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The human right to mental healthcare

-Bridging the rights-gap for women subjected to sexual violence

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Abstract

Sexual violence against women is not only a serious public health problem of epidemic proportions, it's also a violation of women's human rights. The devastating consequences of these events on women's health have been widely documented. The overarching purpose of this thesis is therefore to explore why public healthcare facilities around the world often fail to provide victims of sexual violence with mental healthcare of good quality that is available, accessible and acceptable. In order to investigate this, the legal grounds of specialized healthcare for victims of sexual violence was documented. Secondly, an exploration of whether the Swedish healthcare system provides victims of sexual violence with access to the highest attainable standard of mental healthcare was carried out. Lastly, the history of violence against women was explored in order to identify reasons for why the right to mental healthcare often fail to work in practice for female victims of sexual violence despite apparent agreements. Also, constructive suggestions are put forth regarding what governments can do to provide victims of sexual violence with access to the highest attainable standard of mental healthcare. An interdisciplinary approach of political sociology was used to illustrate the multiple dimensions of human rights. The findings suggest that the right to mental health is an integrated part of the right to health and thus a fundamental right for all human beings. However, the results indicate that the right to mental healthcare for women who have been subjected to sexual violence is not available, accessible and of good quality within the Swedish healthcare system. The study concludes that one of the main barriers to make the right to mental healthcare accessible for this group of patients is the lack of an officially recognized name that include the many different syndromes these women suffer. Findings are discussed in relation to previous research.

Keywords: Sexual violence against women, The right to the highest attainable standard of mental health, Mental Healthcare of good quality that is Available, Accessible and Acceptable. Sweden

Equality, in contrast to all that is involved in mere existence, is not given to us, but is the result of human organization insofar as it is guided by the principle of justice. We are not born equal; we become equal as members of a group on the strength of our decision to guarantee ourselves mutually equal rights

(Arendt 1979: 301)

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1. Introduction

The right to the highest attainable standard of health is one of the fundamental rights of every human being and is crucial in our understanding of living a life with dignity. The right to health includes both freedoms, including the right to be free from interference and discrimination, and entitlements, such as "the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health."[1] The World Health Organization (WHO) defines health in the preamble to their Constitution as: "A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[2] A vital implication of WHO's definition of health is that mental health is an essential component of health, and that mental health is more than the absence of disabilities or mental disorders. The WHO defines mental health as "A state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community."[3] The specific reference to mental health as a target within the United Nation's Sustainable Development Goals (Goal 3, target 3.4) represents a transformative vision: a vision highlighting the inherent right of every person to mental health. Mental health is essential for a human being's individual and collective ability to think, interact with others, enjoy life and to earn a living. Mental healthcare can improve the general health, facilitate socioeconomic development and create a more equitable world. Therefore, the promotion, protection and restoration of mental health is of vital importance and concern for both individuals and societies all over the world.[4]

Despite the growing recognition that mental health is a human right, translating this knowledge into practice has been slow. People across the globe living with mental conditions have been left behind when it comes to the fulfillment of their human rights and equal access to life opportunities and health services. The quality of mental health services is generally inferior to the quality of physical health services (Patel et al., 2018: 1553). Few countries allocate sufficient funds to mental health (Hunt & Mesquita, 2006: 332). Worldwide, investments to develop mental health services are still extremely insufficient. The inability to take this global health crisis seriously results in great human

[1] UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), 11 August 2000, E/C.12/2000/4, available at: https://www.refworld.org/docid/4538838d0.html (Accessed 2019-03-07)
[2] World Health Organization, 2006, Paragraph 1 of the constitution. Available at: https://www.who.int/governance/eb/who_constitution_en.pdf (Accessed 2019-03-07)
[3] World Health Organization, 2019, Mental Health: Strengthening our response. Available at: https://www.who.int/en/news-room/fact-sheets/detail/mental-health-strengthening-our-response (Accessed March 19, 2019).
[4] World Health Organization, 2019, Mental Health: Strengthening our response.

suffering. Poor mental health causes other problems, such as stigmatization and discrimination, which is a fundamental part of the right to health itself. Mental health needs to be considered as a human right itself firstly because there is no health without mental health,[5] and secondly because people living with mental health conditions are a vulnerable group with increased risk of having their human rights abused or ignored (Patel et al., 2018: 1570).

The present paper will discuss the right to mental health in relation to sexual violence against women.[6] Sexual violence against women is a serious violation of women's human rights with both short- and long-term consequences on women's physical and mental health.[7] Nationwide investigations have documented the widespread prevalence of sexual violence against women as well as the devastating consequences of these events. The WHO states that "Violence against women is not a small problem that only occurs in some pockets of society, but rather is a global public health problem of epidemic proportions, requiring urgent action."[8] Furthermore, the WHO makes a specific statement regarding the link between sexual violence and poor mental health, stating that: "Multiple social, psychological, and biological factors determine the level of mental health of a person at any point of time. For example, violence and persistent socio-economic pressures are recognized risks to mental health. The clearest evidence is associated with sexual violence."[9] Still, the modern health care approach, which has provided new evidence on the significance of mental health services for victims of sexual violence, still faces huge challenges.

Psychiatrist Bessel Van der Kolk has spent his career studying trauma treatment and argues in his book *The Body Keeps the Score* that trauma is one of the most urgent public health issues of the West. Generally, however, knowledge of the psychological trauma victims of sexual violence suffer from is not widespread. This results in difficulties for victims of sexual violence to access appropriate treatment (Van der Kolk, 2015: 136). Victims of sexual violence need specialized psychological care to overcome the trauma and to start the process of rebuilding their lives. Research has shown the benefit of providing this care, as part of an effort to heal both body and mind (see for example Herman, 2015; Van der Kolk, 2014). Still, this trauma is often hidden within

[5] The Office of the High Commissioner for Human Rights (OHCHR), The right to mental health. Available at: https://www.ohchr.org/EN/Issues/Health/Pages/RightToMentalHealth.aspx. (Accessed 2019-03-03)
[6] The present paper focuses on the right to mental healthcare. However, it is important to highlight that mental and physical healthcare is fundamentally integrated. Healthcare professionals know that there are multiple links between poor mental health and chronic physical conditions. A growing number of studies shows that sexual violence can have long-term effects on the victims physical health. For example, fibromyalgia, chronic abdominal pain, chronic pelvic pain and auto immune diseases (Van Der Kolk, 2014; Öberg et al., 2010: 14).
[7] World Health Organization, 2019, Sexual Violence. Available at: https://www.who.int/reproductivehealth/topics/violence/sexual_violence/en/. (Accessed 2019-03-19)
[8] World Health Organization, 2013, Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non –partner sexual violence, Geneve, p 3.
[9] World Health Organization, 2019, Mental Health: Strengthening our response.

the context of the healthcare system. Thus, large groups of individuals are left without access to mental healthcare of good quality that is available, accessible and acceptable. This can have devastating consequences for the individual, their families and for future generations. Considering the extent of sexual violence against women and the link between sexual violence and poor mental health, there is an urgent need to further investigate this issue through a human rights lens.

Sweden claim to have a feminist government and has come a long way in improving women's rights. How come victims of sexual violence face difficulties to access mental healthcare of good quality that is available, accessible and acceptable in Sweden? Why is this question not discussed and talked about in public? *Why* is this matter hidden and buried in silence?

Aim and Research Questions

The right to the highest attainable standard of health is the foundation of an effective health system. In order to establish effective health systems, features of the highest attainable standard of health need to be identified. Further investigating the right to mental health care for women who have been subjected to sexual violence is vital in order to increase our knowledge about this issue and to attain improvements. In order to provide victims of sexual violence with access to the highest attainable standard of mental health, exploring the reasons as to why this issue has been hidden within the context of public healthcare systems is essential.

The overarching purpose of this study is therefore to explore why public healthcare facilities around the world often fail to provide victims of sexual violence with mental healthcare of good quality that is available, accessible and acceptable. In order to investigate this further, I will draw on research from different disciplines including human rights law and the medical field. To understand the consequences of human rights law, I will first document the legal grounds of mental healthcare for victims of sexual violence. I will then investigate if the Swedish healthcare system provides victims of sexual violence with access to the highest attainable standard of mental health. To grasp the practical challenges of implementing such healthcare, I will draw on research from the field of medicine and psychology.

The following research questions, therefore, guide this study:

- *How is the right to mental healthcare for women who have been subjected to sexual violence regulated within international law?*
- *Does the Swedish healthcare system provide victims of sexual violence with access to the highest attainable standard of mental health?*
- *How should the Swedish government provide victims of sexual violence with access to the highest attainable standard of mental health?*

2. Methodological approach

This chapter explains how the present study was conducted, which material that has been used as well as weaknesses and strengths of this study.

2.1 The Political Sociology of Human Rights

To illuminate the aim and purpose of this paper, an interdisciplinary approach of political sociology will be used. This in order to examine the political and social consequences (and lack of consequences) of human rights law. In order to grasp the interplay between law and psychology/medicine in regards to the right to mental healthcare for female sexual violence victims, I found it helpful to use an interdisciplinary approach.

The book *The Political Sociology of Human Rights* written by professor Kate Nash was used in this thesis to address the study of human rights from a sociological perspective. Kate Nash argues that it is crucial to study structures (e.g. gender) and organizations (e.g. non-governmental organizations, corporations, states) in order to understand the possibilities as well as the limitations of human rights today. Whether human rights have the ability to transform or alter structures that underpin injustices depends on how we study and conceptualize structures. Nash argues that structures are open to both gradual alteration and radical transformation (2015: 12). According to Nash, constructions are maintained by 'social constructions of reality' and can therefore be 'restructured' (Nash, 2015: 12). The political sociology of human rights includes challenging and remaking common sense understandings and structures to include those people who are currently marginalized or ignored (Nash, 2015: 13). The value of sociology in understanding human rights lies in mapping the multiple dimensions and the complexities of the human rights field (Nash, 2015).

This thesis explores the right to mental healthcare for victims of sexual violence by placing sexual violence towards women in a broader social and political context. By using the interdisciplinary approach of political sociology, the limited effects of human rights law will be explored in order to highlight the importance of politics addressing those structures that deprive people of their rights and of living their lives with dignity. Highlighting the interplay between politics and human rights is a way to demonstrate how the realization of human rights is dependent on political will, in this case a recognition in order to get accessibility in practice. To highlight injustices and theories as to why certain rights are not accessible to right bearers is vital, in order for States and other duty-bearers to develop and implement strategies to protect vulnerable groups. Therefore, the

sociological perspective highlights that we need to question existing structures that are considered normal in order to illuminate the underlying social structures that produce or enforce them.

Problems with understanding sexual violence as a human rights issue will be explored by discussing gender-biased social structures that uphold the dichotomy between the private sphere of women and public sphere of men. It is of vital importance to highlight gender structures in every-day life in order to change lasting, structural problems (Nash 2015: 131).

2.2 Material

Why does the right to mental health care for victims of sexual violence often fail to work despite signed and ratified agreements? Stedman (2013) argues that increased attention to the gap between de jure and de facto human rights protections is one of the key mechanisms to promote women's right and to ensure State accountability to adhere to human rights standards. Raising the many factors involved in this issue is crucial in order to understand the possibilities as well as the limitations of human rights law.

In order to explore the relation between theory and practice regarding the right to mental healthcare for victims of sexual violence, the first research question to be answered is how is the right to mental healthcare for women who have been subjected to sexual violence regulated within international law? In order to map the mental healthcare framework for women who have been subjected to sexual violence, the first part of the paper will use a legal research approach and a documentation of international treaties, conventions and general comments. The right to health is explored by looking at the International Covenant on Economic, Social, and Cultural Rights and General Comment no. 14 of the Committee on Economic, Social and Cultural Rights.
Women's right to health is documented by looking at the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and General Comment no. 24 of the CEDAW.
Women's right to health is documented by looking at the Convention on the Elimination of All Forms of Discrimination against Women, and General Comment no. 24 of the Committee on the Elimination of Discrimination against Women.

To answer the second research question does the Swedish healthcare system provide victims of sexual violence with access to the highest attainable standard of mental health, reports from The National Association Against Incest and Other Sexual Abuse (RISE) were used as material to map which regions in Sweden offer specialized psychological care for victims seeking help for the consequences of sexual violence. Also, statistics from Swedish non-profit organization World of No

Sexual Abuse (Wonsa) that offers specialist care for psychological trauma after sexual abuse were used to illustrate the experiences of victims of sexual violence with the Swedish Healthcare system. Information regarding access to mental healthcare within the Primary Healthcare System for victims of sexual violence was retrieved from the Södersjukhuset (SÖS) website as well as from an online interview with Dr Anna Möller, chief physician at SÖS. This was related to The Group of Experts on Action against Violence against Women and Domestic Violence (GREVIO) Evaluation Report on Sweden from 2019. I also looked at observations from 2006 made by the United Nations Special Rapporteur on the highest attainable standard of health, in a visit to Sweden, and by the UN Special Rapporteur on violence against women, its causes and consequences, also from a visit to Sweden in 2006. I will critically evaluate these different answers in relation to the right to mental healthcare framework, documented in the first part of the thesis.

The third research question under investigation how should government provide victims of sexual violence with access to the highest attainable standard of mental health will be answered by presenting possible solutions to the identified rights-gap. I will draw on current research from the field of trauma research and psychology in order to identify possible ways of addressing this implementation gap. Judith Hermans book Trauma and Recovery will be used to understand the history of the study of psychological trauma and violence against women. Existing diagnostic concepts will be documented and questioned by the use of Hermans' work on psychological trauma as well as Bessel Van der Kolk's book The Body Keeps the Score, highlighting challenges in the interplay between the human rights field and the medical field. Placing this issue in a social and political framework is part of the solution towards bridging the rights-gap for victims of sexual violence.
I will also draw on research from Professor Nora Sveaass' work with human rights violations, rehabilitation and treatment of victims of torture and other serious human rights abuse. The link between the judicial and the medical field will be explored in relation to the question of how governments should provide victims of sexual violence with access to the highest attainable standard of mental health.

2.3 Limitations of the study

A difficulty in conducting this study was to comprehend the vast literature of this subject. Sweden is used to explore whether the right to mental healthcare is implemented and accessible in practice in the Swedish healthcare system for victims of sexual violence. Therefore, only a limited part of the world is represented in this thesis. Healthcare and rehabilitation services vary from country to country depending on factors such as the social and political context, funding and the existing

public health infrastructure. It is important to acknowledge that the situation for women around the world differs greatly. In many parts of the world, victims of sexual violence become excluded from society as a whole, and are living under life-threatening conditions without access to any rights or protections.

Further to this, I want to highlight that the exploration of the history of sexual violence against women in this thesis gives a Western perspective in regards to this subject.

2.4 Scope of the study

While sexual violence can be directed against both women and men, the focus of this paper will be on sexual violence against women. Violence against women is a typical example of systematic violence that has been known but overlooked by State officials all over the world, because not much has been done to sanction or prevent it (Sveaass, 2008: 321).

This section has described how the present study has been carried out, what material has been used and present its limitations. The next part of this thesis will describe two theoretical lenses that will be used to answer the research questions that guide this thesis.

3. Theoretical Framework

In order to investigate why public health-care facilities around the world often fail to provide victims of sexual violence with mental healthcare of good quality that is available, accessible and acceptable, this chapter provides two interrelated theoretical perspectives. By using these theories, I will be able to examine the right to mental health care framework for women who have been subjected to sexual violence from different lenses (from a human rights/political perspective, and from a psychological/medical perspective).

3.1 The social and political aspect of human rights

The book *Trauma and Recovery* written by Dr. Judith Herman will be used as a theoretical framework for the present paper. The following is a short summary of her findings regarding this subject.

The book gives an overview of different types of trauma from sexual abuse, domestic violence and military combat. The book describes a turning point after the Vietnam War, when a group of Vietnam veterans lobbied the American Psychiatric Association to develop the diagnosis Post Traumatic Stress Disorder (PTSD). The diagnosis identified and grouped together the many symptoms that were common among the veterans, giving a name to their suffering. With the new diagnosis of PTSD, a new understanding of these patients emerged. This led to an explosion of extensive research programs to find effective treatments. The motivation to conduct research and develop psychological treatment programs was a result of political pressure from veteran's organizations in the United States. In contrast to this recognition, women's experiences in civil life were hidden in the domestic sphere. It was hard to recognize that the existence of patriarchal conditions in civilian life could co-exist with a democracy in the public sphere. Thus, the first American feminist movement named the Woman Question the "problem without a name" (Herman, 2015: 28).

Not until the 1980s, when PTSD was included in the Diagnostic and Statistical Manual of Mental Disorders (DSM), did it become evident that the syndrome seen in war veterans was similar to the psychological syndrome seen in victims of different kind of sexual violence. However, the PTSD diagnosis is based on experiences of war and does not fit the complex symptom picture of victims of sexual violence and other psychological trauma. Still today, the existing diagnostic categories of psychiatric disorders are not designed for victims of sexual violence or other extreme situations. The continuing anxiety, panic and phobias seen in victims of trauma are different from other

anxiety disorders. For example, depression among victims of sexual violence is different from ordinary depression. Also, the psychosomatic symptoms of victims of sexual trauma are different from other psychosomatic disorders. The absence of an accurate diagnosis has significant consequences for the treatment of this group. The underlying traumatic experience of the patient is not addressed, leading to only partial understanding of the patient and therefore incomplete treatment. Herman calls for new diagnostic criteria to cover the complex psychological trauma suffered by victims of sexual violence, in order to provide these individuals with appropriate care. She describes how patients suffering from psychological trauma from sexual abuse are frequently mistreated within the healthcare system. Without an officially recognized name, patients suffering from complex psychological trauma due to sexual violence may get misdiagnosed and treated for the symptoms of trauma instead of its cause.

Herman argues that psychological trauma such as sexual violence only can be understood in a social context and a broader political framework. The definition of human rights is based upon the perception that all human beings are attributed certain rights simply by the virtue of being human. In theory, human rights belong to every person, but how are they guaranteed in practice? How can the right to mental healthcare for victims of sexual violence be realized and secured? From Hermans' theoretical perspective, victims of sexual violence or complex psychological trauma need a diagnosis in order to access specialized mental healthcare. Herman argues that advancing the study of psychological trauma depends on the support of a political movement for human rights.

3.2 Hannah Arendt's idea of a "right to have rights" and the politics for right-bearing

> *The Rights of Man, supposedly inalienable, proved to be unenforceable - even in countries whose constitutions were based upon them - whenever people appeared who were no longer citizens of any sovereign state* (Arendt, 1979: 293)

In her now classic book *The Origins of Totalitarianism*, Hannah Arendt claims that human rights can only be guaranteed through citizenship (Arendt, 2017: 87). Arendt reflects on her own personal experiences as a refugee and the ways in which people can lose and gain rights. Individuals without citizenship cannot get access to human rights and thus lose their status as right-holders, even though human rights are supposed to apply to everyone by virtue of being human. She therefore calls the right to be a citizen the one right that makes the enjoyment of other civil, political or social rights

possible. Becoming a member of a political community, contrary to merely being human, is a condition for having rights. Arendt therefore calls the right to be a citizen “the right to have rights”. The universal, inalienable and inherent human rights are, according to Arendt, dependent on the willingness of nations to enforce and implement them. Arendt’s analysis thus highlights that rights are not an innate feature of human nature, they need to be materialized in the real world. In other words, a specific status is necessary to become a rights-holder. An analogy can be drawn between Arendt's theory about citizenship and the question about getting a diagnosis. Getting a a diagnosis is the basis for getting adequate treatment in the same way as citizenship is the condition for accessing your human rights.

Drawing on Arendt’s reasoning that rights are not realized only by virtue of being human is relevant still today. Arendt’s process of reasoning is applicable to the topic of the right to healthcare access and can be used to highlight the boundaries of human rights law under the nation state. The Universal Declaration of Human Rights (UDHR) introduces human rights that are universal and inalienable. In practice, however, a sovereign State recognizes nothing superior to itself. The State therefore is the only institution that can acknowledge, protect and enforce the rights of individuals. Healthcare access is an example of a fundamental human right that is inaccessible to many people because they lack citizenship or other political status. This exemplifies the availability of the right to healthcare in terms of declarations and conventions and its inaccessibility to those concretely in need of protection.
A parallel can be drawn to Hermans’ theoretical perspective, which is that victims of sexual violence need a diagnosis in order to access their right to mental healthcare. This implies that a status is needed for the conditions of living a life with dignity, and the protection of human rights. In other words, a person’s human status establishes that person as a right-bearer. What about those individuals who don’t have a diagnosis or other status and therefore can’t access appropriate healthcare? Arendt’s texts highlight the fact that human beings are dependent on the acknowledgement and the protection of the nation state to access their human rights. In other words, “the right to have rights” could mean the recognition of persons worthy of bearing rights.

Arendt’s idea of a “right to have rights” is a way to highlight paradoxes and difficulties within a political framework and will be used in this paper as a way to better understand and explore the political challenges of human rights.

Gender-based violence is nearly universal, affecting women of every class, race, ethnicity and social background in all the pursuits of life and at every phase of the life cycle. The number of its victims exceeds those of war and the most brutal dictatorships of our time

(Copelon, 1994)

4. We know about the effects of sexual violence on mental health

This chapter provides a brief overview of the issue of sexual violence against women by looking at already existing data and studies. This is followed by mapping the effect of sexual violence on women's health, highlighting the great importance of mental healthcare.

4.1 Sexual violence: a global problem

Violence against women is a violation of fundamental human rights such as the inherent dignity and worth of all members of the human family, the equal rights of men and women and the inalienable right to freedom from fear and want.[10] The WHO defines sexual violence as:

> *Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.*[11]

Coercion may involve physical force, psychological intimidation or other threats. It may also occur when a person is unable to give consent due to mental incapability, not understanding the situation, being under influence of alcohol or drugs, or being asleep.[12]

Sexual violence occurs in every country of the world, in every culture and in all levels of society. [13] According to available data from the WHO, one in three women throughout the world will experience physical and/or sexual violence by a partner or sexual violence by a non-partner.[14] The prevalence of a lifetime history of sexual abuse in the general female population is estimated to range between 15% and 25% (Leserman, 2005). However, existing data on sexual violence are fragmented and does not represent the global magnitude of the problem. Shame, fear of not being believed, blamed, or mistreated are some reasons why many women do not report sexual violence

[10] Preamble to the Universal Declaration of Human Rights, signed 10 Dec. 1948, G.A. Res. 217A (III), U.N. Doc. A/810, at 71 (1948).
[11] World Health Organization, 2002. The world health report 2002: reducing risks, promoting healthy life. Chapter 6, p. 149.
[12] World Health Organization, 2002. The world health report 2002: reducing risks, promoting healthy life. Chapter 6, p. 149.
[13] World Health Organization, 2003. Guidelines for medico-legal care of victims of sexual violence, p 1.
[14] World Health Organization, Violence against Women: Global picture health response. Available at: https://www.who.int/reproductivehealth/publications/violence/VAW_infographic.pdf?ua=1. (Accessed 2019-03-03)

to the police.[15] Despite these challenges, it is clear that sexual violence has both short- and long-term consequences on women's mental, physical, sexual and reproductive health.

4.2 The consequences of sexual violence on mental health

Sexual violence has a significant negative impact on the mental health of the population. Individuals with a history of sexual abuse are at greater risk for mental health problems even years after the incident(s). Sexual violence has been linked with numerous serious and long lasting mental health problems, including PTSD, substance use disorders, depression, other anxiety disorders, suicide, and suicidal ideation and attempts[16]. The WHO reports that women exposed to intimate partner violence are more than twice as likely to experience depression and almost twice as likely to have alcohol use disorders.[17] The list of symptoms is long. Rajan et al (2017) conducted a study looking at diagnosis of sexual abuse that have been coded according to the WHO's International Classification of Diseases, and their common registered comorbidities in the total population of Stockholm. It was found that diagnoses of drug and alcohol abuse, psychotic disorders, bipolar disorder, stress anxiety disorders, depression and somatic pain were more common among individuals with a diagnosis of sexual abuse than among individuals without a diagnosis of sexual abuse. In addition to this, Möller et al (2017) describes how sexual violence can negatively affect a person's restoration of trust as well as intimacy to other people because bodily touch has become closely interwoven with something horrific, or feelings of indifference. Therefore, victims of sexual violence are more prone to enter into destructive sexual relationships or prostitution (Möller et al., 2017: 26).

The trauma resulting from sexual violence or abuse can impact a survivor's ability to work. A history of sexual abuse has been linked with high incidents of sick-leave and healthcare visits (e.g. Hilden et al., 2004; Hensing & Alexanderson, 2000). Also, women subjected to sexual violence are even years after the event using medical services more frequently than women that have not been sexually abused (Golding et al., 1988). According to Kimerling and Calhoun (1994), these findings may be explained by interpretation among victims of psychological distress as symptoms of physical illness. Thus, it may be inferred that without appropriate and accessible treatment, patients who have survived sexual violence may be relieved from the symptoms of the trauma rather than from the trauma itself. This may in turn result in decreased quality of life and sometimes lifelong disability for these individuals.

[15] World Health Organization, 2013, p 4.
[16] World Health Organization, 2013, p 8; 28.
[17] World Health Organization. Violence Against Women: Global picture Health Response.

4.3 The impact of child sexual abuse

Child sexual abuse has been linked with adverse health consequences. Numerous psychological and behavioral symptoms have been reported in survivors of child sexual abuse such as depressive symptoms, anxiety, symptoms associated with PTSD, increased or inappropriate sexual behavior, cognitive impairment, body image concerns and substance abuse.[18] The role of childhood incest has also been associated with severe psychotic disorder (Beck & Van der Kolk, 1987), self-cutting and suicide attempts (Van der Kolk, Perry & Herman., 1991) and Anorexia and Bulimia Nervosa (Herzog et al., 1993).

Further to this, multiple studies of female incest survivors have found a higher susceptibility of these women to relationships in which they are further abused, a phenomenon referred to as revictimization (Messman-Moore & Long, 2000; Herman, 1981). Revictimization may occur by means of sexual, physical, and mental abuse. A literature review found that survivors of child sexual abuse had two to three times greater risk of adult revictimization compared to women without a history of child sexual abuse (Arata, 2002). Further to this, research findings have shown that child sexual abuse can impact on later parenting behavior as well as adjustment problems in the survivor's later children (Lalor & McElvaney, 2010; DiLillo & Damashek, 2003; Banyard, 1997). These studies highlights several ways in which child sexual abuse can affect those who have suffered it and also the succeeding generation.

Psychiatrist Van del Kolk has over thirty years of experience with trauma research and has worked with patients who have survived different traumatic experiences, from rape to torture. He states that traumatized people often feel defensive and tense in their own bodies (Van der Kolk, 2015: 100-101). Therefore, survivors of trauma cannot recover until they find a way to feel safe in their own bodies by physical self-awareness. With practice, it is possible for patients who have been sexually abused to reconnect with themselves again by re-educating their mind to feel physical sensations, and their body to tolerate and enjoy touch. Unfortunately, however, medications are often prescribed to blunt sensations instead of teaching these patients how to deal with distressing physical reactions.

In summary, sexual violence can have devastating consequences for the victims, their families and society as a whole. Thus, neglecting care for victims of sexual violence will both increase the societal costs in the long run as well as deprive the country of a large part of its human capital as a

[18] World Health Organization, 2003. Guidelines for medico-legal care of victims of sexual violence, child sexual abuse, Chapter 7, p 81.

consequence of generalized ill health. Still, public healthcare around the world remains insufficient in providing accessible and appropriate healthcare for victims of sexual violence (Herman, 2015; Van der Kolk, 2015). Also, healthcare providers often fail to ask about exposure to sexual violence (Havig, 2008). The effects of sexual violence on women's mental health is in general a neglected area of research. WHO reports that reviews and studies regarding health effects associated with sexual violence is extremely limited and highlights the need for dedicated research and longitudinal studies.[19] The WHO further highlights "the need to find better ways to help the survivors of sexual violence...".[20] Accordingly, there is a need to investigate why public health-care facilities around the world and in Sweden often fail to provide victims of sexual violence with available, accessible and of good quality mental healthcare. Such knowledge may inform interventions to assist these individuals. I will next present how the right to mental health framework for female sexual violence victims is regulated within the scope of international law.

[19] World Health Organization, 2013, p 27; 32.
[20] World Health Organization, 2013, p. 39.

5. The right to mental healthcare framework

The first part of this chapter will use a legal research approach to document how the right to mental healthcare for female victims of sexual violence are regulated within the scope of international human rights law.

The human right to health is recognized in several international instruments. Article 25.1 of the Universal Declaration of Human Rights (UDHR) states that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services." The most comprehensive treaty on the right to health in international human rights law are provided by the International Covenant on Economic, Social, and Cultural Rights (Art. 12).

The International Covenant on Economic, Social, and Cultural Rights (ICESCR) was adopted 1966 and came into force 1976. As of September 2018, 193 of the 169 members of the United Nations are parties to the ICESCR. Article 12(1) of the ICESCR recognize "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".[21] The right to the highest attainable standard of health is underpinned by universally recognized moral values and reinforced by legally binding obligations. However, Article 12 of the ICESCR gives a very brief description of the right to the highest attainable health.

General Comment no. 14 of the UN Committee on Economic, Social, and Cultural Rights' (CESCR) is an explanatory note on what is required for the fulfillment of the right to the highest attainable standard of health (article 12 of the ICESCR).[22] General Comment no. 14 was developed in collaboration with WHO and several others. The document is groundbreaking as it provides a tool to analyze the right to health, making it more accessible for practitioners and policymakers to use. Therefore, general comment 14 bridges the gap between brief, legalistic treaty agreements and practice.

General Comment no. 14 (art. 12.1) notes that the right to health in all its forms and at all levels contains the interrelated and essential elements that health facilities, goods and services should be available in sufficient quantity, accessible to everyone without discrimination, culturally acceptable and of good quality within a country. These obligations apply as much to mental health as to

[21] UN General Assembly, International Covenant on Economic, Social and Cultural Rights, p. 4
[22] UN, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), p. 18.

physical health. Also, Article 12.2 (d) highlights the importance of access to preventive, curative and rehabilitative health services, including appropriate mental health treatment and care.

In relation to women and the right to health, explanatory note 21 in General Comment no. 14 highlights that "To eliminate discrimination against women, there is a need to develop and implement a comprehensive national strategy for promoting women's right to health throughout their life span. Such a strategy should include interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality and affordable health care, including sexual and reproductive services. A major goal should be reducing women's health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence..."

Women's right to health is further recognized in articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). The CEDAW establishes in Article 12 that States shall ensure that women have the same access to healthcare as men and that women are not discriminated against. The CEDAW was adopted in 1979 by the UN General Assembly. Of the 193 members of the United Nations, 189 are parties to the CEDAW. The convention legally binds all State parties to fulfill, respect and protect women's human rights. The purpose of CEDAW is to end all forms of discrimination against women and to promote women's rights in areas such as health.

The Committee on the Elimination of Discrimination against Women is the body of independent experts that monitors implementation of the CEDAW. The CEDAW committee highlights that a significant aspect in the interpretation of the right to health is gender, and that states should integrate a gender perspective in their federal health plans. General Comment no. 24 of the CEDAW committee is an explanatory note of Article 12 of the Convention (Women and Health). Note 15 states that: "Since gender-based violence is a critical health issue for women, State's parties should ensure the enactment and effective enforcement of laws and the formulation of policies, including health-care protocols and hospital procedures to address violence against women and sexual abuse of girl children and the provision of appropriate health services."[23] Additionally, note 25 highlights that: "Women with mental disabilities are particularly vulnerable, while there is limited understanding, in general, of the broad range of risks to mental health to which women are disproportionately susceptible as a result of gender discrimination, violence...".

[23] UN Committee on the Elimination of Discrimination Against Women (CEDAW), CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health), 1999, A/54/38/Rev.1, chap. I.

5.1 The Declaration on the Elimination of Violence against Women

The Declaration on the Elimination of Violence Against Women (DEVAW) was adopted by the United Nations General Assembly in 1993. The DEVAW draws attention to the importance to abandon the prevailing governmental stance that violence against women was a private matter, not requiring state intervention. The DEVAW also recognized the need for a comprehensive definition of violence against women. Article 1 of the declaration defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."[24]

The DEVAW highlights the importance to specify the rights to be applied to ensure the elimination of violence against women in all its forms. The following Articles of the DEVAW mentions the right to health and reparations:

- Article 3 affirms that women are entitled to the equal enjoyment and protection of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. This includes the right to the highest standard attainable of physical and mental health.

- Article 4 (g) obliges States to ensure: "that women subjected to violence and, where appropriate, their children have specialized assistance, such as rehabilitation, assistance in child care and maintenance, treatment, counselling, and health and social services, facilities and programmes, as well as support structures, and should take all other appropriate measures to promote their safety and physical and psychological rehabilitation."

- Article 4 (d) highlights the obligation to provide reparations to women subjected to violence, which places a duty upon the State to: "redress the wrongs caused to women who are subjected to violence; women who are subjected to violence should be provided with access to the mechanisms of justice and, as provided for by national legislation, to just and effective remedies for the harm that they have suffered."

[24] UN General Assembly, Declaration on the Elimination of Violence against Women, 20 December 1993, A/RES/48/104.

5.2 The Istanbul Convention on Preventing and Combating Violence against Women and Domestic Violence

The Council of Europe adopted the Convention on Preventing and Combating Violence against Women and Domestic Violence (the Istanbul Convention) in 2011, and it entered into force in 2014. The Convention calls for governments who have signed and ratified it to take a set of measures to combat all forms of violence against women and domestic violence.[25] Article 4 of the Istanbul convention states that violence against women and domestic violence can no longer be considered a private matter, but that states have an obligation, through a comprehensive and integrated framework, policies and measures for the protection of and assistance to all victims of violence. The Istanbul convention mentions psychological counselling and specialist support services in the following Articles:

- Article 20 General support services states that: "Parties shall take the necessary legislative or other measures to ensure that victims have access to services facilitating their recovery from violence. These measures should include, when necessary, services such as legal and psychological counselling..."

- Article 22 Specialist support services highlights that "Parties shall take necessary measures to provide or arrange for, in an adequate geographical distribution, immediate, short- and long-term specialist support services to any victim of violence."

- Article 25 Support for victims of sexual violence states that Parties shall "provide for the setting up of appropriate, easily accessible rape crisis or sexual violence referral centres for victims in sufficient numbers to provide for medical and forensic examination, trauma support and counselling for victims."

- Article 11 Data collection and research further highlight that Parties shall undertake to support research in the field of all forms of violence covered by the scope of this Convention in order to study the root causes and effects of violence.

Taken together, the Istanbul Convention recognizes the importance of specialized healthcare in the promotion and protection of women's rights, and to facilitate recovery from violence. The countries

[25] Council of Europe, The Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence , November 2014, ISBN 978-92-871-7990-6.

who have ratified the Istanbul Convention are legally obliged to follow every provision of the convention.

To summarize, the right to health framework for women who have been subjected to sexual violence is recognized within the UDHR, the ICESCR, the CEDAW, the DEVAW and several other foundational human rights documents. In practice, however, the UN has stated that even though a historic number of policies and laws against violence of women are now in place, implementation is failing. [26] This both limits women's access to human rights and signals that violence against women is tolerated. It is therefore important to further investigate why this might be the case and how the protection of women's rights can be secured. I will next explore if the Swedish healthcare system provides victims of sexual violence with access to the highest attainable standard of mental health.

[26] UN women, Ending violence against women, 2015.

6. The right to mental health care in Sweden

Sweden has a long history of addressing violence against women in both policy and law. In fact, one of the sub-goals of the Swedish Government's current gender equality policy is to stop men's violence against women.[27] Also, Sweden adopted a national strategy in 2017 to prevent and combat men's violence against women.[28] Two of the national strategy's four goals concern a stronger support for women and children at risk of violence, and improved knowledge and method development. "Support" (Chapter 5.2.4) means all forms of support, including care and treatment. Providing victims of sexual violence with specialized mental healthcare is necessary and required in order to prevent and combat men's violence against women. Sweden has signed and ratified the ICESCR, CRPD, the CEDAW and the Istanbul Convention. As previously mentioned, the CESCR emphasize that healthcare must be available, affordable and offered without discrimination. Does the Swedish healthcare system provide victims of sexual violence with mental healthcare of good quality that is available, accessible and acceptable?

6.1 Specialist clinics and organizations in Sweden

In Sweden, during 2018, 22,500 sexual offences were reported, of which 7,960 were classified as rape.[29] However, only two out of ten sexual offenses are reported to the police, making it impossible to know exactly how common sexual crimes are. Still, there are only a few state-financed clinics in Sweden that offer specialist care for psychological trauma after sexual abuse.[30] These clinics can together treat around 200 children and 200 adults every year.[31] As there has been an evident increase of sexual offenses in Sweden since 2015, the numbers of people that can't access specialist care after reporting a sexual offense increases every year.

Södersjukhuset (SÖS) a major Stockholm General hospital houses Sweden's only specialist emergency clinic for rape victims, offering 24-hour telephone availability. At SÖS anyone can seek

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[27] Government Offices of Sweden, 2016, Summary of the Government Communication 'Power, goals and agency – a feminist policy'. Available at: https://www.government.se/information-material/2017/03/summary-of-the-government-communication-power-goals-and-agency--a-feminist-policy/ (Accessed 2019-07-03)

[28] Government Offices of Sweden, 2016, En nationell strategi för att förebygga och bekämpa mäns våld mot kvinnor, 2016. Available at: https://www.regeringen.se/49d3d6/globalassets/regeringen/dokument/socialdepartementet/jamstalldhet/en-nationell-strategi-for-att-forebygga-och-bekampa-mans-vald-mot-kvinnor_utdrag-ur-skr.-2016_17_10.pdf (Accessed 2019-07-03)

[29] BRÅ, Crime and Statistics, Rape and sexual offenses, 2018. Available at:https://www.bra.se/bra-in-english/home/crime-and-statistics/rape-and-sex-offences.html (Accessed 2019-03-05)

[30] See for example the ASTA team, located at Norrlands University Hospital in Umeå, https://www.1177.se/hitta-vard/kontaktkort/Mottagning-Asta-Umea/

[31] Wonsa, Talande fakta; ord och siffror om sexuella övergrepp i Sverige 2012-2016. Available at: http://www.wonsa.se/content/uploads/2017/10/WONSA0028_Talandefakta.pdf (Accessed 2019-05-25)

emergency care and support after sexual assault, regardless of gender identity. The clinic offers forensic examination as well as counseling to help victims deal with the aftermaths of assault.[32] Dr. Anna Möller, chief physician at SÖS highlights the importance of increasing the general knowledge about sexual assault within the Primary Healthcare System, in order for the victims to receive appropriate help.[33] SÖS receives a broad spectrum of patients, with different needs. Möller states that the first counseling session is enough in many cases of rape. However, a large number of patients have a previous history of sexual assault, or a psychiatric disorder and are in need of more specialized care than what SÖS can offer. SÖS is today referring patients to psychiatric clinics where the average wait times are long, and where this vulnerable patient group don't always qualify or fit into.

There are a few non-profit organizations in Sweden that offers help and support for victims of sexual violence. The organization World of No Sexual Abuse (Wonsa) is currently Sweden's only scientifically approached specialist clinic for adult patients who have been sexually abused in their childhood. Wonsa has one specialist trauma clinic in Stockholm with therapists and doctors with knowledge in how to treat psychological trauma after incest and sexual abuse. Dr. Gita Rajan, founder of Wonsa, started the organization in 2014 due to the shortcomings within the Swedish Public Healthcare system and in the treatments that were offered to victims of sexual abuse or violence.[34] According to numbers from Wonsa, 80% of their patients stated that they received no or insufficient help from the public healthcare system in Sweden.[35] Numbers from Wonsa also show that 80% of their patients did not receive any help the first time they told someone about the abuse; 80% of their patients have tried to get help before they came to Wonsa and that 30% of Wonsa's patients waited for 15 years or more before they told someone about the abuse.[36] These numbers indicate that the right to mental healthcare for women who have been subjected to sexual violence is not of good quality that is available, accessible and acceptable in the Swedish public health-care system.

The National Association Against Incest and Other Sexual Abuse (RISE) provides support and help for women who have been subjected to incest and other sexual abuse in Sweden. In 2017, RISE conducted a survey when they asked their members to answer a number of questions regarding

[32] Södersjukhuset, Emergency Clinic for rape victims. Available at: https://www.sodersjukhuset.se/globalassets/dokument/akutmottagning-for-valdtagna/engelska-akutmottagningen-for-valdtagna-patientbroschyr.pdf (Accessed 2019-03-20)
[33] DN Debatt, "Dubbelt så många unga söker till SÖS våldtäktsmottagning" Available at: https://www.dn.se/debatt/dubbelt-sa-manga-unga-soker-till-sos-valdtaktsmottagning/ (Accessed 2019-03-20)
[34] Wonsa, 2019, About Wonsa. Available at: http://www.wonsa.se/en/about-wonsa/ (Accesses 2019-03-20).
[35] Rajan, G., Founder of Wonsa. From correspondence 2019-06-08
[36] Wonsa, 2019, Numbers that speak for themselves, Available at: http://www.wonsa.se/en/ (Accessed 2019-08-15).

access to care as well as their experiences of the Swedish healthcare system.[37] It was found that 72% of the respondents had never been asked whether they had been exposed to sexual violence by any healthcare professional. Additionally, the respondents stated that 61% of therapist/psychologists, 56% of the doctors within the psychiatry and 54% of the doctors within the primary healthcare system did not have enough knowledge and understanding about sexual violence and its consequences. Regarding diagnosis, 73% of the respondents had been diagnosed with PTSD, 69% with depression, 49% with Chronic Fatigue Syndrome, 31% with Complex Trauma, 26% with an Eating Disorder, 25% with Self-Harm Behaviour, 20% with Chronic Pain, 19% with Dissociative Identity Disorder and 9% with Borderline, among other disorders. The survey also showed that 79% of the respondents had not been referred to any trauma treatment at all or had found treatment on their own.

In 2013, RISE conducted a national survey to explore which regions in Sweden offered specialist psychological care for victims seeking help for the consequences of sexual violence.[38] The survey found that there are few counties (5 out of 21) providing specialist care for victims of sexual violence in Sweden. The survey further showed that the awareness of the existence and the prevalence of the patient group existed among the counties and regions as well as among healthcare providers throughout Sweden. There was also general conviction that existing healthcare facilities (e.g. psychiatric clinics, primary healthcare) did sufficiently meet the needs of this patient group. Thus, most respondents found no need for specialist psychological care for this patient group. However, 80-94% of survivors of sexual violence reported that they did not get sufficient help in the public healthcare system in Sweden. The survey concludes that public healthcare facilities in Sweden to a large extent treat the symptoms of sexual abuse rather than the cause. Taken together, the result from the survey gives reason to question whether the needs of this patient group can be met without specialist psychological care.

6.2 The implementation of the ICECR principles

The right to the highest attainable standard of health is a fundamental human right and the foundation of an effective health system. In General Comment no. 14 (art. 12.1), the Committee on Economic, Social and Cultural Rights advises States to respect the right to health by providing health facilities, goods and services which should be available in sufficient quantity, accessible to

[37] RISE; ”Se mig” - vårdens bemötande och tillgång till specialiserad traumabehandling, 2018. Available at: http://rise-sverige.se/wp-content/uploads/2018/09/medlemsenk%C3%A4t-rise-h%C3%B6st2017.pdf (Accessed 2019-03-19)
[38] RISE, 2013, Kartläggning av specifik verksamhet inom svensk hälso- och sjukvård för vuxna som utsatts för sexuella övergrepp under barndomen. Available at: https://patientforeningenmedusa.files.wordpress.com/2019/04/kartlacc88ggningsrapport-rsci-2013.pdf (Accessed 2019-03-19)

everyone without discrimination and of good quality within a country. Furthermore, General Comment no. 14 (art. 12.2, (d)) advises States to respect the right to health by not denying or limiting equal access to preventive, curative and rehabilitative health services, including mental health treatment and care, for all persons. The numbers from Wonsa and RISE indicates that victims of sexual violence are denied the right to the highest attainable standard of health due to a current shortage of clinics that provide specialist trauma care. Thus, it may be inferred that Sweden does not provide the conditions for victims of sexual violence to enjoy the highest attainable standard of mental health.

This concurs with observations made by the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Special Rapporteur Paul Hunt visited Sweden in 2006, with the objective to monitor the implementation of the to the highest attainable standard of health. The Special Rapporteur urges the Swedish Government in Note 49 of the report to "ensure that mental health care, including psychiatric care and other therapies, is made more accessible for marginalized groups".[39]

Lastly, the UN Special Rapporteur on violence against women, its causes and consequences also recognizes the need for available health services for victims of violence in Sweden. Special Rapporteur Yakin Ertürk visited Sweden in 2006 to address the discrepancy between the progress in achieving gender equality and the reports of continued violence against women in the country. The Special Rapporteur recommends the Swedish government to protect women at known risk of violence by affirming that "Guidance and psychological counselling should also be made available for victims in enabling them to establish a sustainable and safe life on their own."[40]

6.3 The implementation of the Istanbul Convention

The Group of Experts on Action against Violence against Women and Domestic Violence (GREVIO) monitors the implementation of the Istanbul Convention by the parties to the convention. GREVIO published its first Evaluation Report on Sweden in 2019 which covers the

[39] UN Human Rights Council, UN Human Rights Council: Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Mission to Sweden, 28 February 2007, p. 15.
[40] UN Human Rights Council, UN Human Rights Council: Addendum to the Report of the Special Rapporteur on Violence against Women, Its Causes and Consequences, Mission to Sweden, 6 February 2007, A/HRC/4/34/Add.3, p. 23.

situation as at September 2018.[41] The following statements are made in regards of psychological counselling and specialist support services in Sweden:

- Note 125 regarding General support services (Article 20) urges the Swedish authorities to step up efforts to enhance and formalise co-operation structures in relation to cases of all forms of violence against women within and across local authorities, government agencies and women's specialist support services.

- Note 136 regarding Specialist support services (Article 22) highlights that "A service that seems to be less readily available in Sweden is long-term psychological counselling and trauma care for victims of sexual assault and domestic violence...Similarly, long-term psychological counselling and trauma care for domestic violence victims, in particular to address post-traumatic stress disorders, are rarely available within the public health care system... In some of the northern parts of the country, psychological support and counselling is not available at all for victims of domestic violence". Note 137 of the report therefore "strongly encourages the Swedish authorities to take measures to ensure specialist support services with a gendered approach and targeted at creating change, including longer term psychological counselling and trauma care throughout the country."

- Note 145 regarding Support services for victims of sexual violence (Article 25) strongly encourages the Swedish authorities to comply fully with Article 25 of the convention by ensuring sexual violence counselling services are available to all victims.

- Note 58 in regards of Data collection and research (Article 11) "strongly encourages the Swedish authorities to pursue its current efforts in ensuring the contribution of the primary health care sector to data recorded by the National Patient Register with a view to documenting contacts with the health care sector for reasons related to violence, disaggregated by sex, age and relationship of the perpetrator to the victim."

Taken together, the areas identified by GREVIO highlights what Sweden is required to improve in order to comply with the obligations of the convention. These include the need to increase specialist support services that offer long-term psychological counselling, trauma care, and sexual violence counselling. In order for Sweden to increase specialist support for victims of sexual violence, there

[41]GREVIO's (Baseline) Evaluation Report on legislative and other measures giving effect to the provisions of the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention) SWEDEN.

is a need to ensure long-term funding for NGO-run specialist services. There is also a need to introduce a data-collection system to improve healthcare statistics on violence against women.

In summary, the results indicates that the Swedish healthcare system does not provide victims of sexual violence with access to the highest attainable standard of mental health. The results show that mental healthcare facilities for victims of sexual violence are not of good quality that is available, accessible and acceptable. This statement is based upon the numbers from Wonsa and RISE as well as the GREIVO report on Sweden. The statistics from Wonsa and RISE both show that around 80% of their patients state that they did not get sufficient help in the public healthcare system in Sweden. Also, both the RISE national survey and the GREIVO report highlights the need for available and specialized psychological support and counselling clinics for victims of sexual violence across the country. A step in the right direction is that the Swedish Government has declared, in accordance with the Istanbul Convention, that an increased number of clinics or referral centers for victims of sexual offences shall be established in Sweden.[42]

[42] Regeringsförklaringen den 21 januari 2019, Available at: https://www.regeringen.se/tal/20192/01/regeringsforklaringen-den-21-januari-2019/ (Accessed 2019-08-15)

7. The history of sexual violence against women

The principle of universality is the foundation of international human rights law.[43] The Vienna Declaration and Program of Action states that human rights are universal, indivisible, interdependent and interrelated.[44] The difficulties for victims of sexual violence to access available and good quality mental healthcare challenges the principle of universality of human rights law. In order to identify reasons for why the right to mental healthcare often fails to work for female victims of sexual violence despite apparent agreements, an exploration of the history of sexual violence against women is necessary. This in order to consider the present situation for these women in a historical context. The next part of this paper will first set out to examine the study of psychological trauma.

7.1 The political movement of psychological trauma

Throughout the history of the study of psychological trauma, debates have centered over whether these patients' histories are real and credible and whether they are entitled to respect and care (Herman, 2015:7). According to Herman, advances within the study of psychological trauma occur only when supported by strong political movements powerful enough to counteract the social process of denial and silencing (Herman, 2015:9). Historically, three specific forms of psychological trauma have come into public awareness in connection with a political movement. The first to become known was hysteria, a mental disorder attributed to women. The second was combat neurosis which became recognized and emerged from the political context of the antiwar movement. The third and most recent trauma to reach public consciousness is sexual and domestic violence, which grew from the feminist movement in North America and Western Europe.

7.2 Hysteria

Hysteria was until the 1980s a commonly studied psychological disorder of women that could be found in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM). Hysteria was first described medically in 1880 by the French neurologist Jean-Martin Charcot who emphasized observation and classification of the symptoms of his patients. Freud, however, found that it was necessary to talk and to listen to his patients in order to find the cause of hysteria (Herman, 2015:11). By 1896, Freud believed that he had found the cause of these hysterical symptoms, after uncovering traumatic events such as abuse, sexual assault and incest

[43] The OHCHR, "What are human rights?" Available at: https://www.ohchr.org/en/issues/pages/whatarehumanrights.aspx (Accessed 2019-04-20)
[44] UN General Assembly, Vienna Declaration and Programme of Action, 12 July 1993, A/CONF.157/23.

within his patients. Freud published a report on eighteen case studies called The Aetiology of Hysteria where he made the controversial claim that every case of his patients that were diagnosed with hysteria had a history of sexual abuse in childhood (Freud, cited in Herman, 2015: 13). However, within a year, the theory of the origins of hysteria was repudiated by Freud because of its social implications (Herman, 2015: 14). If Freud's theory were true, he would be forced to conclude that incest was also prevalent among the respectable families in Vienna where he had his practice, which was societally unacceptable and beyond credibility (Herman, 2015: 18). Also, as hysteria was so common, holding on to his theory would have recognized the magnitude and depths of sexual exploitation of children and women (Herman: 2015:19). Freud concluded that the stories of his hysterical patients were untrue and that the histories were only fantasies that his patients made up. Though Freud continued to focus on his patients' sexual inner lives, he now insisted that the experiences of women were imagined and represented an expression of their longing for sexual encounters (Herman, 2015:19). Thus, the experiences of these women were again silenced and hidden within the private sphere of the home.

7.3 The recognition of post-traumatic stress disorder

After the First World War, psychological trauma came into public consciousness again. A great number of soldiers started to break down and act in the same way as hysterical women (Herman:2015:20). The existence of combat neurosis was evident, but there was little public or medical attention given to the psychological effects of returning combatants. It was not until the end of the Vietnam War that systematic investigation of the psychological condition of soldiers was undertaken. The insistence came from the antiwar movement and the efforts of the veterans organizations. By the end of the 1970's, the political pressure from the veterans organizations led to a psychological treatment program for veterans and extensive studies on the relationship between combat exposure and psychological trauma (Herman, 2015:27). In 1980, the syndrome of PTSD was officially recognized as a real diagnosis and included in the American Psychiatric Associations official diagnostic manual. This led to large-scale scientific studies and to the development of effective treatments.

7.4 The public sphere of war and politics: the world of men. The private sphere of domestic life: the world of women (Herman, 2015:32)

The early studies of hysteria emerged from the investigations of the lives of women. However, there was no recognition of the fact that violence is a systematic part of the sexual and domestic lives of

women. Not until the 1970's and the women's liberation movement was it acknowledged that the most prevalent post-traumatic stress disorder is of women in civilian life, and not of men in war. The conditions of women's reality have long been hidden in the sphere of private life. The value of private life silenced women's experiences of sexual exploitation and the fear of public humiliation and disbelief. Thus, women had no name for their experiences of assault and violence.

The development of consciousness-raising in groups made it possible for women to share their experiences of rape and other sexual crimes. The purpose was to simulate social change and collective action by empowering women to break through the barriers of privacy (Hermans, 2015: 29). The following poem captures the feelings of a woman speaking about her experiences of sexual abuse:

> *Today, in my small natural body, I sit and learn - my woman's body, like yours, target on any street, taken from me at the age of twelve... I watch a woman dare, I dare to watch a woman, we dare to raise our voices* (Morgan, 1970: 507-508).

Consciousness-raising in the 1970s generated an explosion of research on the subject of sexual crimes. Again, the investigations on the experiences of women confirmed that sexual violence against women and children was widespread and pervasive. The feminist movement generated public awareness of rape which led to the opening of the first rape crisis center in the Unites States in 1971 (Herman, 2015: 31). In 1972, a comprehensive study on the aftermath of rape found that the victim's symptoms resembled those found in war veterans (Burgess & Holmstrom, 1974). However, it was not until the 1980's, after the syndrome of post-traumatic stress disorder was recognized, that it became evident that the psychological syndrome seen in combat veterans was almost identical to the psychological syndrome seen in victims of sexual violence.

7.5 Diagnostic mislabeling

Traumatic events like sexual violence generally involve threats of bodily integrity or threats to life. The victims are faced with helplessness and terror which triggers responses of catastrophe (Herman, 2015:33). These kinds of traumatic events create lasting and profound changes in the victims' cognition, emotion, memory and physiological arousal (Herman, 2015: 34). Traumatic symptoms tend to become fragmented and disconnected from the victim and the present. Historically, this kind of disconnection was described in women diagnosed with "hysteria". After the incident or incidents, victims of sexual violence can refer to images of what happened during rape, but from a distance. This distancing, called dissociation, may as a strategy help the victim to cope in the short-term, but

has in the long run been proven counterproductive (Sveaass, 2008: 315). Generally, however, the knowledge of the psychological changes in traumatized people is not sufficiently widespread. Social judgment and the tendency to blame the victim has influenced the direction of research and diagnosis of post-traumatic syndrome (Herman, 2015: 116). Clinicians and researchers have instead of studying the psychopathology of the victim as a reaction to a traumatic experience, been attributing the abusive situation to the characteristics or underlying psychopathology of the victim. Thus, survivors of complex trauma such as sexual violence tend to be misdiagnosed as having personality disorders still today (Herman, 2015: 117). For example, a study by Herman and Perry (1989) found that 81% of the patients diagnosed with borderline personality disorder at Cambridge hospital reported a history of child sexual abuse and/or neglect. The definition of the patients' problem, a diagnosis, determines their care. Van der Kolk writes: "If their doctor focuses on their mood swings, they will be told they will be identified as bipolar and prescribed lithium or valproate. If the professionals are most impressed with their despair, they will be told they are suffering from major depression and given antidepressants. If the doctors focus on their restlessness and lack of attention, they may be categorized as ADHD ad treated with Ritalin or other stimulants. And if the clinic staff happens to take a trauma history, and the patient actually volunteers to relevant information, he or she might receive the diagnosis of PTSD. None of these diagnoses will be completely off the mark, and none of them will begin to meaningfully describe who these patients are and what they suffer from." (Van der Kolk, 2014: 136-137).

7.6 The need for recognition

Sexual violence against women is recognized as a global public health problem of epidemic proportions.[45] Still, this trauma is often hidden within the context of the healthcare system. An example of this is that the current diagnostic categories of the psychiatric manual do not fit this patient group well (Herman, 2015: 118), leading to difficulties for clinicians to provide appropriate treatment (Van der Kolk, 2015: 136). This is because a definition of the patients' problem, a diagnosis, determines how the healthcare system approaches their treatment and care. Not having a diagnosis confronts medical practitioners and therapists with the dilemma: how do we treat patients who are coping with the aftermaths of sexual violence when we are forced to diagnose these individuals with depression, bipolar illness, borderline personality disorder or panic disorder, which does not even begin to describe what these patients are coping with or suffer from? (Van der Kolk, 2015: 143). Many of the methods that are used to treat trauma today deal with symptoms rather than causes (Van der Kolk, 2014). Therefore, one of the barriers for victims of sexual violence to receive

[45] World Health Organization, 2013, p. 35.

appropriate protection and healthcare is the lack of a diagnosis that incorporates the complex and many symptoms of trauma victims. Herman highlights the need for the syndrome of complex trauma to have an officially recognized name that goes beyond post-traumatic stress disorder (Herman, 2015: 120).

Drawing back to Arendt's theory that citizenship is required to get access to human rights, a parallel can be drawn to the question of whether a diagnosis is necessary for victims of sexual violence to access appropriate treatment. Arendt's idea of the "right to have rights" may be interpreted as a form of recognition which might be vital for victims of sexual violence to access the right to healthcare. Without recognition, a large group of individuals will not be able to enjoy the right to the highest attainable standard of health which includes available, accessible and of good quality mental healthcare. Also, this group of individuals becomes powerless in the sense that they can't claim their rights. In the same way as citizenship enforces the right to have rights, a diagnosis can make the individual feel that she has the right to get adequate help and strengthen her not become a victim but a rights-holder.

7.7 Health Classification Systems: The International Classification of Disease (ICD 11), the Statistical Manual of Mental Disorders (DSM) and the Sexually Abused Injury Syndrome

The ICD-11 is the International Statistical Classification of Diseases and Related Health Problems (ICD), a healthcare classification system by the World Health Organization (WHO). The ICD defines diseases, injuries, disorders and other health related conditions. The primary purpose of ICD-11 classification system is to classify diseases and health related problems in order to collect information and statistics.[46]

Regarding sexual assault and violence, The ICD-11 has developed diagnostic codes, such as: T74.2 Adult sexual abuse; Z04.4 Encounter for examination and observation following alleged rape; and T74.22 Child sexual abuse. These codes serve a valuable diagnostic purpose, for example to illustrate the prevalence of sexual violence against women. However, these classification codes are rarely used and coded into the patients' journal system.[47] Diagnoses of sexual abuse that have been coded according to the ICD are rarely made in the Swedish Healthcare system (Rajan et al., 2017). If the ICD is not used in practice, it loses its purpose to monitor the prevalence of patients that seeks help after sexual violence.

[46] Socialstyrelsen, Diagnoskoder (ICD-10), Available at: https://www.socialstyrelsen.se/klassificeringochkoder/diagnoskodericd-10 (Accessed 2019-04-12)
[47] Allmänmedicin, Tidsskrift för Svensk Förening för Allmänheten. Nummer 2, 2018:25

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a handbook used by health care professionals to guide the diagnosis of mental disorders.[48] The 5th Edition (DSM-5) includes for example the diagnosis 995.81 Adult Physical Abuse by Nonspouse or Nonpartner (APA, 2013: 722). However, even though the origins of many of the diagnoses identified in DSM-5 are known, the diagnoses in the DSM describe surface phenomena instead of the underlying causes (Van der Kolk, 2014: 164). In 2011, the British Psychological Society criticized the DSM-5 for identifying the sources of psychological suffering "as located within individuals" and excluded the "undeniable social causation of many such problems." (Greenberg, 2013: 239).

Also, before the release of the DSM-5 the American Journal of Psychiatry presented the results of validity tests of new diagnoses which pointed out that the DSM generally lacked "reliability" - the scientific measure of consistency and repeatability (Van der Kolk, 2014: 164). Without reliable diagnoses, identifying risk factors and providing proper treatment becomes nearly impossible. This is in agreement with a recent paper by The Lancet Commission on global mental health and sustainable development which highlights the need to improve current diagnostic categories in order to recognize diversity, and to guide detection and intervention (Patel et al., 2018: 1563).

The organization World of No Sexual Abuse (WONSA) has developed the Sexually Abused Injury Syndrome definition, which describes the specific problems that victims of sexual violence or abuse suffer. The Sexually Abused Injury Syndrome describes damage, which includes the multiple symptoms the victims of sexual violence or abuse suffer. The Sexually Abused Injury Syndrome can therefore help healthcare professionals to identify these patients, and to offer these patients appropriate care. Also, WONSA have developed their own classification system for sexual abuse: Sexual Abuse Classification (W-SAC). The W-SAC classification system can be used by healthcare professionals to define the cause and severity of the symptoms and from there allocate recourses to approach their care. Today, most victims of sexual violence are diagnosed with numerous diagnoses over time, and given no structured help within the healthcare system. The Sexually Abused Injury Syndrome and the W-SAC is an attempt from WONSA to make it more straightforward for healthcare professionals to identify aftermaths of sexual abuse. The aim is also to facilitate the development and evaluation of treatment programs and prognosis for patients with injuries after sexual abuse, in order to make appropriate treatment accessible for these patients.

[48] DSM-5: Frequently asked questions, 2019. Available at: https://www.psychiatry.org/psychiatrists/practice/dsm/feedback-and-questions/frequently-asked-questions (Accessed 2019-05-19)

In order to be internationally applicable, WONSA is working to get their treatment programs scientifically validated and published, a process that has started.[49]

In summary, to provide victims of sexual violence with access to the highest attainable standard of mental health, this group of patients firstly have to be recognized through monitoring of prevalence. This is also highlighted in note 56 and 58 of the GREVIOS report which strongly encourages the Swedish authorities to improve the documentation regarding healthcare statistics on violence. Thus, it may be inferred that there is a need for a classification system that addresses and characterizes these patient groups, implemented and used in the public healthcare system in Sweden, and worldwide. Secondly, these patients need to be handled with the same requirements for structure and scientific approach as in other clinical areas such as orthopedics. Here, the implementation of the Sexually Abused Injury Syndrome and the W-SAC in the public healthcare system are important steps along the way. Thirdly, easily accessible clinics need to be opened, where special knowledge is available and can be spread.

[49] Rajan, G., Founder of Wonsa. From correspondence 2019-08-03.

8. Discussion

The overarching purpose of this study is to explore why public health-care facilities around the world often fail to provide victims of sexual violence with available, accessible mental healthcare of good quality. This question is vital in order to establish effective health care systems that provide the conditions so that victims of sexual violence can access the right to the highest attainable standard of health. To examine this question, the first part of this thesis documented the human right to mental healthcare framework for women who have been subjected to sexual violence. The second part of the thesis examined whether Sweden provides victims of sexual violence with access to the highest attainable standard of mental health. The last part of the thesis explored the history of violence against women to get a more in-depth understanding of why the right to mental healthcare fails to work for women who have been subjected to sexual violence. Also, constructive suggestions as to what governments should do to provide victims of sexual violence with access to the highest attainable standard of mental health were put forth. This chapter summarizes the results and explains them in relation to previous research and the chosen theoretical frameworks.

The first research question that guided this thesis was: How is the right to mental healthcare for women who have been subjected to sexual violence regulated within international law? By documenting the legal grounds of mental healthcare for victims of sexual violence, it is clear that the right to mental healthcare is a fundamental human right, acknowledged in many of the foundational human rights documents. The legal grounds of the right to health as well as women's rights is well-established and documented within the scope of international human rights law.

The second question under investigation was: Does the Swedish healthcare system provide victims of sexual violence with access to the highest attainable standard of mental health? The results from this study showed that the Swedish healthcare system does not provide victims of sexual violence access to mental healthcare facilities of good quality that is available, accessible and acceptable. This was confirmed by statistics from the organizations WONSA and RISE showing that a large number of victims that sought help after sexual violence stated that they received no or insufficient help from the public healthcare system in Sweden. These numbers were in agreement with the GREVIO Evaluation Report from 2019 which highlighted that the availability of long-term psychological counselling and trauma care for victims of sexual assault and domestic violence was inadequate in Sweden.

The survey from 2017 that was carried out by RISE also showed that survivors of sexual violence or abuse tend to receive a host of different psychiatric diagnoses such as PTSD, depression, and

bipolar disorder. Thus, this result supports previous research suggesting that psychiatric diagnoses are more common among victims of sexual violence compared to individuals without a history of sexual abuse (see Rajan et al., 2017). The statistics from Wonsa and RISE both show that around 80% of the respondents with a history of sexual violence or abuse experienced that they did not get sufficient help from the public healthcare system in Sweden. These numbers confirm Judith Herman's theory that individuals who have been subjected to sexual violence or abuse are often mistreated within the healthcare system and that the existing diagnostic categories of psychiatric disorders may not be designed for these patients. A diagnosis has serious consequences as it informs subsequent treatment and receiving the wrong treatment can have devastating effects. The results indicate that a large group of individuals in Sweden might be misdiagnosed and thus treated for the symptoms of the trauma rather than from the trauma itself.

The answers from the national survey carried out by RISE in 2013 found that most healthcare providers in the study found no need for specialist psychological care regarding victims seeking help for the consequences of sexual violence. This illustrates a gap between the experiences of the victims of sexual violence and the views of healthcare professionals. Thus, it may be inferred that many healthcare professionals across Sweden are unaware of the special needs of this patient group. The results from the study by RISE supports this claim as the respondents stated that 61% of therapist/psychologists, 56% of doctors within psychiatry, and 54% of doctors within primary healthcare did not have enough knowledge and understanding about sexual violence and its consequences. This also supports Herman's theory that the absence of an accurate diagnosis has significant consequences for the treatment of this group of patients. Methods of treatment are often restricted to the symptoms of the abuse instead of emphasizing the underlying traumatic experiences. How can the causes and underlying experiences of the trauma be addressed by healthcare professionals that are unaware of the needs of these patients?

Further to this, results from the study by RISE showed that 72% of the respondents had never been asked whether they had been exposed to sexual violence by any healthcare professional. The results are in line with the study by Kavig (2008) showing that healthcare providers often fail to ask about exposure to sexual abuse, even when victims want to disclose this information in order to receive help and care. This illustrates the difficulties to communicate experiences of sexual abuse in the healthcare system. If healthcare professionals ask about exposure to sexual violence when assessing conditions that may be caused by sexual violence, both identification of this patient group as well as improvement of subsequent care would follow. It is of vital importance for patients to know that

there are knowledgeable healthcare professionals and clinics where they can seek treatment and feel safe to talk about their experiences.

As previously discussed, the effects of sexual violence on women's health is widely documented. Still, the question regarding the mental healthcare of these women are not talked about and recognized. Why is this matter still hidden and not discussed in public in Sweden? Drawing back to Herman's theory: the conditions of women's realities have been hidden in the sphere of private life, and women for most of history have not had a name to describe their experiences of sexual violence. Still today, women's experiences of sexual violence are often hidden within the context of the healthcare system. Even though women are the target of multiple forms of violence, little attention has been devoted to the care of these women. As highlighted by the WHO, there is a need for studies regarding health effects associated with sexual violence, in order to find ways to help the victims of sexual violence.[50] Goal number five of the UN Sustainable Development Goals is to end 'all forms of discrimination against women and girls everywhere' (SDG, 5.1). How can this goal be achieved without offering women who have been subjected to sexual violence appropriate health care? Today, women's rights have been 'mainstreamed' in the UN, with the aim that women's right to freedom from violence should be as fundamental and of the same level of importance as other human rights (Nash, 2015: 118). However, the UDHR and several other foundational human rights documents state rules of conduct mainly for governments. The main concern of these human rights documents is what takes place in the public sphere, as a result of actions and policies carried out by state actors. The private domestic sphere, which has great impact on the exploitation of women, is constructed in human rights documents as a natural place of family relations (Nash, 2015: 115). For example, as stated by the UN, domestic violence has often been viewed as private matters that are "outside justice".[51] This gap has for a long time supported the stronger recognition given to violence carried out by state actors than violence carried out by private individuals or non-state actors. An example of this is the recognition of PTSD after the Vietnam war. This both limits women's access to human rights and signals that violence against women is tolerated. It is of vital importance to challenge States' restriction of women to the private sphere and the exclusion of women from States' international obligations. Protecting vulnerable individuals and groups is a vital challenge for all societies. States need to develop, implement and monitor plans of action and strategies in order to provide protection to vulnerable groups, such as victims of sexual violence.

[50] World Health Organization, 2013, p. 39
[51] UN Women, Passing and implementing effective laws and policies, 2015, available at: https://www.unwomen.org/en/what-we-do/ending-violence-against-women/passing-strong-laws-and-policies [accessed 5 August 2019]

This group of women needs protection in order to prevent additional psychological or mental burdens connected to the lack of reaction and action from the society (Sveaass, 2008: 321-322).

The third research question that guided this study was: How should the Swedish government provide victims of sexual violence with access to the highest attainable standard of mental health? The national survey conducted by RISE highlights the lack of knowledge within the healthcare system in regards to the need for specialized psychological healthcare for these patients. To name the syndrome that victims of sexual violence or abuse suffer from would represent a vital step of giving them recognition and credibility. Also, the acknowledgment of these individuals as a patient group is an essential step towards providing this group with mental healthcare of good quality that is available, accessible and acceptable and integration in the healthcare system. Thus, a way for governments to ensure in practice that victims of sexual violence get access to the highest attainable standard of health which includes mental healthcare, is to give this patient group an official recognition. This confirms Herman's theory, that victims of sexual violence or complex psychological trauma need to be officially recognized in order to make appropriate treatment accessible for these patients. It was the recognition and inclusion of the diagnosis PTSD in the DSM in the 1980s that led to extensive scientific studies and the development of effective treatments. A parallel can be drawn between the war veterans and victims of sexual abuse. In the same way as PTSD was recognized as a diagnosis and the veterans were able to get help and access the right treatment, the same could be possible for victims of sexual abuse. Referring back to Arendt's idea of "the right to have rights", a status or a diagnosis is necessary for victims of sexual violence, otherwise you can't claim the right to have rights.

The right to mental healthcare is an integrated part of the right to health and a fundamental human right for all people. In theory, women who have been subjected to sexual violence should, as right-bearers, have access to available, accessible, high-quality mental health care. However, victims of sexual violence cannot access appropriate care from a human rights declaration. The results show that there is a need for recognition and protection from the healthcare system which includes knowledgeable and equipped healthcare professionals. Professor Nora Sveaass has worked with human rights violations, rehabilitation and treatment of victims of torture and other serious abuse (Sveaass, 2013). Sveaass argues that the process towards recovery and rehabilitation for those individuals whose rights have been grossly violated is long and complex. The existence of healthcare professionals that are aware and knowledgeable about trauma and the rights of victims is a priority in this process (Sveaass, 2013). The obligation to provide rehabilitative services and redress for victims within the healthcare system rests on political will. Sveaass argues that there is a

need to talk about how rehabilitation for victims is to be understood and addressed in practice. The call for justice for these individuals belongs not only to the judicial or legal world but also to the medical field. Healthcare providers are in a position to address the needs of victims of sexual violence. Thus, communication between caretakers of trauma victims and decision makers is necessary in order for victims of human rights abuses to get redressed and rehabilitated.

Sveaass argues in regard to victims of torture that caregivers need to be aware of the rights of victims as well as the state's obligation to provide this care, in order to oversee the implementation of the right to rehabilitation, meaning the care needed to recover and repair (Sveaass, 2013). The same argument can be used for victims of sexual violence. There is a need for communication between the medical field and the judicial field in order to ensure that people who have been subjected to sexual violence get redressed and rehabilitated. Sveaass states that: "Redress and reparations after torture must therefore consist of a combination of interventions, where legal, social, economic, and health-related actions are needed. Even the best of therapy and care will not have the desired effect if it is provided in a context of impunity and denial" (Sveaass, 2008: 323). This requires help and action from the society where the individual lives. Reparation and rehabilitation is also about acknowledgement and recognition, that a crime or wrong was done against the person. A public recognition confirms the individuals own experience of injustice and can therefore be an important step to deal with the aftermaths of sexual violence, such as the profound feelings of shame and guilt. Sveaass' argument highlights the importance of recognition from society. Where the difficulties of the situations these women find themselves in are not recognized, this may result in self-blame or shame to seek help. If these women's experiences are challenged and not received and confirmed as real experiences, the patient can be retraumatized and get stuck. This leads to suffering for the individual and will also cost the society a great deal because one does not go to the bottom of the problem. Thus, an official recognition which confirms these individuals as a patient group in need of specialized care, might be an important step towards changing gender structures in everyday life. To name the syndrome that victims of sexual violence or abuse suffer from would be a step towards making violence against women unacceptable. This means that it is time to take this issue seriously and take the necessary actions to change this situation.

Political movements are necessary in order to give voice to the voiceless and disempowered. As we have seen in the past, political pressure has brought the study of psychological trauma into public awareness and inspired and sustained change. According to Herman, the study of psychological trauma depends on a political movement strong enough to expand and advance this field of

knowledge (Herman, 2015: 32). Women's experiences should no longer be restricted to the private sphere of domestic life. To eliminate discrimination against women, the issue of specialist care for psychological trauma after sexual violence needs to be acknowledged. The realization of this right is, in line with Hannah Arendt's argument, dependent on the state's willingness to enforce them. Thus, as Herman argues, there is an urgent need for political work towards the acknowledgement of this patient group, and towards advancing the study of psychological trauma.

Conclusion

Victims of sexual violence face difficulties in today's fragmented healthcare environment. It is my hope that this study can contribute to change the present situation for these individuals so that they can receive appropriate care, and to raise awareness among decision-makers and health professionals meeting these individuals. The overarching purpose of this study was to explore why public health-care facilities around the world and in Sweden often fail to provide victims of sexual violence with mental healthcare of good quality that is available, accessible and acceptable. There are many possible answers to this question such as the historical inability to take women's health issues seriously. The GREVIO report which highlights the urgent need of psychological counselling and specialist support services should serve as a wakeup call for Sweden. The Swedish Governments declaration that an increased number of clinics for victims of sexual offences shall be established in Sweden must be closely followed so the declaration does not stay in mere words alone. This matter can no longer be hidden. If society responds to and recognizes these individuals by improving their care and creating justice, the victims will be helped, and the consequences of sexual violence will be diminished in future generations. Such a response from society can help victims towards recognition and redress. A society that is willing to recognize victims of sexual violence as individuals in need of specialized mental healthcare has taken an essential step towards the elimination of violence against women, thus acting in accordance to the basic principles of human rights.

9. Future research / recommendations

Further directions of study might want to map how the treatment of victims of sexual violence looks like in other countries than Sweden. Along these lines, it may be of further interest to explore the effectiveness of treatment when a patient has a diagnosis of sexual abuse, compared to treatment of patients without a diagnosis of sexual abuse.

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