Working With People Who Experienced Sexual Violence

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Introduction

Working with people who have experienced sexual violence requires a survivor-centred, trauma-informed approach. Sexual violence is sexual activity for which consent was not obtained or freely given. Alcohol or drug use, clothing, prior intimacy, gender, sexual orientation, physiological arousal, or the survivor's decision not to resist does not transfer responsibility from the person who committed the assault. The counsellor's role is not to investigate the survivor, decide whether the event was "serious enough," or pressure the person toward a particular legal or medical choice. The immediate tasks are to support safety, restore choice, reduce shame, assess urgent needs, and help the survivor access appropriate services (Centers for Disease Control and Prevention, 2025; World Health Organization, 2013).

The two original case discussions—Susie and Leon—correctly reject victim-blaming and recognize that men can be sexually assaulted. However, the language should be refined. Healing cannot be reduced to positive thinking, meditation, or avoiding work, and a survivor should not be told that feelings are unreal. Trauma responses are understandable adaptations to danger. Effective support recognizes the survivor's emotions while helping the person regain control over decisions, relationships, and daily functioning (Substance Abuse and Mental Health Services Administration, 2026).

Core Principles for Responding to Sexual Violence

Safety Before Disclosure Details

The first concern is whether the survivor is currently safe. A practitioner may ask whether the person is in immediate danger, needs urgent medical attention, has a safe place to stay, or fears contact from the person who caused harm. The purpose is not to demand a complete account. Detailed questioning can overwhelm a survivor and may resemble interrogation. Open prompts such as "What would help you feel safer right now?" and "Is there any urgent medical or practical concern you want us to address?" return control to the survivor (World Health Organization, 2013).

Belief, Validation, and Choice

A helpful initial response is calm and direct: “I’m sorry this happened,” “I believe you,” “It was not your fault,” and “You can decide what happens next.” These statements counter common fears of disbelief and blame. Choice is especially important because sexual violence involves a profound violation of autonomy. The survivor should be offered options—medical care, forensic examination, advocacy, counselling, reporting, safety planning, or no immediate action—without coercion. Laws and mandatory-reporting duties vary, particularly when minors or vulnerable adults are involved, so practitioners should explain confidentiality and its limits clearly (World Health Organization, 2013; World Health Organization, 2017).

Avoiding Retraumatization

SAMHSA describes trauma-informed care as recognizing trauma, responding through supportive practices, and resisting retraumatization. In practice, this means seeking permission before changing topics, conducting an examination, contacting another professional, or involving family. The practitioner should explain what will happen, allow pauses, and accept “no.” A survivor may appear calm, confused, angry, detached, inconsistent, or unable to remember events in a linear order. These reactions do not establish whether an assault occurred; they may reflect shock, fear, intoxication, fragmented traumatic memory, or individual coping style (Substance Abuse and Mental Health Services Administration, 2026).

Case One: Supporting Susie

Susie wakes after an assault in circumstances involving alcohol or drugs. Her likely concerns may include physical injury, pregnancy, sexually transmitted infections, memory gaps, fear of not being believed, and shame about having been intoxicated. The practitioner should state unambiguously that intoxication does not create consent. Consent must be freely given and can be withdrawn. A person who is incapacitated cannot provide valid consent (Centers for Disease Control and Prevention, 2025).

Immediate Medical and Forensic Options

Susie should be offered timely medical care from a trained provider. Depending on the time elapsed, her preferences, and local protocols, care may include treatment of injuries, pregnancy testing, emergency contraception, testing or preventive treatment for sexually transmitted infections, HIV post-exposure prophylaxis, toxicology considerations, and a sexual-assault forensic examination. A forensic examination can preserve evidence even when a survivor is undecided about reporting, but availability and rules differ by location. The provider should not promise legal outcomes and should avoid presenting an examination as an obligation (World Health Organization, 2013).

If Susie suspects drug-facilitated assault, some substances leave the body quickly. She can be informed that prompt medical advice may be useful, while also being reassured that delayed presentation does not invalidate her experience. She should be encouraged to preserve any items she wants examined, but she should not be blamed if she has showered, changed clothing, or cleaned the area. Health and emotional support remain appropriate regardless of evidence preservation.

Responding to Shame and Self-Blame

Susie may repeat questions such as “Why did I drink?” or “Why didn’t I notice the danger?” A counsellor can distinguish responsibility from hindsight: people make ordinary decisions to drink, socialize, trust acquaintances, or accept transportation; the perpetrator makes the decision to exploit or ignore the person’s lack of consent. The counsellor should not argue aggressively with Susie’s feelings. Instead, the practitioner can acknowledge them and explore the standards she is applying to herself. Asking how she would respond to a friend in the same situation can expose the unfairness of self-blame.

Friends, Social Networks, and Betrayal

Friends who describe the accused person as “a good person” may intensify trauma by treating social reputation as evidence. People who commit sexual violence are not always strangers or visibly dangerous. The CDC notes that the person responsible is often known to the survivor. Susie may need help deciding whom to tell, how much to disclose, and what boundaries to set with people who minimize the event. A supportive friend can accompany her to appointments, help with meals or transportation, and respect her decisions rather than becoming another person who takes control (Centers for Disease Control and Prevention, 2025).

Longer-Term Therapy

Possible post-traumatic reactions include nightmares, intrusive memories, avoidance, hypervigilance, difficulty concentrating, depression, anxiety, substance use, dissociation, sexual concerns, and changes in trust. Not every survivor develops post-traumatic stress disorder, and recovery does not follow a fixed schedule. Evidence-based trauma therapies may include trauma-focused cognitive behavioural approaches, cognitive processing therapy, prolonged exposure, and eye movement desensitization and reprocessing when delivered by qualified clinicians and chosen collaboratively. Stabilization, sleep support, grounding skills, and practical assistance may precede intensive trauma processing (Substance Abuse and Mental Health Services Administration, 2026).

Mindfulness or breathing exercises may help some people regulate distress, but they should be optional. Closing the eyes or focusing inward can be uncomfortable for some survivors. Grounding through movement, sensory objects, paced breathing, naming items in the room, or contact with a

trusted person may be more suitable. The goal is not to suppress emotion but to increase the ability to remain present and choose how to respond.

Case Two: Supporting Leon

Leon is a male survivor whose assault occurred in a dating or sexual context. He may face the same trauma reactions as any survivor and additional stigma created by myths about masculinity. Cultural expectations may tell him that men always want sex, should be able to prevent assault, or cannot be harmed by a woman or another man. These beliefs can delay disclosure and make him interpret fear, freezing, or compliance as personal weakness.

Physiological Response Does Not Equal Consent

Leon may be distressed by erection, ejaculation, orgasm, lubrication, or other involuntary bodily responses during an assault. A practitioner should explain that the nervous system can produce physiological arousal in response to stimulation regardless of desire, emotional willingness, or consent. A bodily response does not prove enjoyment and does not make the event consensual. This information should be offered without asking intrusive questions that are unnecessary for care.

Recognizing Freeze, Submit, and Dissociation

Popular discussion often focuses on fighting or fleeing, but people may freeze, become compliant, dissociate, or attempt to reduce harm. These are survival responses, not consent. Leon's later belief that he "should have fought harder" can be examined in light of what his nervous system perceived at the time. The therapist should avoid imposing a single trauma model or telling him exactly how he must feel. His response may include anger, numbness, fear, grief, confusion, or no immediate emotional reaction (Substance Abuse and Mental Health Services Administration, 2026).

Masculinity, Identity, and Sexual Orientation

Sexual assault does not determine a survivor's sexual orientation or gender identity. Leon may worry that victimization changes what his sexuality "means," especially if the person who assaulted him was male. The therapist should separate identity from the perpetrator's actions and allow Leon to discuss sexuality without assumptions. If he is gay, bisexual, heterosexual, transgender, or questioning, the same principle applies: assault is defined by absence of consent, not by the genders of the people involved (Centers for Disease Control and Prevention, 2025).

Help-Seeking and Confidentiality

Leon may prefer a male or female therapist, an anonymous hotline, a specialist service for male survivors, or a general sexual-assault program. He should be given choices rather than told that one service is automatically appropriate. The practitioner can discuss confidentiality, reporting options, medical care, and crisis resources. Screening for suicidal thoughts, self-harm, severe substance use, or immediate danger should be direct but compassionate. Asking about suicide does not create the idea; it allows urgent support when risk is present.

What Practitioners Should Not Do

Several responses can cause further harm. Practitioners should not ask why the survivor drank, went home with someone, stayed in a relationship, failed to fight, delayed reporting, or returned to the person who harmed them in a way that implies blame. They should not promise that reporting will produce conviction, that therapy will erase memories, or that forgiveness is necessary for recovery. They should not contact family, police, an employer, or a partner without consent unless a clearly explained legal duty applies (World Health Organization, 2013; World Health Organization, 2017).

It is also inappropriate to treat all distress as pathology. Anger, fear, disrupted sleep, distrust, and avoidance can be normal responses after violation. Diagnosis may become useful when symptoms persist and impair functioning, but the person should not be reduced to a disorder. The practitioner should attend to culture, disability, race, immigration status, religion, sexual orientation, and economic dependence because these can affect safety, access to care, and fear of institutions.

Building a Collaborative Recovery Plan

A recovery plan can include immediate safety, medical needs, legal information, emotional support, housing, work or school accommodations, sleep, substance-use support, and connection with trusted people. The survivor chooses priorities. Small decisions—where to sit, whether a door remains open, whether notes are taken, and whether a support person attends—can restore a sense of control (Substance Abuse and Mental Health Services Administration, 2026).

Progress should be measured by the survivor’s goals rather than by disclosure volume or willingness to report. One person may want to return to work, another to sleep without nightmares, another to feel safe in relationships, and another to pursue justice. Setbacks do not mean failure. Anniversaries, court proceedings, media coverage, medical examinations, or unexpected sensory reminders may reactivate distress.

Conclusion

Effective work with Susie and Leon begins with belief, safety, informed choice, and freedom from blame. Susie's intoxication does not excuse the assault, and Leon's physiological response or gender does not create consent. Both survivors may benefit from medical, forensic, advocacy, and therapeutic services, but each should control which options are pursued. Trauma-informed care does not demand a perfect narrative or a standard emotional response. It creates conditions in which survivors can regain autonomy, receive accurate information, and define recovery on their own terms (World Health Organization, 2013; Substance Abuse and Mental Health Services Administration, 2026).

References

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