Hernández, & Granados-Gámez, 2016; Talsma, Boström, & Östberg, 2015). Additionally, in certain communities, individuals who make these reports may face a risk of violent reprisal from the perpetrator or others who wield power in the community (Bhana, 2015).

Even if children and their caregivers report the abuse or the abuse is discovered/ reported by others, families may be reluctant to pursue a trauma-specific treatment. In addition, among children and adolescents who have externalizing problems, parents and caregivers may be particularly reluctant to engage in trauma-focused treatment (McKay & Bannon, 2004). Engagement in trauma-focused treatments is further complicated by the context in which much CSA occurs, with many of the core predictors of disengagement and attrition from treatment, such as family stress, lack of access to resources, and the caregiver's own mental health needs, highly prevalent among families in which CSA occurs (Ingoldsby, 2010; Wamser-Nanney & Steinzor, 2017).

Barriers faced by survivors of sexual harassment in workplace and educational settings

There is a lack of research examining barriers to treatment seeking among survivors of sexual harassment. However, research has evaluated barriers to sexual harassment reporting within the workplace, which could represent an important step in receiving mental health treatment. Specifically, this work has examined reporting rates and barriers related to internal reporting, that is making a report of sexual harassment to a person or office within the organization in which the harassment occurred. This work supports that reporting sexual harassment is relatively rare and is the least frequently chosen response to harassment (Bergman et al., 2002; Brooks & Perot, 1991; Cortina & Magley, 2003; Culbertson & Rosenfeld, 1994; Firestone & Harris, 2003). There are numerous reasons that survivors do not report, including: (a) fears about job loss, (b) fear of retaliation, (c) concerns about being labeled as being overly sensitive, (d) reluctance to be seen as a victim, and (e) beliefs that nothing will be done (Fielden, Davidson, Woolnough, & Hunt, 2010; Wear, Aultman, & Borges, 2007). Further, organizations which are more tolerant toward sexual harassment are the ones in which sexual harassment is most likely to occur; not surprisingly such organizations are also more likely to respond negatively to sexual harassment reports. Examples of such responses include minimizing the seriousness of the harassment, retaliating against the reporter, and not pursuing appropriate remedial actions (Bergman et al., 2002). Thus, for many survivors, reporting sexual harassment is unlikely to result in an appropriate resolution to the harassment, and may instead lead to further psychological (e.g., distress, mental health symptoms) and economic (e.g., job loss, demotion, transfer) harm.

Recommendations

Policy

Concerted legal and public policy efforts are necessary to address the global issue of sexual assault, abuse, and harassment. Successful efforts that serve to prevent sexual assault, abuse, and harassment and provide care to survivors will have a substantial public health impact. We provide the following policy-level recommendations as essential.

- While substantial legal reforms have occurred in a number of countries regarding various forms of sexual victimization, there is still significant variability internationally in laws regarding sexual assault, abuse, and harassment, and a lack of legal recognition of certain forms of sexual assault, abuse, and harassment in a number of geographic areas. Thus, additional legal reforms are necessary to improve universality of laws and policies addressing sexual victimization; such reforms could be modeled based on previously implemented legal reforms in similar cultural contexts.
- Organizations and educational systems should have universal and clearly delineated anti-harassment policies and initiatives. Such policies should be modeled on those implemented previously in similar cultural contexts when possible. Organizations should also designate trained contacts within the organization who can offer support and guidance to employees who experience harassment. Further, organizations should commit resources to fund independent ombudspersons to investigate and resolve harassment claims.
- Policies are needed to support concerted, long-term, multi-pronged education and prevention programming focused on changing norms and practices regarding sexual assault and harassment. In addition to standalone programming and education, issues related to sexual assault, abuse, and harassment should be embedded into education and prevention efforts targeting other related issues, such as sex discrimination, HIV infection, substance use, human trafficking, intimate partner violence, and child welfare.
- Policies are needed to ensure universal screening for sexual assault, abuse, and harassment in educational and health care settings and evidence-based strategies for mandated reporting by professionals and administrators of allegations of sexual victimization. These policies are essential to increase identification of sexual victimization survivors and provide care to those experiencing trauma and stress-related symptoms. Education and training should be provided to educators and health care providers regarding how to identify and respond to survivors of sexual assault, abuse, and harassment, as well as on mandatory reporting procedures.
- Mechanisms to provide anonymous reports of sexual assault, abuse, and harassment are likely to increase reporting and reduce fears regarding retaliation. Likewise, policies should be enacted and enforced to protect individuals who report instances of sexual victimization from various forms of retaliation. Further, strong protections should be enacted to protect survivors from retaliation, invasion of

their privacy, and further traumatization during any disclosure and investigative processes regarding allegations of sexual assault, abuse, or harassment.

- Policy efforts should focus on increasing access to care for survivors of sexual assault, abuse, and harassment. These include providing training in empirically supported treatments to providers who work with survivors in multiple settings, implementing novel ways to disseminate evidence-based treatments (e.g., treatment via telehealth, treatment by trained lay providers, treatment integrated into culturally based healing practices), reducing barriers to care among survivors (e.g., providing free or low cost transportation, providing affordable treatment in community settings and in institutions, integrating care into health care settings), and increasing the number of trained providers from marginalized groups.
- Various forms of sexual assault, abuse, and harassment are likely to remain prevalent in cultural contexts in which women and girls yield limited legal, social, and economic power. Thus, policy efforts focused on providing educational, legal, and economic empowerment to girls and women should be considered a necessary part of sexual assault and harassment policy reforms.
- Given the ubiquity of sexual assault, abuse, and harassment among a number of marginalized groups, policy efforts specifically targeting sexual victimization among members of these groups is imperative. Such efforts could include legal reforms focused on formally recognizing sexual victimization against these groups, increased sanctions for sexual violence against marginalized individuals (e.g., hate crime laws), increased prosecution of sexual assault incidents involving marginalized individuals, and the development of culturally informed sexual victimization services.

Practice

Given the prevalence of sexual assault, abuse, and harassment worldwide as well as the long-term impact of sexual assault, abuse, and harassment, education and training opportunities should be offered to providers working in multiple settings regarding how to appropriately care for survivors of sexual assault, abuse, and harassment. We provide the following recommendations for providers assisting survivors of sexual assault, abuse, and harassment.

- Given the association of sexual victimization experiences with health risk behaviors and physical health problems in adolescence and adulthood, health care providers should routinely screen for a sexual victimization (both current and past) history in all patients and clients, and be aware of local resources available for evidence-based assessment and treatment of child or adult sexual victimization survivors.
- Given the prevalence of sexual assault, abuse, and harassment, and other forms of violence in many marginalized populations, comprehensive screening for exposure to sexual victimization and other forms of violence should be routinely conducted by all service systems and providers working with these populations.

- Providers working with children in which there is suspected or reported CSA should ensure that a complete mental health assessment is conducted. This assessment should utilize reliable and valid instruments to evaluate trauma impact, as well as assess for other experiences of violence. Further, when feasible, information should be obtained from multiple sources including the child, parents and other caregivers, as well as other relevant sources (e.g., teachers, health care providers, case workers). Such assessment is necessary to ensure that the impacts of the CSA and other trauma experiences are identified and appropriate care is initiated.
- Trauma-focused, cognitive-behaviorally based treatments should be provided as first-line treatments for child and adult survivors who are experiencing trauma-related symptoms.
- Psychopharmacologic treatment should only be used when there is a clearly established indication and should not be utilized as a first-line treatment for child or adult survivors of sexual assault experiencing trauma symptoms.
- Providers working with survivors of sexual harassment should be aware that sexual harassment can lead to the development of mental and physical health symptoms, and as such, should offer evidence-based treatment for survivors reporting mental health symptoms, including trauma-focused treatments as appropriate.
- Providers should be cognizant of the fact that many sexual victimization survivors have multiple mental and physical health concerns as well as lack key resources (e.g., stable housing and employment, a violence free home and community environment), and as such should assist survivors in obtaining the multidisciplinary services necessary to address their needs.
- Providers working with sexual assault and harassment survivors from all backgrounds, and particularly those from marginalized groups, should be mindful to provide culturally informed treatment and should seek out opportunities to further their understanding of the experiences, norms, and preferences of the patients and clients to whom they provide services.

Research

While substantial advances have been made in research on sexual victimization, there are a number of significant gaps that represent priority areas for future work. We recommend the following as key priority areas for sexual assault, abuse, and harassment research.

- While the prevalence of multiple forms of sexual victimization is well-documented in certain geographic areas, we still have only limited knowledge of the prevalence of different forms of sexual victimization in a number of areas of the world, including in parts of Africa, Asia, and Central and South America. Similarly, we lack information about the impact of sexual victimization experiences among individuals residing in these geographic areas and how trauma-related distress may manifest similarly or differently in varied cultural contexts and among groups of individuals, including refugee, migrant, aboriginal, Native, and other minority groups.
- Research is needed that focuses on developing efficacious sexual assault, abuse, and harassment prevention programs.
- Research is needed to evaluate the impact of legal reforms and public policy initiatives on the prevalence of different forms of sexual victimization, as well as help seeking among survivors. Prevention efforts which are culturally informed, sustained, multi-pronged, and involve multiple community stakeholders are most likely to be efficacious.
- Research is needed that focuses on adapting empirically supported trauma treatments for sexual assault, abuse, and harassment to be effectively delivered in novel cultural contexts, as the vast majority of extant treatment research has been conducted among survivors in the United States. Such research should utilize multidisciplinary teams including embedded researchers and community leaders to determine how best to adapt these interventions to be responsive to survivor needs, cultural values and beliefs, and available community resources.
- Even survivors who have access to sexual victimization resources rarely utilize them, supporting a need for research focused on how to reduce barriers to treatment seeking and increase participation in services among adult survivors and the families of CSA survivors. Such work could be focused both on understanding and increasing utilization of traditional forms of service provision (e.g., individual and group therapy) as well as efficacious and promising non-traditional interventions (e.g., telehealth, online group support and treatment, self-help interventions, complementary/alternative therapies).
- Research is needed to evaluate the impact of extant psychotherapy and pharmacotherapy interventions on outcomes beyond PTSD and depression.

- There is a need for research focused on evaluating how trauma-focused intervention components can be integrated into other forms of treatment with survivors of sexual victimization (e.g., substance use treatment, treatment for disruptive behavior disorders in children).
- There is a need for research evaluating the impact of a sexual assault or harassment history on response to treatment for other mental and physical health issues common among survivors (e.g., psychotherapy for chronic pain, pharmacotherapy for depression, weight loss treatment for obesity).
- There is a need for research focused on the development and evaluation of interventions for individuals with challenging clinical presentations, including those who present with severe emotion regulation difficulties and challenges in forming and maintaining interpersonal relationships.
- Further research is needed to identify factors associated with resilient outcomes following sexual assault, abuse, and harassment.
- Research is needed to examine how historical and ongoing trauma and adversity affect sexual victimization survivors' adjustment and their ability to benefit from different forms of treatment.
- There is a need for research focused on identifying the biological, psychological, and social mechanisms via which different forms of sexual victimization lead to specific mental and physical health outcomes.
- Research is needed to evaluate the efficacy of trauma-focused interventions for sexual assault and abuse survivors from marginalized groups, as well as focused on long-term outcomes among these individuals, including risk and resilience factors.
- Research is needed to delineate the long-term psychological and physical health outcomes associated with experiences of sexual harassment within educational and work settings.
- There is a need for research focused on the development and evaluation of treatments for survivors of sexual harassment who experience negative mental health outcomes.

Professional organizations

Professional organizations such as ISTSS have the potential to play a key role in informing policy, practice, and research related to sexual assault, abuse, and harassment. We make the following recommendations for such professional organizations.

- Highlight high-impact research related to sexual assault, abuse, and harassment in professional conferences and journals.
- Offer educational programming for providers regarding evidence-based assessment and practice in working with survivors of sexual assault, abuse, and harassment through a variety of mediums including webinars, self-paced home study, and continuing education workshops.

- Facilitate networking opportunities for professionals whose research and clinical work focuses on sexual assault, abuse, and harassment, such as via the formation of special interest groups, listservs, and networking events at conferences.
- Develop educational materials including example syllabi, PowerPoint presentations, podcasts/films/documentaries, and sample class assignments for instructors interested in integrating content related to sexual assault, abuse, and harassment into their undergraduate and graduate courses.
- Facilitate collaborations between researchers, clinicians, government, and non-government agencies in sexual assault, abuse, and harassment related initiatives.
- Advocate for funding agencies and other stakeholders to develop and prioritize funding opportunities related to sexual assault, abuse, and harassment.
- Develop initiatives to increase the number of clinicians and researchers from marginalized groups with training and research interests related to sexual assault, abuse, and harassment including through such initiatives as awards, training grants, special interest groups, and other networking opportunities.
- Foster international collaborations, particularly those including clinicians and researchers operating in contexts in which there is limited resources available addressing sexual assault, abuse, and harassment.