Every year in the United States millions of women are victims of rape, sexual assault, and other forms of sexual violence. In order to determine what might be done in public libraries to extend support to victimized women and prevent sexual violence, this study sought to identify the information needs of sexually assaulted women. Interviews were conducted with three “companions,” or victim advocates, responsible for assisting callers to the Orange County Rape Crisis Center’s 24-Hour Help Line. The interviews revealed key areas of information need among victims of sexual violence, including information related to reporting crimes of sexual violence, interacting with law enforcement, the procedures of the sexual assault forensic exam, and facts about sexual violence against women. These findings were applied in the development of recommendations for public libraries and librarians seeking to address sexual violence against women in the communities they serve.
SUPPORTING VICTIMS, STRIVING AGAINST VIOLENCE: HOW PUBLIC LIBRARIES CAN SERVE THE INFORMATION NEEDS OF SEXUALLY ASSAULTED WOMEN

by

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A Master’s paper submitted to the faculty of the School of Information and Library Science of the University of North Carolina at Chapel Hill in partial fulfillment of the requirements for the degree of Master of Science in Library Science.

Chapel Hill, North Carolina
April 2016

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Introduction

Rape is defined by the United States Federal Bureau of Investigation as: "Penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim" (Federal Bureau of Investigation, 2014). In 2011, 19.3% of women responding to the CDC's National Intimate Partner and Sexual Violence Survey reported being raped, or experiencing an attempted rape, at some point, at least once, over the course of their lives (Breiding et al., 2014). Nearly 2% of women reported being raped at some point – at least once – during the past year, meaning that in 2011 at least 2,500,000 women in the United States were subject to either a completed or attempted rape (Breiding et al., 2014; Howden & Meyer, 2011). Given that many women do not make reports to law enforcement when they are raped – a phenomenon attributable in part to the social stigma associated with sexual victimization, as well as fear of reprisal by their abuser should they report, in complex entanglement with a variety of other personal and/or social inhibitors – it is likely that 2,500,000 is in fact an underestimation of the true scope of the rape atrocity in the United States (Planty et al., 2013). It is also critical to note that rape is not the only manner of sexual assault to which women are subject in this country. If we expand our definition of sexual violence to include non-penetrative forms of assault, such as sexual coercion, unwanted sexual contact (e.g., fondling, groping, etc.), and "noncontact" sexual experiences (e.g., being forced to view pornographic media,
undesired exposure to another's sexual exhibitionism as in "flashing," etc.), we are confronted by the following figures: a 5.5% 12-month prevalence for non-penetrative sexual assault among women in the United States, and a lifetime prevalence of 43.9% (Breiding et al., 2014). These statistics stand to starkly illuminate the public health crisis constituted by sexual violence against women in this country.

What no statistics can sufficiently illustrate, however, is the profound personal crisis that the experience of sexual violence represents for assaulted women. Sexual violation is considered a traumatic event, along with natural disasters, combat, and life-threatening accidents, and is associated with a number of serious and potentially long-term physical, psychological, emotional, and social consequences for victims. In the immediate aftermath of the rape or assault, victims commonly suffer from increased anxiety and fear, shame, guilt, self-blame, helplessness, a sense of disgust at their bodies, and social withdrawal (Mason & Lodrick, 2013; Jordan, Campbell, & Follingstad, 2010). These early presentations of distress can progress into more glaring, more severe and persistent manifestations, including generalized and phobic anxiety, depression, and such intrusive symptoms as flashbacks, nightmares, sleeping problems, emotional detachment, affective numbing, poor concentration, confusion, and anger, all of which are consistent with a diagnosis of Post-Traumatic Stress Disorder, or PTSD (Mason & Lodrick, 2013; Jordan, Campbell & Follingstad, 2010). PTSD is a distressing and disruptive mental health condition that can be disabling for those affected. It is characterized by three categories of symptoms: 1) re-experiencing of the traumatic event; 2) avoidance of stimuli connected with the traumatic event and a notable numbing of responsiveness to stimuli generally; and 3) increased arousal, alertness or vigilance (Mason & Lodrick,
For a formal diagnosis of PTSD to be made, symptoms must linger for over one month past the traumatic event and result in clinically significant distress, and/or impairment in one or more areas of functioning (e.g., social or occupational) (Mason & Lodrick, 2013). In fact, PTSD is the most common mental health outcome of sexual violence. It is not merely a potential but a likely sequela of rape and sexual assault. One review of the literature on the psychological consequences of sexual violence found that, in the majority of studies, between 33-45% of women with a lifetime history of sexual assault were reported to develop PTSD (Campbell, Dworkin, & Cabral, 2009). Significantly, research has also shown PTSD to be more common among sexual violence survivors than any other group of trauma survivors, including survivors of serious accidents and natural disasters, and even soldiers returning from combat (Olantunjo et al., 2009; Kessler et al., 1995).

For women who have been subject to sexual violence, the disabling symptoms of PTSD can persist for months and even years after the assault occurs. In order to cope with continuous flashbacks and nightmares, as well as the symptoms of hyperarousal, many women "self-medicate" with alcohol and other substances, which can advance into substance abuse (Jordan, Campbell, & Follingstad, 2010). Campbell et al.'s review (2009) found that 13–49% of female sexual violence victims develop a dependency on alcohol, while 28–61% may turn to alternate illicit substances for relief. In addition to PTSD and substance abuse, feelings of shame and humiliation can persist long after the sexual violence event, contributing to reduced self-esteem, social anxiety, and depression (Mason & Lodrick, 2013; Campbell, Dworkin & Cabral, 2009; Jordan, Campbell, & Follingstad, 2010). Somatic complaints, particularly headaches, muscle tension, and
stomach upset, have also been identified as long-term consequences of sexual victimization (Mason & Lodrick, 2013). Finally, the rate of suicidal ideation and suicide attempts is higher among women who have been subject to sexual violence than non-victims (Mason & Lodrick, 2013). Campbell et al. (2009) found that 23–44% of victimized women reported thoughts of ending their own lives.

Although the research supplies clear evidence that sexual assault is devastating for many women, producing extreme disruption, distress, and difficulty, there are many factors that affect an individual's response to trauma, and thus psychological reactions to sexual violence will vary from woman to woman. One factor known to significantly influence the severity of a victim's symptoms subsequent to a sexual assault is the social response she receives. When women's experiences of sexual violence are ignored, go unrecognized, or are diminished, or when women are blamed for their assaults, ostracized or even subject to punitive violence for the sexual violence they've endured, these negative responses predict for more severe mental health sequela, and thus a lessened prospect for recovery (Mason & Lodrick, 2013). The association between social response and psychological outcomes for victims of sexual violence highlights the importance of providing victimized women with empathic, understanding, and compassionate responses in as many social arenas as possible, in order to promote healing and protect against the development of disabling long-term consequences.

Librarians, particularly those working in the public library setting, are uniquely well-situated to offer community-level support to victims of sexual violence. Positing that the high level of trust that the public places in public libraries carries over to some degree onto the librarians who work in them, as trusted members of the communities they serve
public librarians are impelled to make use of their position to pursue opportunities to provide meaningful support to those who can most benefit from their assistance and attention (Horrigan, 2015; Varheim, Steinmo, & Ide, 2008; Willingham, 2008). Sexually victimized women cannot be excluded from this category. The purpose of the following study is therefore to determine how librarians can support victims of sexual violence, through information provision services, with consideration given to both the informational content and delivery method. In this study, the focus will be placed on female victims, as women are disproportionately impacted by sexual violence compared to male peers. The question at the core is this: what information do women who have experienced sexual violence need, and how can librarians apply their professional skill set to addressing these needs?

While Westbrook and others have undertaken commendable efforts to researching what libraries and librarians can do to assist victims of intimate partner violence, scant study has yet been committed to addressing the needs of victims of sexual assault (Westbrook, 2008; Westbrook, 2009; Westbrook & Gonzalez, 2011; Westbrook, 2015; Wilmoth, 2008). Although an improved appreciation of the serious and multilayered information needs of sexually assaulted women is apt to be of use to information professionals across a variety of domains, as well as advocates and others working within victim services organizations, the current study will be geared toward developing an understanding of sexually victimized women's needs that can be applied in the public library setting. Through the implementation of information support services that represent the public library as a known safe space for sexual assault victims, where women who have been assaulted can find the information they need within their own communities, the
public librarian not only provides a meaningful practical service to each individual victim, but, by opening a novel avenue of support, the librarian casts herself as an agent of social change, shifting the community consciousness from victim-shaming and victim-silencing and toward inclusivity, empathy, and compassion for women who have experienced sexual violence.
Literature Review

I. The Unmentionable Epidemic: Sexual Violence as a Public Health Crisis

Sexual violence represents a serious public health problem internationally as well as in the United States (Jewkes, Sen, & Garcia-Moreno, 2002). Along with physical violence, psychological violence, and deprivation/neglect, sexual violence is identified by the World Health Organization as one of the four types of interpersonal violence, and encompasses a wide range of violent acts. These include: rape, non-penetrative assault, sexual coercion, sexual harassment, sexual abuse of children, forced marriage, female genital mutilation, and sexual exploitation in the form of forced prostitution and trafficking (Jewkes, Sen, Garcia-Moreno, 2002). Due to low reporting rates and limited research, the available data on the prevalence of these various forms of sexual violence is fragmented and incomplete, making it difficult to estimate the extent of the problem worldwide. However, recent studies do provide some idea of the scope of sexual violence in the United States. Breiding et al. (2014) found that an estimated 19.3% of women in the United States have endured a rape or attempted rape in their lifetimes, while an estimated 43.9% of women have experienced other forms of sexual violence. Although both men and women can be victims of sexual violence, women are far more likely to be victimized than their male peers. Compared to the lifetime prevalence of nearly 20% for rape among women, the same study found an estimated 1.7% lifetime prevalence of rape among men, and a 23.4% lifetime prevalence of other forms of sexual violence (Breiding et al., 2014). A Bureau of Justice Statistics (BJS) study found that less than 10% of all
rape or sexual assault victimizations recorded in the National Crime Victimization Survey (NCVS) between 1995 and 2010 involved a male victim (Planty et al., 2013). While sexual violence against men is not a negligible concern, it is apparent that women are disproportionately targeted for this type of violence. This is true around the world as it is in the United States (Jewkes, Sen, Garcia-Moreno, 2002). There is also evidence to indicate that while women are most frequently the victims of sexual violence, men make up the majority of perpetrators (Breiding et al., 2014). Greenfeld (1997) determined that in nearly 99% of single-victim rape/sexual assault incidents the perpetrator was male. In addition to being male, a second characteristic common among perpetrators of sexual violence is a relationship of some kind with the victim. Research has shown that in nearly 78% of sexual violence incidents, the perpetrator was an intimate partner, family member, friend or acquaintance of the victim (Planty et al., 2013). While sexual violence is directed at women of all ages, races, and socioeconomic levels, there is evidence to suggest that younger women, women of color, women in low-income households, and women living in rural areas experience the highest rates of sexual violence (Planty et al., 2013; Breiding et al., 2014). Women with a history of childhood sexual abuse, mental illnesses, or learning disabilities are also at increased risk of being assaulted by sexual predators who take advantage of their vulnerabilities (Mason & Lodrick, 2013).

Each year rape, sexual assault, and other forms of sexual violence negatively impact the lives of millions of women. Sexual violence is associated with myriad immediate and long-term physical and psychological health consequences among victimized women, representing a major public health burden. Among the most common physical health correlates of sexual violence are acute injuries, sexually transmitted
infections, and pregnancy. Research has shown that 36% of rapes cause physical injury to the victim (Chrisler & Ferguson, 2006), such as black eyes and orbital swelling, genito-anal injuries and bruising, bites, burns, restraint or binding injuries, internal injuries, broken bones or teeth, and knife or gunshot wounds (Marchbank, Lui & Mercy, 1990). Hemorrhage, shock, and severe pain are not uncommon among victims of sexual violence, and femicide – the murder of women – is highly associated with sexual violence in the United States, meaning that death must be included as a possible acute, severely negative health impact of rape or sexual assault (Jina & Thomas, 2013). As it is often difficult for women to compel their rapists to wear condoms, victims of sexual assault also face an increased risk of sexually transmitted infections, such as gonorrhea, syphilis, hepatitis B, and HIV (Jina & Thomas, 2013). In addition to the immediate symptoms related to the various infections, these sexually transmitted infections can also lead to longer term health complications including urinary tract infections, pelvic inflammatory disease, cervical cancer, and infertility (Chrisler & Ferguson, 2006). Unwanted pregnancy is another immediate consequence of sexual violence which also inheres tremendous long-term consequences. Pregnancy itself must be understood as a health condition associated with considerable discomfort and potentially life-threatening complications. Unwanted pregnancies in particular have been found to negatively impact women's physical as well as mental health (Jina & Thomas, 2013). The yearly rape-related pregnancy rate among women and girls between the ages of 12 and 45 years of age is estimated at 5% (Holmes et al., 1996).

In addition to the immediate health effects of sexual assault, there are also a number of medium- or long-term consequences that can occur in the period following the
assault, even arising potentially long after the assault. Women who have experienced sexual violence are more likely than their nonvictimized peers to report dysmenorrhea (painful menstruation), dyspareunia (painful intercourse), vaginal bleeding or infections, chronic pelvic pain, chronic pain syndrome, gastrointestinal symptoms, migraines, fibromyalgia, hypertension, low energy, insomnia, fatigue, weakness, and overall poor health (Eby, Campbell, Sullivan & Davidson, 1995; Chrisler & Ferguson, 2006; Jina & Thomas, 2013). Victims of sexual violence have also been found to experience a high reported number of cardiopulmonary and neurologic symptoms, such as shortness of breath, palpitations and cardiac arrhythmias, chest pain, asthma, hyperventilation, dizziness, faintness and chronic back and facial pain (Jina & Thomas, 2013). These disruptive, debilitating somatic symptoms can persist months, even years after an assault occurs (Chrisler & Ferguson, 2006). Rape victims have also been found to be more likely than nonvictims to report the chronic diseases diabetes, asthma, and arthritis (Wasco, 2003).

Equally as varied and severe as the potential physical consequences of sexual violence for women are its associated psychological impacts. Many different factors influence an individual's response to trauma, meaning that psychological reactions to sexual assault can vary significantly between victims. Every victimized woman will respond differently to the violence perpetrated against her (Mason & Lodrick, 2013). However, common psychological responses in the immediate aftermath of a sexual assault include feelings of shock, denial, fear, confusion, panic, shame, bodily disgust, helplessness, guilt, and self-blame (Jina & Thomas, 2013; Mason & Lodrick, 2013). These symptoms tend to peak at three weeks after the assault, remain high for one to two
months, then gradually dissipate (Jina & Thomas, 2013). Burgess and Holmstrom (1979) famously described the symptomatology associated with early reactions to sexual assault as "rape trauma syndrome." Post-traumatic stress disorder (PTSD) is also frequently diagnosed among women who have been subject to sexual violence. In a review of studies on the impact of sexual assault on women's mental health, Campbell, Dworkin and Cabral (2009) found that most studies reported a 30-45% prevalence of PTSD among women with a lifetime history of sexual assault. PTSD is an extremely distressing and disruptive condition associated with such intrusive symptoms as flashbacks, nightmares, poor concentration, difficulty sleeping, and decrements in school and work performance (Mason & Lodrick, 2013). In some cases assault-related PTSD resolves within a few months; in others, it can persist for years subsequent to the sexual assault event (Resick, 1993). Other long-term mental health consequences of sexual violence for women who are assaulted include depression, generalized and social anxiety, diminished self-esteem, phobias and panic disorders, negative body image, self-harm, and suicidal ideation and behavior (Resick, 1993; Chrisler & Ferguson, 2006; Campbell, Dworkin & Cabral, 2009; Mason & Lodrick, 2013; Jina & Thomas, 2013). A higher risk of suicide is associated with sexual violence than non-sexual physical violence, and research has evinced that as many as 40% of victimized women consider suicide after their assaults (Resick, 1993; Campbell, Dworkin & Cabral, 2009; Jina & Thomas, 2013).

In addition to the numerous, serious, potentially life-threatening physical and psychological consequences outlined above, sexual violence is linked to a host of risky health behaviors that can worsen the recovery outcomes of women who have endured an assault. Many women turn to alcohol and other substances to cope with the PTSD
symptoms and emotional fall-out of sexual assault trauma, leading to substance dependency and abuse disorders (Resick, 1993; Campbell, Dworkin & Cabral; Mason & Lodrick, 2013). Victims of sexual violence are also vulnerable to heavy use of cigarettes and reliance on prescription medications (Jina & Thomas, 2013). High-risk sexual behaviors – e.g., engaging in unprotected sex, sex with multiple partners, participating in paid or transactional sex, and having sex under the influence of alcohol/drugs – are a further potential sequela of sexual violence that can put women at risk for sexually transmitted infections and further sexual assault and abuse. It is a fact that women who are sexually assaulted once are more likely to be assaulted again in the future. This is called revictimization, and it is associated with increasingly debilitating health outcomes with each subsequent assault (Tjaden & Thoennes, 2006; Campbell, Dworkin & Cabral, 2009; Walsh et al., 2012). A third self-destructive behavior observed in women who have experienced sexual violence involves unhealthy or disordered eating habits (e.g., fasting, vomiting, abuse of diet pills) (Jina & Thomas, 2013). Faravelli, Guigni, Salvatori and Ricca (2004) found that 53% of rape victims had developed an eating disorder within four to nine months after the rape event, compared to 6% of women who had experienced a different, life-threatening but non-sexual trauma.

Although it may seem cold to reduce the suffering that women experience as a result of sexual violence to a matter of dollars and cents, in order to stress the public health burden presented by this epidemic, it is necessary to consider the economic costs associated with rape and sexual assault. In general, research suggests that women who have been sexually assaulted rely heavily on the health care system. Amstadter et al. (2008) found that in a sample of 3,001 women, 38% of sexually victimized women
sought help from a medical professional subsequent to being assaulted. Researchers estimate that about 25% of rape victims are sufficiently seriously injured to require immediate medical attention (Chrisler & Ferguson, 2006). The average cost of medical care per sexual assault is approximately $516 (Chrisler & Ferguson, 2006). Koss (1994) also found that following a sexual assault, victims' visits to physicians increased by 56%, from approximately four visits yearly prior to the assault to approximately seven yearly visits after the assault, an increase bound to incur its own costs. The psychological sequelae of sexual assault, as well as the social stigma and victim-blaming prone to accompany this type of violence, leads women to seek mental health as well as physical health care following an assault. Research suggests that 38-54% of women solicit the assistance of a psychiatrist, psychologist, or counselor following a sexual assault experience (Chrisler & Ferguson, 2006; Amstadter, 2008). Chrisler & Ferguson (2006) estimated that women raped average approximately 12 visits to a mental health professional, accruing an average total cost of nearly $1000, more than one-third of which is typically paid by the victim herself. Their figures specifically refer to women raped by an intimate partner, but it can be inferred that physician visits and costs would be similar for women raped by non-intimates as well. In order to pursue medical or mental health care, or as a consequence of the health detriments reviewed above, sexually victimized women often take unpaid time off from work. Chrisler & Ferguson have calculated that the earnings lost for all victims of assault by an intimate partner totals over $4,000,000 per day. Considering the devastating physical and mental health effects that sexual assault has on victimized women by the millions and the staggering economic toll of these assaults, sexual violence against women warrants recognition as a public
II. Social Etiology // Political Ends: A Feminist Analysis of Sexual Violence and Women's Oppression

That sexual assault is detrimental to those victimized is a matter of general consensus; virtually no one is prepared to come out in support of men's violence against women, and yet rape and sexual violence in its myriad forms is nonetheless endemic in the United States. This apparent paradox is explained away by a series of claims, most typically issued in rapid succession: rape is inevitable, rape is natural, men's urge to rape is at base instinctual, as an animal drive it is therefore carnivorous or cannibalistic; men's sexual needs are intense and cannot be controlled (Wrangham & Peterson, 1996; Thornhill & Palmer, 2000; McKibbin, Shackelford, Goetz, & Starratt, 2008; Muller & Wrangham, 2009). These assumptions accrue, piling onto one another to concretize as a fatalistic resignation that rape is woven into men's DNA; consequently, it defies solution. There is simply nothing to be done. One cannot argue with nature. Thus, despite being deemed unacceptable, interpreted as an inevitability, rampant sexual assault is tacitly sanctioned as acceptable.

One enduring contribution of the feminist movement of the 1970s and '80s is the insight and rigorous insistence that sexual violence is not natural – not biologically determined – nor inevitable – not an immovable reality – but rather a product of the social systems, structures, and processes of patriarchy, defined concisely as male social dominance. Feminist activists and writers like Susan Griffin (1971), Susan Brownmiller (1975), Andrea Dworkin (1976; 1983; 1987), and many others, have argued that rape and other forms of sexual violence against women are to be construed as sociocultural not natural phenomena, symptomatic of a human sexuality molded within the context of
patriarchal society. Furthermore feminists hold that sexual violence is political: a tactic by which men assert and maintain the power of all men as a sex class privileged over and against all women (Brownmiller, 1975; Dworkin, 1976). As a symbolic expression and physical realization of male power and female powerlessness under patriarchy, sexual violence consolidates sex class stratification; with each act of sexual violence a man perpetrates against a woman the sociopolitical disparity between the sexes is expanded. At the same time the construction of women's essence and function in male supremacist society as sexual objects is enforced, as is men's essential role as the owners and masters of female objects. Dworkin (1976) wrote that the definition of women as objects, realized through rape and other forms of sexual assault, is rooted in the "resolute conviction" that "women were put on this earth for the use, pleasure, and sexual gratification of men" (p. 32). It is a conviction men learn through socialization into patriarchal masculinity and exercise through acts of sexual violence. When masculinity is defined as male aggression and physical potency, violence, and superiority over women, rape becomes evidence of its achievement. The male rapist is aggressive and virile, he dominates by force, he exerts power over women, asserting himself as women's superior. Thus a man is made. By contrast, when femininity is defined by passivity and subordination to males, to be sexually victimized actualizes a woman as “feminine”: she is denied self-determination, dispossessed of her body, overtaken and subordinated to the will of another. Thus a woman is made (Dworkin, 1983). Griffin (1971) writes: "...the passive woman is taught to regard herself as impotent, unable to act, unable even to perceive, in no way self-sufficient, and finally, as the object and not the subject of human behavior" (p. 33). Sexual violence, as a widespread practice constituting a social institution, has the
function of educating women in these fundamental lessons. Hence, at the core of the feminist interpretation of sexual violence is the assertion that sexual violence against women is both a product of our social reality of sexual inequality and an instrumental tool in the establishment and enforcement of that reality.

The argument that sexual violence is natural hence inexorable assumes that men rape women because an uncontrollable urge toward coitus is an innate characteristic of the human male, an assumption carrying with it the implication that all men, everywhere, will rape women, as a function of some unfortunate quirk of male wiring. What this assumption fails to take into account is the reality that rape is not similarly endemic in every culture, whereas men are equally biologically male more or less universally. It follows that rape is not an inherent tendency of the male organism, but rather an expression of social and cultural forces. In her cross-cultural study of rape in tribal societies, Sanday (1981) offered compelling evidence in support of the feminist posit that rape, like all sexual behavior, is not determined merely by biology, nor individual psychology, but by the complex of values, ideologies, and attitudes comprising one's sociocultural context. Sanday found significant variance in the incidence of rape between the different tribal cultures she researched, and, furthermore, that the cultures with a high incidence of rape were markedly different from those with a low incidence. Cultures where rape was prevalent, termed "rape prone," were characterized by the social stratification of men and women, male dominance, the objectification of women into men's belongings, and high levels of other forms of interpersonal violence (p. 63). In these cultures, sexual interaction was conceived as essentially hostile, and masculinity inseparable from aggression. The sexual encounter represents a contest between the male
and the female, one men are meant to win by coercion and by force as a ritualized substantiation of male dominance. Rape, as an extreme iteration of this ritual-contest conception of heterosexuality, emerges as one facet in an overarching pattern of male violence and sexual inequality. As might be anticipated, cultures which were more violence in general displayed higher rates of sexual violence. Conversely, the societies with a low incidence of rape that Sanday studied were characterized by greater equity between the sexes, a respect for women as community members and mothers, minimal interpersonal violence, and an attitude of reverence toward nature. Men and women were not separated into divergent social groups but work together, as equals; women were valued members of their communities, not men's property; sexual encounters were not combat situations, nor was masculinity constructed around the image of the warrior. Because sexuality and violence were not yoked together, sexual violence only rarely arose. Sanday's findings support the feminist assumption that rape is not an expression of men's biological configuration, but of socialization into aggressive, domineering masculinity. A social etiology for sexual violence emerges: the valorization and toleration of violence generally – and male violence in particular – fused to a foundational ideology of male supremacy. In the United States, violence pervades popular entertainments, the male warrior looms large as a primary hero figure of the cultural mythos, relations between men and women are conceptualized in terms of the so-called "battle of the sexes," and the current congress is over 80% male (Griffin, 1971; Manning, J.E., 2015). During witness testimony in the 2015 trial of Owen Labrie, accused of raping a fifteen-year-old female fellow student at a prestigious boarding school in New Hampshire, it was discovered that male students at the school commonly referred to engaging in sexual
intercourse with a young woman as "slaying" her (Manning, A., 2015). What these few cursory examples illustrate is that violence is not merely tolerated but actually celebrated in our culture, that masculinity is yoked to aggression, sexuality and violence are entangled, and serious political inequality exists between men and women. The United States therefore meets criteria to be classified a rape prone society. That almost half of all American women will be subject to some form of sexual violence in their lifetimes stands in stark support of Sanday's theory of the social etiology of rape (Breiding et al., 2014).

In order to understand sexual violence as an expression of culturally encoded hostilities against women, premised in a sexual inequality materially realized and ideologically based, it is useful to consider sexual assault within the framework of hate crime. Hate crime refers to criminal acts motivated by hatred or prejudice based on some aspect of the victim's identity, such as his or her race, religion, or sexual orientation.

Gender-motivated crimes have also fallen into this category in the United States since the passing of the Violence Against Women Act of 1994 (Center for Women Policy Studies, 2001). Sheffield (1992) described hate crime as the consequence of the virulent beliefs, stereotypes and images of themselves and others that individuals inherit from the culture in which they are raised. These belief systems solidify as ideologies, serving to shape our perception of the world or how the world ought to be. Racism is an ideology; so too is sexism. An "-ism" ideology develops thusly: first, individuals are separated into groups according to some surface characteristic of their person – their skin color, or the sort of genitals they have – and then a hierarchy is erected, so that persons of a certain skin color or genital anatomy are recognized as superior to persons with an alternative skin color or genital anatomy. The superior group is established as socially dominant, and a belief
system is propagated by the ascendant group to justify and sustain its own dominance. Dominance is further maintained through acts and threats of violence against the group defined as inferior (Sheffield, 1992). These acts are hate crimes. Walters & Tumath (2014) have made a persuasive argument for including crimes which demonstrate animosity toward women within the framework of hate crime legislation in the United Kingdom, where sex is not currently included among the personal characteristics potentially motivating a hate crime. They suggest that, since female sex is the principal risk factor for sexual violence victimization, and since the majority of acts of sexual violence against women are committed by men, these crimes represent "gendered" violence, an expression of men's hostilities against women. Although sexual violence is not directed exclusively at females, and occurs in same-sex relationships as well as heterosexual ones, Walters & Tumath have asserted that women are the most likely out of all other groups to be sexually victimized, solely because they are female.

Having established rape and sexual assault as types of violence that specifically target women as women, the authors then highlight the parallels that exist between sexual violence offenses – rape, in particular – and hate crime. First, rape is a form of bodily violence enacted to subjugate women. Through the physical act of rape, a man puts a woman "in her place" – as per the patriarchal definition: below him – by overpowering her, compelling her by force or coercion to submit to his authority. Each rape occurs within the context of a male supremacist society, such that when a man rapes a woman, he acts as a representative of the dominant male sex class in service of its agenda: to enforce the subordination of not only the individual female victim being raped but also women collectively, as a sexual subclass (Walters & Tumath, 2014; Brownmiller, 1975).
It is therefore an ideologically motivated, issuing from prejudices prescribing women's proper position in society. Sexual violence is also an expression of misogyny, defined as hatred of, or hostility toward, women. Within the plexus of belief systems in place to justify the male supremacist social structure there are a multitude of denigrating stereotypes about women, and particularly about female sexuality (Sheffield, 1991). Having been indoctrinated into contempt for women as a function of these stereotypes, men are primed to aggress against them. Kate Millett (1970) expressed the role of misogyny in sexual violence eloquently when she wrote: "In rape, the emotions of aggression, hatred, contempt, and the desire to break or violate personality, take a form consummately appropriate to sexual politics" (p. 44).

Further parallels exist in the consequences incurred by sexual violence and hate crime. The hate crime victim is not targeted as an individual, but as a member of a particular group. Thus a hate crime is harmful not only to the individual victim, but to others like her, through the message of disdain and the threat of potential violence it communicates to every other member of her group (Walters & Tumath, 2014). In this way hate crime instills fear and a sense of social devaluation widely throughout the hated group/community in order. This promotion of widespread fear is purposeful, a powerful means of maintaining an oppressed population's subjugation. It is difficult to fight for one's freedom when one is frightened even to leave the house. As a tactic of oppression, hate crimes and the threat they carry serve to preserve the social order, dictating where members of the targeted group can go, what they can do, effectively demarcating the limits of their lives. The purpose and consequence of sexual violence is similarly oppressive. When one woman is raped, the message sent to all women is that they too
could be attacked, that they must be careful or they will become victims themselves. Indeed, Brownmiller has famously described rape as the "conscious process of intimidation by which all men keep all women in a state of fear" (p. 5). Card (1991) and Sheffield (2007) have further clarified the process as sexual terrorism, a social control strategy inhering severe consequences for victimized women as well as every other woman made afraid and menaced into compliance with patriarchal directives. In rape prone societies like the United States, the omnipresent danger of sexual violence is a basic reality for women, glaring as a lurid thread embedded in the weave of women's lives. To avoid victimization, a woman may take exhaustive and exhausting measures to protect herself: she will stay inside after dark, will not go out alone, will not venture into certain parts of town; she will take care to dress in a way unlikely to provoke potential rapists, she will try to please men in hopes they will not rape her (Griffin, 1971; Sheffield, 1991). Because it restricts women's capacities, mobility, options and opportunities, cornering women into the roles and behaviors allotted them under patriarchal rule, sexual terrorism is an integral force in the process of female socialization (Card, 1991). The major tasks of sexual violence as sexual terrorism are A) to forcibly effect the "feminization" of women as docile, submissive, and subservient to males; and B) to encourage women's dependency on men, by means of the implicit lesson that in order to avoid violation a woman must attach herself to a man who will protect her from the other men who would rape her (Card, 1991). In combination these dual functions of sexual violence contribute to the social subordination of women to men, precluding authentic equality between the sexes. Where rape is endemic, freedom for women is a fantasy. Through sexual violence, as a hate crime against women, a terrorist institution,
and the explicit physical expression of misogynistic, male supremacist ideology, men's social dominance and women's marginalization are enforced, reinforced, and perpetuated. For this reason, the suspension of sexual violence is essential in the reconstruction of a fair and free society.

III. Help Seeking in a Social Ecology of Contempt

In the aftermath of being sexually victimized, most women first seek assistance and support from informal sources, such as friends and relatives, rather than formal services, such as law enforcement. The resource sought most commonly by victims of sexual violence is the emotional support of their friends and families (Postmus et al., 2009; Ullman & Filipas, 2001). In pursuit of such support, two out of every three victimized women will disclose their assault to someone at some point after the assault, most often to a close friend, partner, or relative (Ullman & Filipas, 2001). Amstadter et al. (2008) found the prevalence of formal help seeking to be relatively high among victims of sexual assault as well, with 60% of women in their sample reporting that they had sought help from a formal support service subsequent to victimization. The major formal resources contacted by victims of sexual violence, from most frequently to least frequently contacted, are mental health care providers, medical professionals, law enforcement, rape crisis centers, and clergy (Ullman & Filipas, 2001). Should a woman decide to pursue charges against her attackers, the criminal justice system serves as an additional formal support (Campbell, Dworkin, & Cabral, 2009). Burgess & Holmstrom (1974) developed a typology of the support and services women seek post-assault, dividing these into two categories: crisis requests and counseling requests. In the immediate post-assault period, women tend to ask for more concrete, material assistance,
such as medical care to treat injuries or test for sexually transmitted infections, or the aid of a police officer in apprehending her attacker. Due to their proximity to the assault event and the urgency of the needs expressed, Burgess & Holmstrom call these types appeals for assistance "crisis requests." In contrast, "counseling requests" are made later in the post-assault period and tend to be of a more ephemeral character. As the immediate crisis situation is left behind and women move into the phase of processing and healing from the injury of assault, the support they seek shifts from material to affective assistance. Specifically, Burgess & Holmstrom identified four main classes of affective supports sought: confirmation of concern, an outlet for ventilation, clarification, and advice. Inherent in these requests is victims' desire to feel cared about and acknowledged as valuable individuals; to share the burden of their assault with someone who will listen without judgment; to discuss the confusing, often painful thoughts, emotions, and behaviors that can surface as a result of victimization; and to obtain information about the options available to them in handling legal, social, physical or mental health concerns connected to their assaults (Burgess & Holmstrom, 1974). Such requests are a vital focus of rape crisis centers. A product of the feminist anti-rape movement of the 1970s, rape crisis centers are nonprofit organizations committed to providing empathetic emotional support to women through 24-hour hotline services, support groups, one-on-one advocacy, and additional support (Sullivan & Carlton, 2001). RCC advocates additionally respond to sexual assault victims' more concrete "crisis requests," often offering hospital accompaniment services for individuals who would like to receive medical assistance but do not want to go to the hospital alone, police accompaniments, and legal advocacy. RCC advocates can also assist victims in securing safe housing, low-cost mental health care,
and financial assistance. By striving to fulfill both "crisis requests" and "counseling requests," rape crisis centers provide comprehensive and compassionate support for victims of sexual assault. A recent study found that women who received aid from a rape crisis center in the U.K. experienced significant decreases in post-traumatic stress symptoms (e.g., flashbacks and panic attacks), as well as reductions in depression, anxiety, and reliance on such negative coping strategies as substance use and self-harm (Westmarland & Alderson, 2013). In a recent trend, rape crisis centers have begun coordinating more formally with law enforcement, hospital staff, and the legal system, forming what are known as Sexual Assault Response Teams to improve victims' experiences of seeking help from formal support services and increase offender accountability in the criminal justice system. These SART collaborations are increasingly popular in the United States, recommended for adoption by many national anti-violence agencies (Greeson & Campbell, 2015).

The unfortunate reality is that rape crisis centers and SARTs owe their development in large part to formal community service providers' long history of failure to adequately serve sexually assaulted women. Campbell et al. (1999) found that although 40% of the women in their sample had contact with the medical or legal system in the post-assault period, the majority received only minimal services from these agencies. Serious issues have been identified in the formal community response to sexual assault, such as failure to provide comprehensive medical services to victims, low arrest and prosecution rates of perpetrators, and poor treatment of victims by formal system personnel (Greeson & Campbell, 2015). Consequently, women's expectations of formal systems are low; indeed, anticipation of ineffectual or negative responses from formal
systems constitutes a leading barrier preventing sexually assaulted women from seeking help (Ullman & Filipas, 2001). Women of color are particularly disinclined to reach out to formal services for this reason, fearing that they will not be taken seriously as legitimate victims by predominantly white institutions because of their race (Ullman & Filipas, 2001). Women have good reason to be dubious of formal community supports, since women who turn to medical professionals, police officers, and legal counsel for assistance commonly report negative experiences in their interactions with these official service providers (Campbell et al., 1999; Campbell, Dworkin, & Cabral, 2009). Examples of negative responses women encounter when seeking help from these systems include being blamed for their own assaults, patronizing or condescending behavior, disbelief, and attempts to appropriate decision-making power on the part of service personnel (Campbell et al., 2001). Negative social responses of this kind on the part of systems whose ostensible purpose is to provide assistance can be severely damaging to victims of sexual assault. Campbell et al. (1999) have described the insensitive treatment sexually assaulted women receive from formal systems as a form of revictimization, even terming these stressful and traumatic help experiences as "second rapes." Research suggests that negative social responses to disclosures and help seeking efforts are associated with a worsening of post-traumatic stress symptoms, a higher frequency of physical health symptoms, and general decrements to post-assault recovery among victims (Campbell et al., 1999; Campbell et al., 2001; Ullman & Filipas, 2001). Women assaulted by an acquaintance or intimate and who receive little assistance but face disbelief or incredulity from formal system personnel are particularly vulnerable to revictimization (Campbell et al., 1999). Furthermore, negative responses have been found to be more hurtful to
victims of sexual assault than positive responses are helpful (Campbell et al., 1999; Cambell et al., 2001). Although research suggests that positive social support from families, friends, and intimate partners facilitates sexually assaulted women's recovery, and is related to lower levels of psychological distress, post-traumatic stress symptomatology, and chronic health conditions, the healing influence of positive support is not as strong as is the damaging influence of negative disbelieving, victim-blaming, dismissive, and condescending responses (Campbell, Dworkin, & Cabral, 2009). Negative responses consistently hurt more than positive responses help victims of sexual violence.

The social responses that a sexually victimized woman receives from those to whom she discloses her assault are a crucial determinant of the level of psychological repercussions associated with victimization. The trauma of rape and other forms of sexual assault is not merely the result of the attacked body's physiological response to a critical incident of intense violence, pain, and fear (Wasco, 2003). Nor are post-assault reactions purely a function of each individual victim's personal psychological configuration and coping skills. These notions decontextualize sexual violence against women. To take such a narrow and mechanistic view of trauma is to fail to acknowledge the cultural, social, relational, and biographical factors that contribute to a woman's experience of sexual violence within a patriarchal society (Wasco, 2003). No woman is raped in a vacuum. Instead, her experience is shaped by the messages she receives from her sociocultural environment about what has happened to her, as communicated through the responses she receives from members of her support network and from formal support systems, in combination with the messages latent in the guiding ideologies and value
systems of the society in which she lives (Campbell, Dworkin, & Cabrall, 2009). In a rape-prone culture such as that of the United States, women who disclose sexual victimization are frequently blamed for being attacked, discredited as liars who desired to be assaulted, and are subject to painful shaming and stigma from social peers as well as social institutions (e.g., law enforcement). These harsh conditions inevitably influence victims' experiences of sexual violence. To fully grasp the damage done by sexual violence against women, it is necessary to move beyond the mechanistic, reductive trauma model and develop a more contextualized, inclusive conceptualization of the subjective experience of sexual assault (Wasco, 2003).

Campbell, Dworkin, & Cabral's (2009) ecological model of the impact of sexual assault on victimized women's health is particularly helpful in this regard. In their model, which builds from Neville & Heppner's (1999) "Culturally Inclusive Ecological Model of Sexual Assault Recovery", a victim's psychological outcome post-assault is understood as the aggregate result of multiple factors in operation within each of the series of systems that comprise a woman's contextual environment, or ecology. At the individual level, factors such as the victim's age, race or ethnicity, socioeconomic status, marital status, education level, preexisting health/mental health conditions, coping style, and lived experiences are considered influential. The second level of analysis within the ecological model takes into account characteristics of the assault itself: the victim-offender relationship, the violence of the attack, the severity of injury, the presence of threats to kill the victim, weapon use, and substance use or incapacitation at the time of the assault. Next is the microsystem level, which explores the impact of the social responses women receive when they disclose their assaults to members of their immediate social network.
Whether social support is provided or denied by close contacts is known to substantially influence a woman's post-assault health status (Campbell et al., 1999). The fourth level in the model combines the mesosystems and exosystems of Bronfenbrenner's (1979) ecological theory of human psychological development to analyze how women's interactions with formal systems and resources affect the assault experience. At this "meso/exosystem" level, interactions with the legal and medical systems represent potential sources of secondary victimization, while semi-formal support from rape crisis advocates is perceived as a means of mitigating the negative effects of other less victim-centered systems. Fifth is the macrosystem, at which level the authors consider the influence of the rape prone culture, taking into account such factors as the prevalence and weight granted to rape myths, stereotypical ontologizations of women, and male social dominance. The final level in the ecological model proposed by Campbell, Dworkin, & Cabral is the chronosystem. Here, the cumulative effects of a woman's experiences across her lifespan are examined, to determine how a history of sexual violence or abuse might affect a woman's experience of each successive assault. The chronosystem was integrated into the model specifically to address the role of revictimization on women's experience of individual assault events.

Within Campbell, Dworkin & Cabral's model, self-blame is cited as a particularly resonant element of processes occurring within every system of the social ecology. Because it functions at every level of the model rather than arising from any one level in particular, the authors conceptualize self-blame as a "multilevel meta-construct." At the individual level, self-blame is associated with PTSD and depression; at the micro and meso/exo levels, victim-blaming intensifies self-blame and in turn produces increased
mental health symptomatology; at the macrolevel, sociocultural ideas of women's role in provoking or deserving sexual violence are internalized and affect self-blame; at the chronosystem level, victims who have been multiply victimized have been found to experience heightened self-blame and higher levels of trauma. Although the authors do not mention it expressly in discussing their model, perhaps an additional salient meta-construct to examine in relation to the social responses sexual assault victims encounter seeking help in a patriarchal society would be misogyny. Self-blame is a prominent consequence of the misogynistic attitudes surrounding sexual violence and women's victimization, but it would seem that misogynistic beliefs beyond victim-blaming influence women's destructive internalizations and the social responses they receive from others following a sexual assault. Victim-blaming itself is a product of misogyny, and there are many others—the denigration of female sexuality, notions of sexual violation as irremediable defilement and disgrace, negativizations of female nature as weak and female character as conniving, the reduction of women to commodities for male use. By recognizing the primacy of misogyny in its myriad manifestations, it is possible to gain broader insight into the intricate and multivalenced complex of psychological sequelae associated with sexual assault, including diminished sense of self- and social worth, feelings of objectification, shame, and bodily disgust (Wasco, 2003). In a society where hatred for women as sexual objects is the standard, healing from sexual assault is bound to be the exception.

That sexually victimized women often have negative, potentially detrimental experiences in seeking help from the services and institutions officially in place to help them indicates a need not only to improve these services and institutions so that women’s
experiences become less negative, but also to open and broadcast new avenues by which women can receive the information and support they require in the aftermath of victimization.

IV. Information in Crisis & The Librarian's Imperative

A growing body of research in the field of library and information science suggests the important role libraries can play in providing meaningful assistance to vulnerable and disadvantaged members of their local communities. In the last fifteen years, studies have been conducted exploring how libraries can improve or institute services for immigrants (Jones, 2013), teenagers from low-income households (Adeyemon, 2009), individuals recently released from prison (Morris, 2013), minority and underserved populations (Overall, 2009), persons with disabilities (Playforth, 2004), the mentally ill, (Ford, 2002), and homeless LGBTQ youth (Shelton & Winklestein, 2014). As diverse as these populations are, each faces conflicts and challenges which set them at the margins of "mainstream" society, and all can benefit from the support which public libraries, as community information resource centers, are well-situated provide.

Since sexual assault victimization is inherently oppressive and often isolating due to the social stigma attached to sexual violence, women who have been sexually assaulted should be recognized as marginalized individuals and assisted accordingly. Unfortunately there has been extremely little research regarding sexually assaulted women in LIS. Indeed, only Wilmoth (2008) seems to have addressed sexual assault victims to any extent. There has however been significant research into a population whose situation in many aspects resembles that of sexual assault victims: women who are in, or have recently left, abusive relationships (Harris, 1988; Harris, et al., 2001; Dunne, 2002;
Westbrook, 2008; Westbrook, 2009; Westbrook & Gonzalez, 2011; Westbrook, 2012; Houston & Westbrook, 2013; Westbrook, 2015). The complex and deeply personal nature of the intimate partner violence (IPV) context yields a sensitive and pressing constellation of information concerns for women as they endeavor to protect themselves, secure law enforcement, legal, and medical assistance, and navigate the numerous abrupt life changes required to escape and move forward from an abusive relationship. The intricacy and gravity of these individual's needs presents librarians with an opportunity and imperative to develop effective modalities of targeted information support service for women in the IPV crisis context. Although the IPV and sexual assault are not twin phenomena, these two types of violence against women are nonetheless closely related, and in fact often interconnected as a result of the frequency of sexual assault within abusive intimate relationships. For this reason, research conducted into the information needs, processes, and concerns involved in the IPV crisis context, as well as how libraries can develop strategies to support individuals in crisis, offers many insights relevant to the "sister" context of sexual assault.

An invaluable contribution of the LIS research on victims of IPV is its emphasis on the need to understand the importance of specific contextual factors in influencing an individual's information interactions, in terms of her information needs and desires, her information-seeking approach, and her affective associations with various information sources, artifacts, and provisory methods. An IPV victim's overall context can be conceived as the gestalt of her broader sociocultural context, her personal situation (the nexus of biography, involved actors, and perspectives unique to the individual), and critical incidents (Westbrook, 2012). A critical incident is an event which provokes a
shift in the IPV situation, such as an escalation in abuse severity that pushes a woman toward seeking external support (Westbrook, 2012). In combination, these factors produce an infinite variety of singular crisis contexts. It is critical to remember that there are as many variations of the IPV context as there are victims: each woman's experience is uniquely her own, and this should be recognized and respected when endeavoring to offer information support (Westbrook, 2009; Westbrook, 2012). Assuming that IPV is a monolithic experience which each victim ought to respond to and navigate along one “appropriate” course limits one's ability to be genuinely supportive (Westbrook, 2015). Dunne's (2002) work provides further insight into the complexity of the IPV context by proposing the "person-in-progressive-situations" model, which focuses on the relationships among situations in which an individual experiencing IPV is apt to find herself. The personal crisis IPV represents for affected individuals is not static, but rather a process incorporating a number of potentially reiterative phases, each with its own associated needs, behaviors, and barriers (Dunne, 2002; Westbrook, 2009; Westbrook, 2015).

Westbrook identifies three progressive situations in the IPV context: 1) consideration of a life change; 2) criminal justice or shelter services engagement; and 3) planning to leave the shelter, or post-shelter life (Westbrook, 2009). These phases are not necessarily discrete, and each individual will move through them at her own pace, as her own constellation of sociocultural, personal-situational, and incidental factors indicates. Although it is invaluable to be aware of the progressive situations involved in the IPV crisis context when developing information support services, it is to acknowledge and respect each victim's progress, and not to assume or attempt to impose a linear trajectory
(Westbrook, 2015). The "person-in-progressive-situations" model reveals implications for those concerned with the information needs and processes associated with sexual assault. While the life changes associated with sexual assault may not be as extreme as in the case of IPV, and the progressive phases somewhat less distinct, sexual assault is nonetheless life-changing and the recovery process can encompass a wide variety of phases, depending on how the victim elects to proceed post-assault. It is therefore worthwhile to consider how the "person-in-progressive-situations" model might be applied to the experience of sexual assault.

Research also suggests that there is considerable overlap between the types of information sought and information providers contacted by victims of IPV and victims of sexual assault. In her detailed overview of the information needs of IPV victims, Westbrook (2015) identifies the many different needs that emerge in each of a victim's three progressive situations. I will not endeavor to list them all; however, a few salient examples of related needs include information pertaining to: working with the police, securing protection from assailants, medical care, legal concerns and justice system procedures. Each of these areas of need are likely to emerge in the context of sexual assault crises as well, indicating that public reference librarians should educate themselves about the commonly utilized support services in their communities and be prepared to assist patrons in crisis with accessing and utilizing these services, as well as evaluating and interpreting the information they provide. It is integral to know what victim services agencies are available in one's local community, and to coordinate information sharing with these agencies. In this way the library can serve as an "information hub" providing centralized support by integrating the information provided
a variety of disparate agencies into a comprehensible product, and by improving access to
resources and services relevant to women experiencing gendered violence, be it sexual
assault or IPV (Westbrook, 2011; Westbrook & Gonzalez, 2011).

A third major insight to be drawn from the research into the information needs
and behaviors of IPV victims is recognition that victims' information needs are not
merely material, but also affective. IPV, like sexual assault, represents a source of
distress and disruption in the lives of women who experience it. The asymmetrical power
dynamic between an IPV victim and her abuser, and the controlling, domineering, and
denigrating behaviors entailed in IPV abuse, function to undermine the victimized
individual's sense of personal control and self-efficacy (Dunne, 2002; Westbrook, 2009;
Westbrook, 2012). Interactions with police and other rigid, procedural community
support agencies can mirror the power dynamic experienced in the abusive relationship, a
continuation of the victimized individual's loss of control of her situation (Westbrook,
2012). Librarians developing support initiatives to assist women affected by IPV or
sexual assault should therefore make every effort to avoid any further appropriation of
victims' self-determination. Westbrook (2012; 2015) warns against relying on the
standard "medical model" approach in the IPV crisis context, wherein the librarian
diagnoses the problem, prescribes the "best" information, and then expects the patron to
use it and be "cured." Instead, the affective and experiential correlates of the IPV crisis
indicate taking an empowerment-centered approach, by adopting methods of provision
which work to improve the patron's self-confidence, sense of control and self-efficacy
(Wilmoth, 2008; Westbrook, 2015). This is also the approach recommended by the single
paper that has been published on the topic of information needs, behaviors, or services
related to sexual assault (Wilmoth, 2008). In an empowerment-centered approach, the assisting librarian would help the IPV- or sexual assault-experiencing individual to build her own information procurement and evaluation skills, and answer questions by providing options rather than advice. This approach is victim-centered, necessitating an acceptance on the part of the information support person that each woman is in her own place, has her own needs, and must make her own choices (Wilmoth, 2008). She should not be pushed nor prodded nor lured in any given direction, as "right" as that direction may seem from an external perspective. Instead, every opportunity should therefore be made to give the victim room to make her own decisions. By providing non-pressuring support and information that initiates and facilitates personal decision-making, librarians can play a role in empowering victimized individuals toward attaining a safer, healthier, and more positive life situation for themselves—at their own pace, on their own terms (Westbrook, 2015). This is as true in the context of sexual assault as it is in that of IPV.

Public librarians, as visible and accessible community information channels, have a daily opportunity to provide assistance to individuals in need. Because public libraries are community organizations open to everyone, people come into the library from a wide range of backgrounds and situations, with an infinite variety of questions, conflicts, and challenges. The public librarian should be prepared to help anyone who stands before the reference desk, no matter their backgrounds, their situations, their questions or challenges. The role of the public librarian is first and foremost one of public service, and we are doing the communities we serve a disservice if we are unprepared to assist with the most serious and challenging information concerns, if we do not take the initiative to develop responses to the most pervasive problems in our communities, and if
we do not reach out to their most vulnerable constituents (Westbrook, 2015). A commitment to serving marginalized and underprivileged groups is a central tenant of the librarian ethos, evident in service guidelines, professional organizations, ethics codes, library science scholarship, and professional education (Wray, 2009). Hence, the public librarian is compelled not only by an ethical responsibility to strategize ways of serving those most in need, but also a professional responsibility to continuously develop effective information resources and services to meet these individuals' needs (Westbrook & Gonzalez, 2011). In the case of women who have experienced IPV as well as sexual violence – a vulnerable population to be sure, marginalized as victims of a crime associated with tremendous social stigma, and on a more fundamental level as women within a patriarchal culture, who have felt the oppressive power of such a culture in its rawest iteration – such resources and services are needed. Fortunately, librarians are well equipped to provide the support that these women need. Public librarians have the training, the informational skills, and the ethical directives to make a real difference for these individuals in their time of need (Westbrook, 2009). As advocates, public librarians can offer "on-the-ground" aid to women who have been sexually victimized, drawing on the skills of the profession of librarianship to develop integrated information resources, and on the directives of public service to provide sensitive, constructive emotional support. Public librarians also have the opportunity, as a function of libraries' positioning as community centers, to foster community-level pro-social shifts in attitudes and action by addressing the pervasive, pernicious social problem of gendered violence, pursuing an active role in collaboration with other community agencies to advance as communities beyond the inequalities that are at the root of sexual assault, IPV, and the many other
violations of women's bodies and beings that are so common, and so destructive, within our society.

Because sexual violence against women occurs on a massive scale in the United States and around the world; because it is psychologically, physically, emotionally, socially devastating to those victimized; because sexual violence as a hate crime against women generates and perpetuates the patriarchal system of sex inequality through the social marginalization of women; because we live in a society where women who have been assaulted are not receiving the support they need to heal but instead face harrowing revictimization from the "support services" they turn to for help; because public librarians have the skills and professional ethical prerogative to support vulnerable and marginalized members of the community, there is significant evidence that the public library and its librarians have a role to play in assisting sexually victimized women and working to combat sexual violence. In order to determine the nature of that role more clearly, the study to follow aims to identify the information needs of women who have experienced sexual assault, to offer public librarians an understanding of the information they will be expected to provide in supporting victims. Drawing on the identified needs as a guide, this paper will then present a series of recommendations for sensitive, integrated, and victim-centered information provision services public librarians can institute to support victimized women and contribute to the exigent work of community-level sexual violence prevention.
Methods

To identify the information needs of women who have experienced sexual assault, a series of semi-structured interviews were conducted with a purposive sample of volunteer “companions” experienced in staffing Orange County Rape Crisis Center's (OCRCC) 24-Hour Help Line and supporting victims/survivors on location at the center. OCRCC companions offer over-the-phone as well as in-person informational and emotional support to victims/survivors of sexual violence and their loved ones. Given their extensive experience in assisting sexually assaulted women, companions are uniquely positioned to provide invaluable insights into the types of information women seek in the wake of an assault. To recruit participants, an email invitation to participate was delivered via a staff member at OCRCC to all companions active as volunteers for the organization. Three interviews were conducted for the purposes of this preliminary research, with each interview lasting approximately one half-hour’s duration. Interviews were held in locations chosen by the participants and varied from the OCRCC office to a local coffee shop. Each interview was audio-recorded, transcribed, and then analyzed for major patterns and themes. The transcribed interview content was then analyzed to identify themes through careful attention to recurrent statements, language, and ideas expressed by the interviewees. Each identified theme was assigned a specific color, with which all statements falling within that theme category were highlighted.

No information that could be used to identify any of the participants in this study was collected or recorded. Accordingly, the study was determined to be exempt by the
University of North Carolina – Chapel Hill’s Institutional Review Board on December 2, 2015.

A Note on Language

Throughout the Introduction and Literature review sections of this paper, women who have been subject to sexual violence are referred to as victims or victimized women. In the latter half of the paper, beginning in the Findings section, a new term appears: “victims/survivors.” This switch was made to accommodate the terminology used by the companions interviewed during the study, who preferred to use the word “survivor” over “victim” when referencing someone who had been sexually assaulted. This reflects a general shift away from the word “victim,” viewed as potentially disempowering to women who have been raped, assaulted, or otherwise sexually violated. The idea is that to call an assaulted woman a “victim” implies that it was a weakness or powerlessness on her part that made her vulnerable to the assault she endured. “Survivor” is seen as a more positive, empowering term, in that it suggests the woman’s strength in living through and moving beyond her assault experience.

As well-meaning as the shift from “victim” to “survivor” may be, from a political perspective it is problematic. A victim is someone who someone else has harmed (or killed) as a result of a crime, or who has been harmed in an accident or other event. Hence, in the case of sexual assault, the victim is the person who has been harmed, by the assaulter, as a result of the crime of sexual assault. To refer to a woman as a victim does not mean that she is innately weak and susceptible to violence due to some personal flaw. Rather, it suggests that she has been harmed, that someone harmed her, and that the injury she endured was a crime. To refer to her as a survivor – meaning, “a person who survives” – obscures the fact that someone harmed her and that the injury constituted a
crime against her person. It therefore neither sufficiently condemns the men who perpetrate rape and assault nor draws adequate attention to the social implications of sexual violence against women in a patriarchal society.

For that reason, while incorporating the term “survivor” into the language of the Findings section and onwards to reflect the terminology used by the Orange County Rape Crisis Center companions, the term “victim” was retained to emphasize that what happens to women when they are raped and assaulted is not like a natural disaster that one survives. It is a crime, committed against her by another person. Our language should not make the crime nor the criminal disappear.
Findings

A review of interviewees’ responses revealed four salient topic categories pertaining to the informational and support needs of sexually assaulted women:

• Types of questions asked by women calling the Help Line after an experience of sexual victimization;

• Types of information routinely provided by companions to women calling the Help Line;

• Informational resources and reference materials utilized by companions when responding to Help Line callers;

• The non-informational elements of extending support to victims/survivors of sexual violence.

Types of Questions Posed by Victims/Survivors

Each of the companions interviewed reported regularly receiving questions from victims/survivors of sexual violence about interacting with formal service institutions, such as law enforcement, the health care system, and the criminal justice system, in the wake of an assault experience. Questions related to reporting the sexual assault to the police seem to be the most prevalent. Interviewees explained that many women had questions regarding reporting because the process of making a sexual assault report in North Carolina is complex and confusing, involving three different levels of reporting: blind, anonymous, and full. Many women who have experienced sexual assault are reluctant to speak to the police at all, much less file a full report. One companion gave the following example of a typical sequence of reporting-related concerns:
A lot of people show a lot of concern over, if I want to make a report, or have an exam, or talk to a cop, does that mean that I have to disclose everything? Does that mean that my rapist will know? Because I don’t want to start any trouble or anything.

Another companion described many calls starting with victims/survivors asking about their reporting options, while the third companion stressed the importance of providing victims/survivors with “really good information” on the different reporting options and the reporting process in general.

Interacting with the police is anxiety-producing for many victims/survivors of sexual violence, and therefore a main topic of inquiry. One companion said that, in working with Help Line callers, she had observed that people in minority groups seemed particularly uneasy about speaking to the police, because members of these groups did not trust the police to provide them with protection. Questions about interacting with law enforcement revolved around what it would entail to meet with police officers initially, and the various forms of follow-up investigation that police might conduct.

Questions on going to the hospital for medical care or to undergo a sexual assault forensic exam, also known as a “rape kit,” for the collection of DNA and other forensic evidence, are also common. Victims/Survivors often ask where they can go to receive medical attention and what they can expect from the sexual assault forensic exam. Companions respond to these questions by walking callers step-by-step through the process of receiving medical care and undergoing the forensic exam:

…if they’re talking about the medical exam, we’ll discuss checking in to the emergency department, meeting with the nurse and how they do all the regular intake stuff, of checking your blood pressure and whatnot, then the different steps of the exam and then getting discharged from the hospital and follow-up with all of that.
Other questions posed by callers to the Help Line concern the process of pursuing legal action against their attackers. In this vein, women ask a variety of practical, procedural questions, such as: “do they need a lawyer, do they have to go to court, do they have to appear at every court hearing.” One companion described these types of questions as “logistical.” She explained that victims/survivors had a lot of questions about what they should expect in court, what to wear, and when and where to go. Like reporting crimes of sexual violence to the police, navigating the criminal justice system is a complex endeavor that is daunting to many women who have been assaulted.

Two of the three companions also mentioned victims’/survivors’ questions explicitly about sexual assault itself, most prominently: what is rape? Frequently, conversations with victims/survivors begin with questions regarding the legal definition of rape.

I’ll get people who call and they’re like, ‘this and this happened–was I raped?’ They’re just not even sure. There’s a really blurry line of did I give consent, was I raped. They want us to define [rape] for them so that they can better understand it. I think there’s a lot of misconception and misunderstanding about the whole concept.

Other victims/survivors express a desire to learn more about sexual assault in general. Some victims/survivors are especially interested in the prevalence of sexual violence, and want to know statistics, other research findings, or more information about the history of sexual violence.

Further types of questions cited by companions included inquiries about shelters and obtaining long-term medical help in dealing with health problems associated with the trauma of sexual violence.
Types of Information Provided

In speaking about the various types of information they most often provided to women calling the Help Line, all three companions mentioned therapy referrals and information about OCRCC’s own in-house support group programs. These referrals relate to the victim/survivor’s long-term post-assault healing process rather than the immediate crisis of a sexual attack. Two of the companions spoke of making referrals to local domestic violence resources and services, since in many cases sexual violence overlaps with other forms of abuse within relationships.

We make a lot of referrals to the Compass Center, (...) since we only do sexual assault, but a lot of time sexual assault is a component of abusive relationships, so we oftentimes refer people over to CC, because they can work a lot more with protection orders, and custody concerns and things like that.

On a similar note, one companion mentioned providing information on shelters for women seeking sanctuary from abusive partners, but lamented that “there are not a lot of shelters around here” to which she could refer Help Line callers.

Two companions reported regularly offering information on the subject of “rape myths”: misconceptions about sexual violence, its perpetrators and its victims, that prevalent in U.S. culture. Prominent among these myths are the notions that sexual assault is perpetrated by strangers, that physical force must be used for an attack to be an instance of sexual assault, and that the victim is at fault for the crime perpetrated against her, for being in the wrong place at the wrong time, for dressing “seductively,” or for trusting the wrong people. One companion noted that it was this final myth – of the victim’s responsibility for the assault – that she most hopes to “debunk” for the victims/survivors she assists.

Companions also spoke of the significance of offering information about the
experience of trauma, and of Rape Trauma Syndrome in specific. As one companion explained:

…we’re also trying to figure out a lot more questions about the subjective experience of trauma: what it’s like for them, personally, to go through trauma, is this normal and things like that. That’s a good opportunity to give information about flashbacks, and PTSD; there’s a subset of PTSD called “rape trauma syndrome,” so we can talk more about the physical and emotional impacts of that.

She also spoke of making a proactive effort to give victims/survivors as much concrete information as possible on the steps entailed in, as well as the possible consequences of, filing a police report. In her experience, victims’/survivors’ interactions with law enforcement had unexpected consequences for the victims/survivors themselves. Specifically, these interactions involved “more extensive follow-up” by the police than victims/survivors anticipated when they filed their reports.

People think they’ll just go in and tell their story, but then the police may contact them again for further info; the police will contact the perpetrator, and anyone else who has info about who was involved. I think people are not prepared for that side of it.

Thus, the companion understood it as her responsibility to make clear to victims/survivors the sequence of events likely to follow filing a report, as a means to reduce intensified anxiety brought about by unanticipated law enforcement actions.

Another companion described this type of proactive information provision as “giving [the survivor] every possible bit of information that they might need in order to make a decision and feel comfortable making that decision.”

Finally, companions briefly noted that they not infrequently made referrals to various other sexual-violence-specific and community-specific resources, including
RAINN (the Rape, Abuse, and Incest National Network), local Spanish-language services, and religious organizations.

**Useful Resource Materials and References**

At the beginning of their training, companions receive a reference manual intended to serve as their primary resource when responding to Help Line callers. This manual features information on how to report a sexual assault, the medical options available to victims/survivors, how to proceed through any legal actions, information about “sister” community organizations (e.g., domestic violence centers), the impact of sexual assault, and general facts about sexual violence and rape culture. One companion cited as particularly helpful the reference manual’s inclusion of conversation flow-charts and “quick guides,” which make it easy to “flip through when you’re on the phone with someone and find exactly what you’re looking for.” Another companion said that she was most grateful for the focus on the history of sexual violence within the context of “systems of oppression,” and on the meaning of oppression in U.S. society more broadly.

**Non-Informational Support**

More than simply providing the concrete facts, references and referrals helpful in minimizing victims/survivors’ confusion and anxiety following an assault experience, the role of companions at OCRCC is to serve as emotional support persons for victims/survivors who simply need to speak to someone who cares, and who will listen. Each of the three companions identified emotional support as the primary and most valuable service she performed as an advocate for victims/survivors of sexual violence. Although they did not disavow the importance of the information they provided, they considered it secondary. One companion explained that, while sometimes callers to the
Help Line had very specific questions and wanted specific information, more often they were calling with “a need for more general support” and validation.

Companions described emotional support as consisting of four essential elements: active listening, belief, validation, and empowerment. Active listening is considered the fundamental skill a companion must develop to support victims/survivors of sexual violence, and so a significant portion of the training OCRCC companions undergo focuses on building such skills. One companion reflected this emphasis when she averred, “Active listening is the best support that we can offer.” When victims/survivors call the Help Line, what they need more than anything else is “someone who is going to listen to them, and is not going to judge them.” To listen in a way that indicates engagement without judgement, so that the victim/survivor feels she is safe to be open, is the challenge of active listening. One companion explained it as a process of taking oneself out of the conversation, while still being present. She explained active listening as

…being able to be there, but not be important at all in the conversation. To be supportive, but to not really exist. So much of it is just making space for the survivor to kind of figure things out for themselves, and to feel what they need to be feeling, basically. So you’re really just making space and letting them not have to be alone in that space.

Another companion gave an alternative definition of active listening when she described it as “the act of giving people different words,” by listening carefully to what the victim/survivor is saying, identifying the underlying emotions, and then speaking those ideas and emotions back to the victim/survivor in a different way, to give them a different perspective on what they’re feeling and how they’re behaving. In this way, the support person acts as a “sounding board” to help the victim/survivor clarify her own understanding of what she has experienced and is experiencing following the trauma of
sexual violence.

The second component of emotional support mentioned by companions was belief. Given the culture of intense skepticism that surrounds women’s claims of sexual violence against them, expressing belief in women’s testimony is a powerful affirmation. As one companion stated, “Even just saying things like, ‘I believe you,’ is really important.” It is therefore a general rule of supporting victims/survivors of sexual violence to always believe, without questioning, the accounts they give of their experiences.

Closely related to belief is the support element of validation. If belief addresses the injurious cultural tendency of dismissing as unreliable women’s accounts of sexual assault experiences, then validation functions to counter the tendency to discredit women’s experiences themselves, to disqualify the hurt that women feel when they are attacked and minimize the impact of sexual trauma. Women are told to “get over it” and to “put it behind them” rather than encouraged to process their feelings and pursue what they sense as necessary for their recovery, be that counseling, criminal charges against their attacker, or the care of friends and family. One companion put a point on this when she said:

Maybe there is a lot of social pressure around [the survivor] that is telling them that their experience isn’t valid, or that it didn’t happen and they should just stuff it or not worry about it, forget about it and move on, and our role is to teach them that it is real and it is something that they should acknowledge in order to move forward in the healthiest way possible.

In other words, the companion supports the victim/survivor’s emotional health by helping her to accept that her emotions are real and by giving her the space to experience and process them as needed, instead of repressing them in accordance with the directives of a
culture which would hold sexually victimized women in silence.

The final aspect of emotional support discussed by companions is empowerment, or the effort to assist the victim/survivor in restoring a sense of self-determination over her body and her life. All three companions emphasized the importance of empowering victims/survivors in their work supporting callers to the Help Line. They spoke of how critical it is, when speaking to a victim/survivor, to never tell her what she should do, what the companion thinks would be best for her, or to give her advice to take any one course of another. A sexual assault experience represents a serious loss of control for the victim/survivor, who was at the time of the assault denied the right to make her own choices regarding body and sexuality. To advise a victim/survivor on what she should do following an assault, in one’s own opinion, is a further denial of her efficacy as an independent agent in the world. To be genuinely supportive, and restore to the victim/survivor her damaged sense of self-determination, it is necessary to give her the opportunity – to empower her – to make her own decisions. Empowering victims/survivors, then, is the process of carefully, without pressure or coercion, encouraging victims/survivors to reclaim their right to their bodies and lives, as one companion explained:

…we’re not there to tell [survivors] what to do, it’s this whole mode of shifting the conversation from our telling them what they should do, to giving them autonomy again: this is your body, this is what happened to you, so you get to decide… By the end of the conversation, hopefully [the survivor] feels that their body belongs to them, and this is their decision, not the center’s.

Companions do not advise victim/survivors of sexual violence on what to do after being sexually assaulted. Instead, to empower the women they assist to make their own decisions, it is the responsibility of companions to supply their clients with as much
information as possible to inspire in them a sense of competence and confidence as decision-makers and moral agents, assured that they are making the best choice for them given the full range of options their companion has presented.
Discussion

To apply the nascent understanding of sexually assaulted women’s information needs gained in conversation with OCRCC companions, five initial recommendations will be proposed for actions that public libraries might take, and services or programs that public libraries might institute, to assist victims/survivors and combat sexual violence against women within their communities. These recommendations do not represent the entirety of possible programs, services, and strategies by which public libraries might address the pervasive problem of sexual violence against women; there are no doubt a multitude of different approaches to be imagined and implemented. What is outlined below should be considered only a skeleton from which to build, a nascent view of the shape our efforts might take.

Recommendation 1: Connect & Collaborate

A critical first step that we can take as public librarians to improve public service in any area, as well as our overall public value as community centers, is to actively pursue and strengthen relationships with other community agencies (Willingham, 2008). It is a truism that in order to maximize local resources, collaboration is essential. Collaboration also fosters creative problem-solving and increased visibility around the subject of concern. With regards to the problem of sexual violence against women, it is imperative that public libraries initiate contact with their local rape crisis center, if such exists. Although there are many rape crisis and sexual assault response service organizations across the United States, they are by no means ubiquitous, so it is possible
that there may be no such center nearby with which the library might partner. Another possibility is that the “local” center could be several counties away from the public library. In these cases, distance should not dissuade proactive librarians from reaching out. While the relationship established may involve less direct collaboration, even at a distance the connection is likely to be valuable for all involved: the public library, the rape crisis center, and the victims/survivors themselves.

One obvious benefit of partnerships between public libraries and rape crisis centers is that the libraries could work to promote the services offered by these centers, so that more women would be made aware of the availability of these services and take advantage of them. Librarians leading social outreach projects could also work with these centers to develop targeted reference services and additional programs to support victimized women within the library itself. The rape crisis centers could materially benefit from partnering with the public library by using the library as a place to hold meetings, classes, and other such events. One companion interviewed in this study expressly mentioned how helpful access to library space would be to organizations like OCRCC, which are grant- and donor-funded and tend to have limited office space for their events. Collaboration between public libraries and rape crisis centers could also result in enhanced informative materials, as librarians could apply their professional skills to create easy-to-understand guides to subjects such as reporting sexual violence to the police, cited by all three companions as a point of substantial confusion among victims/survivors of rape and assault.

In addition to partnering with rape crisis centers, public libraries could engage in
relationships with members of the Sexual Assault Response Team (SART), such as law enforcement, forensic units at local hospitals, and concerned individuals in the district attorney’s office. The library could even take initiative in involving itself in the SART, as an information resource for victims/survivors of sexual violence and community institution active in violence prevention. As suggested by Westbrook & Gonzalez (2011), librarians could also contribute by coordinating effective and efficient sharing of information across the various agencies, to support these agencies so that they can be of greater help to the victims/survivors who seek their assistance.

Recommendation 2: Trainings for Library Staff On Sexual Violence Against Women, Active Listening, & Empowerment Counseling

Before library staff can provide meaningful service to victims/survivors of sexual violence, they must first understand the basic nature of the problem of sexual violence against women in our society. To this effect, introductory trainings on rape culture and how sexual violence against women sustains sexual inequality are recommended. That one companion interviewed in this study specifically mentioned the importance of learning about sexual violence within the context of “systems of oppression” in the United States during her training with OCRCC in changing her perspective and informing her interactions with victims/survivors stands to support this recommendation. These trainings could also serve to undermine in the minds of library staff the common but damaging “rape myths” referenced by all three companions, e.g. that the victim is always somehow to blame for the violence perpetrated against her. Although we like to think of librarians as exceptionally caring and acute individuals, none are untouched by the influence of the culture in which we live. Because rape myths shape the dominant understanding(s) of rape in our culture it therefore cannot be assumed that library
professionals have not internalized their messages to some extent.

Second, library staff need to understand how to competently, compassionately navigate conversations about sexual violence with women who approach the desk with related reference questions. To equip library staff with the skills necessary to provide informationally and emotionally supportive service to victims/survivors, public libraries should provide training workshops on active listening and empowerment counseling, the two support strategies highlighted in the findings of this study.

Both categories of trainings could be led by staff or volunteer advocates from local rape crisis centers. This is yet one more reason why developing relationships with such organizations is so important if public libraries are to create programs and services related to sexual violence victimization and prevention.

**Recommendation 3: Make Literature on Sexual Assault Available & Visible**

A simple way for public libraries to demonstrate support for victims/survivors while simultaneously spotlighting men’s sexual violence against women as a subject of community concern would be to acquire – or create – pamphlets and other materials about the resources available to victims/survivors of sexual assault, how to report, the seriousness of the problem of sexual violence against women in the United States, and tips for how friends and family can support victimized loved ones. These materials might be obtained from local rape crisis centers or, as mentioned above, created in-house by library staff, who should be familiarized with all of the resources and services outlined in the literature. It is necessary that staff be made aware of the content of these materials, or at least have copies available behind the reference and circulation desks, so that they can effectively respond to questions posed by victims/survivors. It is critical that these
materials be readily accessible elsewhere as well, so that victims/survivors can find them on their own if they are anxious about disclosing their victimization to library staff. As one companion explained, “a lot of people don’t want to have to ask for help, so it’s helpful to just have [the information] visible, so they can do it on their own and not have to involve other people.” Making the literature readily accessible will also have the effect of drawing violence against women to the surface of community consciousness, making it a part of the conversation rather than a concealed epidemic, to be suffered in silence and private shame.

Public librarians might also turn their attention to building stronger collections on the subjects of sexual violence, rape, and assault, women’s accounts of sexual trauma and healing from victimization. One companion stated that many victims/survivors are interested in reading these types of books, of which the OCRCC has its own lending library. Since not all rape crisis centers are likely to have their own libraries, public libraries have the opportunity to fulfill this need through targeted collection development. Librarians might even work with rape crisis centers to create topical reading lists for interested victims/survivors. Works on these lists would then be purchased for library collections, if not already included.

A third suggestion along this vein would be the placement of signage or business cards in the library’s restrooms with information about local rape crisis centers, victim advocacy organizations, or hotline numbers. These signs/posters could also indicate that librarians were available to help connect individuals to relevant resources and services, though obviously only if the library staff were trained in providing this specialized reference service.
Recommendation 4: Public Classes on Supporting Victims/Survivors and Preventing Violence

Based on the discussions with companions conducted during this study, it is evident that a need exists for increased public awareness about the services and resources available to victims/survivors of sexual violence, so that they themselves can obtain assistance, or be directed toward such assistance by people within their social networks, e.g., friends and family members. It is equally important that the community at large be informed on the nature of sexual violence against women, and how to be supportive to victims/survivors, so that more women have more – and more effective – support persons within their social networks. To this end, public libraries could hold classes to teach people about community and online resources for victims/survivors of sexual violence, the realities of rape as a counter to dominant “rape myths,” and “best practice” techniques for extending support to victims/survivors, including believing, active listening, and the empowerment counseling approach. One companion also mentioned holding classes on healthy sexuality and rape culture for young adults. Ideally these classes would be led by educators from rape crisis centers, but the more resource-oriented programs could certainly be conducted by library staff.

As with the third recommendation above, for a public library to hold classes and programs on the subject of sexual violence would have the important secondary benefit of bringing this problem to the fore of community consciousness as one to be addressed in the interest of progress toward a more just, equalitarian, and peaceful society.

Recommendation 5: Publicly Establish the Library’s Role in Supporting Victims/Survivors and Combatting Rape Culture

For the public library’s commitment to ending sexual violence against women to serve as intended and shift public consciousness toward a recognition of the seriousness
of this social and public health problem it is necessary for that commitment to be
broadcasted in no uncertain terms. Silent, unstated opposition to sexual violence cannot
create social change toward its termination. Rather, the library’s affiliation with rape
crisis centers and other community agencies working to combat rape culture must be
common knowledge. Some ideas for announcing the library’s position on men’s violence
against women include placing posters promoting the rape crisis center’s services on
community bulletin boards in the library, organizing the types of classes and public
conversations discussed in Recommendation 4, and collaborating with rape crisis centers
and other organizations on community outreach events related to sexual violence
prevention. Because people tend to trust their public libraries and feel positively about
libraries as social spaces, these simple measures on the part of library staff to put a
spotlight on the activities of existing community organizations working against sexual
violence could do much to direct public attention toward sexual violence against women
as a social problem demanding remedy.

**Recommended Further Research**

Library professionals eager to move forward in developing public library services
and programs related to sexual violence against women would be apt to benefit from
further research into the current status of sexual violence as a concern being addressed –
or not – in public libraries. Of particular value would be to survey public librarians
regarding their own understanding of sexual violence against women as a social
phenomenon, their knowledge of community resources serving victims/survivors of
sexual violence, the prevalence of rape in their communities, their own attitudes toward
sexual violence, as well as whether or not they had taken any steps in the past, in their
professional capacity as librarians, toward confronting the issue. Gathering data on public librarians’ understanding, knowledge, and attitudes about sexual violence could assist in determining the extent to which public librarians are already thinking about sexual violence as an issue for the library to confront, what steps librarians have already taken to support victims/survivors, and how public librarians might best be galvanized to participate in the work of sexual violence prevention.

Limitations

Several factors may have limited this study’s capacity to thoroughly explore the subject of female sexual violence victims’/survivors’ information needs. Most notably, the fact that only three interviews were conducted to complete the study has obvious negative implications for its comprehensiveness. A second notable limitation is that all three of the participants in this study were associated with the same rape crisis center, and therefore underwent the same training, were instilled with the same philosophy of service, and so are likely to have similar perspectives on the types of information and support most valuable to sexually victimized women. A related factor further narrowing the perspective of this study is that all of the interviewees were based out of the same geographic area: Chapel Hill, North Carolina. To correct for these issues – as well as to improve the study overall – the sample population could be expanded to include victim advocates from multiple different rape crisis centers and organizations, located in different areas in the United States, who would have been exposed to a variety of different training strategies and approaches and worked with more varied demographic populations. An additional expansion, to be undertaken only with greatest care, would be to conduct interviews with women who have experienced sexual violence about the
information they found most useful and the types of support most meaningful to them following their victimization. The inclusion of victims’/survivors’ perspectives would be invaluable in the furtherance of this research.

Another limitation that may have influenced the results of this study is the bias of the researcher herself. As a feminist activist and advocate for raped and sexually assaulted women, she came into this research with deeply held beliefs about sexual violence against women, its causes and consequences, and what might be done to end it. There is little doubt that these convictions bled into her work in each phase of the study.
Conclusion

Sexual violence against women, in the form of rape, non-penetrative sexual assault, abuse and harassment, is a sociopolitical and public health crisis affecting the lives of millions of women in the United States and untold millions more around the world. The consequences are grave, both for individual victims of this violence and for women collectively, as the social group targeted for attack. Men are the primary perpetrators of this violence (Breiding et al., 2014). For individual women, the physical, psychical, and emotional health impacts of rape and sexual assault can be severe. As a social phenomenon, the high rates of sexual violence against women, in combination with the severity of the detriments to well-being suffered by those who are victimized, represents a major force in the production and perpetuation of sex-based social inequality and the marginalization of women. The sexual violence many women experience is traumatic and can be disabling in the long-term, such that it undermines women in their ability to lead healthy, fulfilling lives. The sexual violence that men perpetrate against women holds women in terror and bondage, limiting women’s capacity to move freely through the world. Because sexual violence touches the lives of so many women, it undermines and limits women in general, as a social group. As Sheffield (2007) writes, these effects are not coincidental; indeed, they are the underlying purpose of men’s sexual violence against women, which she has termed “sexual terrorism.” Sexual terrorism’s purpose, as a strategy of social control implemented by men within a male-dominated society, is to maintain male power over women’s lives.
Endemic sexual violence against women is therefore antithetical to free and equal human society. If we aspire to live within such a society, we all must join the movement to end sexual violence and the sex-based social inequality it bolsters.

The goal of the current study is to begin imagining ways that public libraries and library professionals might become more active in this movement. At the outset, the purpose was to identify the information needs of female victims/survivors of sexual violence, to lay the foundation for a series of recommendations for measures that public libraries could take to provide informational support to these women within their communities. In addition to supporting women, an underlying goal was to find means of leveraging the privileged position of the library as a trusted social institution to raise public consciousness at the community level around the problem of sexual violence against women. To complete the study, interviews were conducted with three “companions,” or victim advocates, responsible for answering calls to the Orange County Rape Crisis Center’s 24-Hour Help Line. Since these companions routinely speak to sexually victimized women in need of support, they were knowledgeable about the types of information and assistance these women often seek. Over the course of the interviews, several areas of information need significant for sexually victimized women became clear. The companions stressed victims’/survivors’ need for high quality information pertaining to the processes of reporting an assault to the police, of undergoing a sexual assault forensic exam, and pursuing legal action against their assailants. Other common questions sought clarification on what actions constituted rape and information about sexual violence as a social problem. Companions also discussed the types of information that they regularly provided to Help Line callers, such as referral information to
therapists, support groups, and other support services, as well as information about rape trauma syndrome, the sub-type of PTSD associated with sexual violence. Also oft-mentioned was the subject of “rape myths,” or popular cultural misconceptions about rape. Companions expressed their wish to debunk these myths when they arose in conversation with victims/survivors. Finally, companions expressed their sense that, although the informational support they extended to victims/survivors was critical, the primary and most valuable service they performed was the provision of emotional support. They described emotional support as comprised of four elements: active listening, belief, validation, and empowerment. In practice, these four elements equate to listening attentively to victims/survivors without questioning whether or not their disclosures are factual, while confirming that their thoughts and feelings are valid and encouraging them to make their own decisions about what steps to take in the aftermath of a sexual assault experience.

Based on the findings on sexually assaulted women’s information needs gathered through the interviews, five recommendations were developed as possible actions public libraries might initiate to reach out to victims/survivors of assault within the communities they serve. These recommendations aimed to be simple, inexpensive strategies for incorporating services specifically designed to assist sexually assaulted women in the community as well as addressing sexual violence itself as a community problem. First, it is recommended that public libraries cultivate partnerships with local organizations such as rape crisis centers and Sexual Assault Response Teams (SART’s), where available, in order to collaborate on programs and the development and dissemination of information materials. Second, public libraries are advised to train library staff on sexual violence, its
pervasiveness and its consequences, relevant local services and resources, and the various support techniques outlined by companions, such as active listening and empowerment.

Public libraries might additionally consider making literature (e.g., pamphlets, fact sheets) related to sexual violence against women available in visible locations around the library, so that women could access the information without having to risk disclosure through speaking to library staff. Of course, librarians should also have these materials on hand and be trained in providing the information within to inquiring patrons. Developing quality collections of sexual-violence-related materials is also advised. A fourth recommendation would be to host classes within the library on such topics as resources for victims/survivors, how to be supportive as the friend or family member of a victim/survivor, and sexual violence prevention. Finally, public librarians should strive to make the library’s commitment to intervening against endemic sexual violence against women common knowledge. In this way, libraries can be established as community leaders in the movement to end sexual violence.

Public libraries are in an ideal position to take a leading role in this critical effort within the communities they serve. In the public perspective, libraries are among the most trusted of all community institutions, indicating an indispensable opportunity to galvanize public consciousness on the issue of sexual violence against women and catalyze public action to confront it as a social problem (Willingham, 2008). Librarians are also uniquely well-suited to provide substantive informational support to victims/survivors of sexual violence, who often require assistance in navigating the criminal justice system following an assault and in seeking medical care or therapy, and for whom receiving non-judgmental, sensitive social support is key in the healing
process. Through extending support to victims/survivors of sexual violence, and making visible the library’s stance against sexual violence, public libraries can counteract the trauma of sexual assault for individual women while simultaneously serving as community-level agents of change in the project of social transformation, to create communities that support rather than shame women who have been victimized, to destabilize patriarchy and to eradicate sexual violence as a commonplace experience among women. Men’s sexual violence against women is pervasive in the United States; hence, it is a problem in every community and since public libraries are in a position to address it, it is imperative that we not shy from the leadership role available to us. Ultimately, the librarian’s imperative is quite simple: if we can help, we should; having determined that we can, is it not our obligation to do so? We owe it to our communities to commit our resources to recreating them as spaces free of violence and oppression, just as we owe it to each and every woman to work for a world where she can lead a life free from terror and assault.
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