Issues
NO. 7 JUNE 2007
AUSTRALIAN CENTRE FOR THE STUDY OF SEXUAL ASSAULT

"Ripple effects" of sexual assault

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This paper discusses some of the widespread effects of sexual assault on families, professionals and society as a whole, demonstrating the significance of sexual assault as a social issue.

This paper is about how the effects of sexual assault are wide-reaching. As well as the profound effects of sexual assault on victim/survivors, a victim/survivor's family members and friends, workers in the sexual assault field, and society as a whole are affected by sexual assault in detrimental and still under-recognised ways. These "ripple effects" of sexual assault are the subject of this paper. We use the term "ripple effects" as a metaphor to describe the effects and costs of sexual assault on a victim/survivor's personal and professional networks, and the broader society within which they exist. As Remer and Ferguson (1995) state, "victimization has a ripple effect, spreading the damage in waves out from victims to all those with whom they have intimate contact" (p. 407). In this paper, we concentrate mostly on the ripple effects of the sexual assault of adults.

The most recent statistics show that sexual assault remains prevalent in Australia. The Australian Bureau of Statistics' Personal Safety Survey (Australian Bureau of Statistics [ABS], 2006) found that 19.1% (or nearly 1 in 5) women have experienced sexual violence (defined as sexual assaults and sexual threats) since the age of 15, and that 1.6% of women over the age of 18 had experienced sexual violence in the past 12 months (Morrison, 2006).

The most recent statistics show that the prevalence of sexual assault remains unacceptably high in Australia.

Research documents a myriad of harmful effects experienced by primary victim/survivors as a result of being sexually assaulted. The impact on the individual includes psychological and emotional effects such as: intense fear of death and disassociation during the assault; anxiety and ongoing fears (Petrak, 2002); feelings of low self esteem, self-blame, and guilt; shock, confusion, and denial; self-harm, suicidal ideation (Stepakoff, 1998) and attempted suicide (Petrak, 2002); and post-traumatic stress disorder (PTSD) (Calhoun & Resnick, 1993 cited in Astbury, 2006). Physical effects

Australian Government
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Australian Centre for the Study of Sexual Assault

The Australian Centre for the Study of Sexual Assault aims to improve access to current information on sexual assault in order to assist policymakers and others interested in this area to develop evidence-based strategies to prevent, respond to, and ultimately reduce the incidence of sexual assault.

The Australian Centre for the Study of Sexual Assault is funded by the Office for Women, Australian Government Department of Families, Community Services and Indigenous Affairs through the Women's Safety Agenda. The Centre is hosted by the Australian Institute of Family Studies.

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Acknowledgements

Thanks to our two external reviewers (Ms Vanessa Swan and Dr Jan Breckenridge) for their extremely helpful comments and reviews. Thanks also to Institute staff for their comments and assistance (Dr Daryl Higgins, Ms Haley Clark and Ms Ellen Fish).

ACSSA Issues are peer-review publications.

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ISBN 978 0 642 39549 8

Edited by Ellen Fish
Typeset by Woven Words
Printed by Impact Printing

of sexual assault include: chronic diseases, headaches, eating disorders, gynaecological symptoms, irritable bowel syndrome, and damage to the urethra, vagina or anus. Sexual assault can have profound effects on the relationships and social life of the victim/survivor, impacting intimate partner, friendship and family relationships (Crome & McCabe, 1995). It can disrupt and alter a victim's work life, leisure activities and community life. Furthermore, victims can suffer "secondary victimisation" through their experience of the response of the criminal justice system and health service providers (Ahrens, 2006) and receive other harmful and negative responses from friends, family and broader society (Davis & Brickman, 1996). Sexual assault may have financial costs, including loss of earnings, loss of earnings capacity, medical expenses, counselling expenses and, of course, a myriad of intangible costs not measurable in monetary terms (Mayhew & Adkins, 2003).

The sexual assault of an individual does not occur in a vacuum. Research on the ripple effects of sexual assault suggests that the effects of sexual assault extend well beyond those numbers of individuals indicated in prevalence statistics (which are themselves often underestimates and the subject of debate, see Neame & Heenan, 2003). Thus, the aim of this paper is to look at the ripple effects of sexual assault and demonstrate the scope and significance of sexual assault as a major social issue, affecting many more people than the prevalence statistics suggest, and costing society as a whole.

A paucity of research exists on the ripple effects of sexual assault, consistent with their lack of recognition. Much of the research that does exist is within the field of trauma. Trauma research has recognised that witnessing violence or abuse against a "significant other", or being exposed to traumatic material in other ways, is traumatic within itself, creating "secondary victims" of sexual assault and other traumas. In this paper, we discuss concepts of "secondary traumatisation" and "vicarious traumatisation". The other body of research that exists on the ripple effects of sexual assault has documented the effects of sexual assault on people's interaction with their local space, including literature on the social geographies of fear, and the impact on wider society, such as studies that have financially "costed" sexual assault.

The structure of the paper is as follows:

- The paper begins with a short critical discussion about the concept of "trauma", a key term in this field.
- Secondly, the paper reviews the research on the effects of sexual assault on non-perpetrator family members and friends of victim/survivors (secondary traumatisation).[1]
- Thirdly, it examines the literature on the effects of sexual assault on counsellor–advocates and other professionals working in the sexual assault field (vicarious traumatisation).
- Fourthly, it will consider how fear of sexual assault impacts on the way women in particular are able to lead their lives in public space.
- Finally, it will consider the costs of sexual assault on broader society, including a review of research performed on the economic costs of sexual assault. The article will conclude by considering the implications of the ripple effects of sexual assault.

A paper on the ripple effects of sexual assault has many limitations, not only because the ripple effects of sexual assault are under-recognised, but also because the ripple effects are potentially endless. This paper is limited to discussing just some of the ripple effects of sexual assault that have been researched and documented so far. We have not, for instance, discussed the ripple effects of rape as a weapon in war/civil strife, and the ripple effects of rape in refugee communities—these need to be the topics of other papers. We have also not discussed the ripple effects of sexual assault and trauma in Australian Aboriginal communities. Where appropriate, we indicate the gaps in existing research, and opportunities for further research and consideration.

Examining the concept of "trauma"

Some ripple effects of sexual assault on individuals have been conceptualised through the concept of "trauma". The concept of "secondary traumatisation" is used to describe the effects of sexual assault experienced by non-perpetrator family members of victim/survivors. "Vicarious traumatisation" is used to conceptualise the effects on counsellors and other professionals working in the sexual assault field. We look at both these concepts in detail in this paper. Before going on to discuss them, it is important to examine the concept of "trauma" itself.

Useful aspects of the concept of "trauma"

The concept of trauma has been useful in understanding the effects of rape. Judith Herman's ground-breaking work *Trauma and recovery* (1992) validated and legitimised the effects of the trauma of rape. Wasco (2003) argued that the trauma response model and clinical diagnosis of post-traumatic stress disorder helped to

1 The term "secondary traumatisation" should be distinguished from the term "secondary victimisation". Secondary traumatisation refers to the effects of the sexual assault on people who were not the primary victim of the assault, but are nonetheless adversely affected by it, for example, non-perpetrator family members and intimate partners. By contrast, secondary victimisation refers to the process that occurs for (primary) victim/survivors when they disclose sexual assault and receive negative or inadequate responses from family, friends or systems (including legal, health and therapeutic systems) that lead to further trauma for the victim/survivor (see Astbury, 2006).

acknowledge the significance of the harm caused to people who have been sexually assaulted, and the extent of the violation they have experienced. PTSD offers a "scientific explanation" for their distress, which does not blame the victim for "bringing it on herself" (Gilfus, 1999, cited in Wasco, 2003). This stands in contrast to previously held conceptions of "maschochism" or "hysteria", which focus on the pathology or illness of an "hysterical" individual, rather than the traumatic event/s that caused the victim/survivor's understandable distress (Wasco, 2003, p. 310).

Also, applying PTSD to rape victims connects rape to an extensive body of research on treatments that may effectively alleviate painful symptoms of PTSD, including exposure therapy, cognitive behavioural process and others (see Astbury, 2006, for an extensive review of these treatments). For both primary and secondary victims of sexual assault who suffer from "chronic and severe distress", these treatment options can be extremely valuable.

Furthermore, acceptance of PTSD as a valid condition by the health care system means that victim/survivors who experience PTSD may access mental and physical health care, which may be essential for recovery.

Finally, measuring levels of trauma (as some of the literature we use in this paper has done) can lend further evidence to the fact that violence against women is pervasive and has severe and widespread effects. For example, measuring trauma levels in family members of survivors of sexual assault, or of various professionals who work in the field, can produce quantifiable "evidence" of the ways in which they have been affected. Thus, the examination of the concept of trauma has been and continues to be a useful way of understanding the effects of sexual assault, and a practical way of assisting both primary and secondary survivors to access the services they may need.

We engage with literature that uses concepts of trauma in this paper. Firstly, because it constitutes almost the only literature written about the ripple effects of sexual assault. Secondly, as mentioned above, because the concept of trauma provides a way of measuring and illustrating how the "wounds" of sexual assault are not limited to the primary victim/survivor, but are pervasive throughout society.

Criticism of the concept of "trauma"

While engaging with the concept of trauma, however, we do this with knowledge of the concept's limitations.

Various measures of trauma are not always adequately sensitive to diversity. For instance, trauma measures may be developed with one population group, who may have different life experiences and perceptions of life experience to other population groups. For example, Green, Chung, Daroowalla, Kaltman, and DeBenedictis (2006) found that a trauma measure of "stressful life events", developed with US college women, was not entirely consistent with the experience of stressful life events experienced by low-income black women. While the black women on low incomes ranked items such as death, physical violence, violent relationships, sexual abuse, rape and serious illness as similarly traumatic as the college women, they did not rank robbery, being threatened with a weapon or attempted rape as traumatic and, in addition, nominated miscarriage, emotional abuse, substance abuse and eating disorders as additional traumatic life events. Green et al. hypothesised that not nominating robbery or being threatened with a weapon as traumatic may have been because of the ubiquitous nature of trauma in these women's lives: "in a life with rape and murder among one's significant others, a robbery or threat may seem less traumatic" (2006, p. 1206).

Similarly, the authors suggested that not ranking attempted rape as traumatic may be because many of the women had been raped or molested, and all seemed to know someone who was, suggesting that within this context, an attempt that did not succeed may not be seen as particularly problematic (in comparison to actual rape).

Different contexts may also influence the effects of rape. Within a trauma model, an effect of rape for both primary and secondary victims is generally understood to be a "shattered world view", which is said to lead to profound feelings of distrust and other negative experiences. However, as Wasco (2003) pointed out, this is imagined from the position of an individual for whom the world has previously (that is, before the assault) been "basically safe and fair". In fact, for many—and particularly for the most disempowered—other profound and traumatic harms might have already been experienced. Thus, an experience of sexual assault may not necessarily shatter these assumptions about the world, because the world has been and already is experienced as unsafe and unjust. That is, while rape will always be a traumatic experience and a violation of human rights, the effects of this trauma for an individual may be different in different contexts.

Similarly, a long-term "symptom" of vicarious traumatisation among professionals working in the field, following prolonged exposure to traumatic material, is "disrupted" or "distorted" "cognitive schema" (fundamental beliefs about the world, other people and oneself). While acknowledging the distress disrupted cognitive schema can cause, it could also be suggested that, rather than these views necessarily being disrupted or distorted, they may in fact be a more accurate reflection of the reality of unfortunate aspects of the world, reflecting knowledge that workers have acquired through working in the field. Thus, some trauma measures reflect dominant views about the world that many people do not share.

Researchers also point out that certain symptoms of trauma, rather than being viewed as problems to be treated, need to be viewed in a more positive light—as "coping mechanisms" an individual has adopted for protection and other purposes. Hyper-vigilance, for example, has been found to, in fact, effectively protect a victim/survivor from further violence. Also, it may be difficult to generalise about symptoms of trauma. The ways people experience and express trauma will be culturally and even locally specific, making it difficult to accurately state what, in general, symptoms of trauma will always be. This highlights the importance of conducting research on cultural sensitivity, difference and translation.

Finally, trauma conditions such as PTSD do not encompass all the individual effects of sexual assault. Depression, low self-esteem, self-blame and stress-related physical symptoms experienced by victim/survivors of rape, are all examples of psychological symptoms or effects that are not included in PTSD (although they may be noted as "associated features", rather than "diagnostic criteria" for this condition). And as this paper points out, the effects of sexual assault are much more wide-ranging than these.

Indeed, as already mentioned, a trauma model tends to look at and measure the effects on the individual of a traumatic event, classify "symptoms" and indicate the helpfulness of certain "treatments". While this is crucial in validating an individual's experience and alleviating their pain, on its own it can also have an individualising effect: our focus on the effects of rape stays at the level of the individual. This is problematic if we are also to view rape as a social problem, with social solutions.

Overall, these criticisms and others indicate the limits of using the trauma model in mapping ripple effects of sexual assault.

"Secondary victims" of sexual assault

Non-perpetrator family members, partners, friends and children of victim/survivors are affected by a sexual assault and its aftermath (Daane, 2005), yet there has been relatively little primary research and supporting literature focused on the impact of sexual assault on these "secondary victims". To the extent that secondary victims are considered in the literature, the focus is usually on the manner in which their response to the victim/survivor's experiences helps or hinders the primary victim's recovery.

This is an important concern. Higher levels of unsupportive behaviour by family members has been found to be more likely for sexual assault victims than for victims of non-sexual assaults (Davis, Taylor, & Bench, 1995; Davis & Brickman, 1996). Research has found that the response of family members to a victim/survivor's disclosure of the sexual assault, but particularly the negative responses, can be a determinant of how damaging the sexual assault ends up being to the victim/survivor (Ullman, 1996). Negative and/or otherwise inappropriate responses by family members to a victim/survivor can have many profound negative effects on the victim/survivor, and can lead to a shattering of family relationships, communication and functioning. For instance, pressure from family members on the victim/survivor to remain silent or lie about the sexual assault can be particularly damaging (Ullman, 1996), and indeed inhibit any further disclosures (Ahrens, 2006) and help-seeking. Conversely, being believed and being listened to can be particularly helpful (see Morrison, in press, for an in-depth discussion of these issues).

Higher levels of unsupportive behaviour by family members has been found to be more likely for sexual assault victims than for victims of non-sexual assaults

In addition, this issue of response to disclosure and the limited research on the impact of sexual assault on secondary victims themselves reveal some persistent themes. The most common theme is that secondary victims often experience the effects of trauma as well, sometimes with similar symptoms to those of primary victims. As Figley and Kleber (1995) put it:

> Nearly all publications focusing on people confronted with extreme stress events exclude those who have experienced the event indirectly or secondarily and concentrate on those who were directly traumatized (i.e. the "victims" or "survivors"). Yet, diagnostic descriptions of what constitutes a traumatic event … clearly suggest that mere knowledge of the exposure of a loved one to a traumatic event can be traumatizing as well. (p. 77)

Figley and Kleber (1995) go on to define a "secondary traumatic stressor" as "the knowledge of a traumatizing event experienced by a significant other" (p. 78).

This suggests that the support needs of secondary victims warrant attention in their own right. Indeed, if we recognise the impact of sexual assault on the people who care about victim/survivors and address their needs, it will not only assist a group whose needs have been previously overlooked. It will also better equip these people to provide a support network for the victim/survivor, which would greatly assist the primary victim/survivor's recovery and provide an overall better response to victim/survivors.

Why use the term "non-perpetrator family members"?

We use the term "non-perpetrator family member" in order to acknowledge the extent to which family members and significant others are themselves the perpetrators of sexual assault. The existing research on secondary victims usually fails to point this out. We also acknowledge that members of the perpetrator's family and other people who are significant in the perpetrator's life may also be affected, sometimes profoundly, by the sexual violence their family member has perpetrated towards another. However, that is not the focus of this paper.

The concept of "secondary traumatisation"

The term "secondary tramatisation" is generally used to refer to the ripple effects of sexual assault where a secondary victim experiences similar trauma symptoms to the victim/survivor themselves. Remer and Ferguson (1995) outlined a model of "trauma processing" that can be used to understand the effects of rape on both primary and secondary victims. The specific aspects that apply to secondary victims are:

- *Trauma awareness:* The secondary victim may not always know all the details straight away. Each disclosure by the primary victim may result in a new level of awareness for the secondary victim, both in terms of their knowledge of what happened, and the effects on the primary victim.
- *Crisis and disorientation:* For healing to occur, the trauma must be recognised, "dealt with", or "integrated". This recognition involves a degree of being "off balance".
- *Outward adjustment:* An appearance of coping, but without the full depth of the trauma having been "integrated". This occurs at both personal and relational levels. Established relationship patterns will prevail, as if there had been a return to the previously existing status quo, usually until the primary victim begins to "move on" in her/his own healing process.
- *Re-organisation:* New forms of relating will develop as a result of the "integration and resolution" of the trauma. Reorganisation will also occur in terms of the personal cognitive schema of primary and secondary victims.
- *Integration and resolution:* The trauma is integrated and resolved within the person's life; the person has "recovered".

The literature suggests this is not a linear process. Individuals may return to various stages from time to time in a back-and-forth process. For example, if a primary victim feels she or he can trust a family member to respond in supportive ways, they may disclose further aspects of the abuse over time, perhaps prompting a return to the "awareness" phase. This may also mean the healing of the secondary victim is intertwined with that of the primary victim.

For healing to occur, the trauma must be recognised, "dealt with", or "integrated". This recognition involves a degree of being "off balance".

Are secondary victims of sexual assault actually primary victims dealing with their own experience of abuse?

Most studies on secondary traumatisation do not identify the direct experiences of abuse of secondary victims. However, in the few that do, individuals have been found to experience symptoms of secondary traumatisation even if they have not been abused themselves (Nelson & Wampler, 2000; 2002). We discuss this at more length when reviewing the literature on vicarious traumatisation in professionals,

which contains studies that suggest that a professional's own abuse history is not a predictive factor in regard to experiencing vicarious traumatisation (see section below). Research suggests that witnessing the harm that sexual assault causes to someone else is also traumatic within its own right. One's own history of abuse will, however, be fundamental to these issues, and more research needs to be done on the experiences of victim/survivors in this regard.

Secondary trauma and intimate partners of victim/survivors of sexual assault

Research has found that intimate partners of victim/survivors may experience secondary trauma as a result of the sexual assault of their partner. For example, Nelson and Wampler (2000; 2002) studied couples of whom one or both partners had a history of childhood sexual or physical abuse. They measured stress symptoms and relationship functioning of 96 heterosexual couples, with a comparison group of 65 couples with no history of abuse. They found that non-abused individuals displayed traumatic symptoms similar to their abused partners, and that non-abused partners of abuse survivors had significantly higher levels of trauma symptoms than their peers in the comparison group. Similarly, Wiersma (2003) interviewed six couples (five heterosexual couples and one lesbian couple) of whom one female partner was a survivor of child sexual abuse. The study focused particularly on communication issues within the relationship. The study found that abuse-related issues, such as whether, how and when to raise issues about the abuse, can be a constant factor in communication between couples.

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Female partners of male victim/survivors of sexual assault

While research exists on female partners of male victim/survivors of other traumas, such as participation in war, little research exists on female partners of male victim/survivors of sexual assault. Jacob and Veach (2005) found that female partners of male victim/survivors of child sexual abuse commonly experienced abuse themselves at the hands of their victimised partners. The study was conducted with 10 female partners of male survivors of child sexual abuse. The women reported experiencing abuse, rape and unwanted sexual attention from these men. They also reported being blamed for their partners' anger. Most of the women believed that the abusive sexual behaviour of their male partners was an "acting out" of their childhood sexual abuse. The women also spoke about feelings of sadness and empathy for their partner. The authors qualify these findings by speculating that the women who volunteered to participate in the study may have been partly motivated by a wish to disclose their experiences of violence at the hands of their partners.

Jacob and Veach (2005) contend that male partners and female partners need to be understood as distinct populations. That is, the effects on and responses of female partners of victim/survivors are of a different kind to those for male partners. Results of studies of female and male partners would confirm this.

Male partners of female victim/survivors of sexual assault

The bulk of the literature on secondary victims has focused on the intimate heterosexual male partner of female victim/survivors (see below for a discussion on this focus). Authors write that male partners are affected by and respond to

the sexual assault of their partner in a myriad of ways, ranging from extremely unhelpful to extremely supportive (Daane, 2005).

Rodkin, Hunt, and Owen (1982, cited in Foley, 1985) suggested four major themes relevant to male partners of female victim/survivors: guilt and self-blame; desire for revenge and frustration; jealousy, anger and a sense of loss; and the need to protect or confine the victim. These themes are reflected in other studies.

Holmstrom and Burgess (1979) categorised men's reactions to the rape of their female partners as either "modern" (that is, they see rape as an act of violence causing injury to the victim) or "traditional" (that is, the men see rape as sexual, and focus on the emotional harm/stigma caused to themselves). In Holmstrom and Burgess' study, nine men took the "modern" view that rape was an act of violence that had caused injury to their partner. They found six men took the "traditional" view, focusing on their own hurt (including feeling betrayed, ashamed and repulsed by their partner). They also tended to blame their partner for the assault.

Smith's (2005) more recent study consisted of open-ended interviews with five male partners of adult female rape victim/survivors. She identified four main themes emerging from the interviews: the male partner's immediate painful thoughts and feelings; his relationship with the victim; his world view on male attitudes; and the long-term effects of the trauma. While the men generally described PTSD-like symptoms, some of their responses also reflected an acceptance of common societal "rape myths". Smith stated that the men were at times "critical of the victim … making inappropriate and negative comments" (p. 149). She wondered if this may have been part of their response to such an horrific experience. Smith argued that, from a therapeutic perspective, it is important to be able to hear these men express such damaging rape myth beliefs—which can be unhelpful to both primary victim and partner—in order to help dispel them.

[Smith] identified four main themes emerging from the interviews: the male partner's immediate painful thoughts and feelings; his relationship with the victim; his world view on male attitudes; and the long-term effects of the trauma.

Chauncey (1994) interviewed 20 male partners of female child sexual abuse survivors and found that the men generally felt highly responsible for others, and prone to self-doubt, self-blame and guilt. When discussing the guilt a male partner may experience over their "failure to protect" their partner, Smith (2005) found this could often result in the female victim/survivor having to provide emotional support to her partner at precisely the time she most needed to be receiving such support herself.

Overall, a shift over time seems to have occurred in the way the effects of this trauma on the male partner of victim/survivors is represented in the research. Comparing the work of Holmstrom and Burgess (1979), for example, with Nelson and Wampler (2000; 2002), there is a marked shift from conceptualising a male partner's unhelpful responses as being "unsupportive" and "traditional" in the earlier work, to similar patterns of behaviour being described as "symptoms of trauma" in the later study. Smith (2005) combined both perspectives. This is perhaps due to the development and impact of clinical concepts of trauma on the sexual assault field. While this shift presents perhaps a more compassionate understanding of men as partners, there is also an implicit danger of reinforcing and justifying harmful reactions based on what could be seen as values of male

privilege and entitlement if men's stereotypical and pejorative views of victim/survivors are not challenged.

Questioning the focus on male heterosexual partners in secondary victim literature

The focus on male intimate partners in the literature on secondary victims of sexual assault is said to be because "the one who is probably most important both in the initial reaction to the rape and in providing support afterwards is the male significant other (e.g. husband, boyfriend)" (Cwik, 1996, p. 102). Remer and Ferguson (1995) made a similar statement: "the majority of the secondary victims of sexual assault are male, because the majority of primary victims are female" (p. 407). Yet, perhaps the assumption that the "wounds" of rape will be greatest for the male sexual partner of the female victim/survivor itself reflects traditional notions of sexual ownership and entitlement. The intimate heterosexual relationships of rape victims, if they are in one, may not always be the most important relationship in their lives. Other studies suggest friends and family members also play a crucial role for victim/survivors, and the effects of the sexual assault on these people can also be profound (Ahrens & Campbell, 2000; Davis & Brickman, 1996; Davis et al., 1995). Furthermore, in those situations where the male intimate partner is the perpetrator of the sexual assault, non-partner supporters will obviously be crucial.

It also needs to be noted that almost all the couples studied so far have been heterosexual. Clearly, more research needs to be done on the response to sexual assault within same-sex couples, validating the harm that will be caused to a partner in a gay or lesbian relationship if their partner is raped, and studying responses.

Secondary trauma, parents and other family members of victim/survivors

We have not found any research to date devoted to the secondary trauma of (non-perpetrator) parents and other family members of people sexually assaulted in adulthood. Much of the literature on parents of adult victim/survivors and other family members instead addresses the response of these people to the disclosure of rape, and to the victim/survivors themselves. This literature discusses the responses that are helpful and thus assist with support and recovery, and responses that serve to re-victimise the victim/survivor and impede their recovery.

However, some of the research on families in general, and family therapy in the context of sexual assault in particular, does discuss the impact of sexual assault on family members, including parents (for example, Cwik, 1996; Feinauer, 1982; Davis et al., 1995; Silverman, 1978). (Some of the key texts still used in this field were written decades ago.) This literature states that, following the sexual assault of a family or loved one, family and friends often experience considerable emotional distress and physical and psychological symptoms that can disrupt their lifestyles and family structures (Cwik, 1996). Responses of family members to the assault, including shock, helplessness, rage and so on, which can "parallel the affective responses of the victim" in the acute post-traumatic period (Silverman, 1978, p. 169). Feinauer (1982) stated that victim/survivors and their families "have a sense of isolation and estrangement from others. They may feel violated and different. They may lose their sense of community and belonging" (p. 38). Both survivors and family members may feel a "sense of devaluation and guilt" (White & Rollins, 1981, p. 105) or "devaluation and shame" (Silverman, 1978, p. 168).

These feelings may be reflected in both self-blame and blame directed toward other members of the family. Overall, this literature emphasises the extent to which the crisis of rape can have a significant impact on family and marital relationships. It may also "bring to the surface" other longstanding relationship issues (White & Rollins, 1981, p. 104). Again, this literature tends to focus more on male family members, including partners/husbands and fathers.

By contrast, there is a relatively large body of research on the parents of victim/survivors of child sexual assault, including intra-familial rape, about which we do not have the space to fully engage with here. Whereas male family members tend to be the focus in literature dealing with adult victim/survivors, the body of research on child sexual assault tends to focus more on mothers (see Breckenridge, 2006, for a recent review of many of the articles in this field). In this field, much of the research again focuses on the mother's responses to disclosure of the abuse, and her own history of abuse (Breckenridge & Davidson, 2002). This literature points out that the relationship between this and secondary traumatisation is not straightforward (see Breckenridge, 2006).

However, some of this research also demonstrates the profound harm parents can experience because of the sexual assault of their child. It is worth briefly mentioning some of these studies here because of their potential relevance to the issue of the parents of adult victim/survivors. Studies of parents of child victims of sexual abuse have found these parents suffer clinical levels of distress at up to three times the prevalence of the general population (Manion, McIntyre, Firestone, Ligezinska, Ensom, & Wells, 1996; Newberger, Gremy, Waternaux, & Newberger, 1993). Manion et al. studied 93 parents (63 mothers and 30 fathers) of extra-familial child sexual abuse victims, and compared this group to 136 "non-clinical" parents (74 mothers, 62 fathers), and concluded that parents experience secondary traumatisation when sexual abuse of their child is disclosed. Similarly, Newberger et al. studied 44 mothers and 2 maternal caregivers of child victims of sexual abuse over one year. Perpetrators included biological fathers of the children and other male partners of the women. The research found that mothers experienced significant symptoms of traumatisation, with 55% of the group scoring in the "clinical range" in the first interview. Symptoms diminished over the 12 months but were still present for a substantial number of the group. Newberger et al. pointed out that the definition of PTSD includes effects from "serious threat or harm to one's children" (p. 95).

Hill (2001) described a UK study based on interviews with 11 women attending a peer support group for mothers whose children had been sexually abused. A sense of guilt and failure as a mother was a common initial reaction to discovery of the abuse. Many of the women also described strong feelings of anger towards men in general, and feelings of depression. Some mothers expressed their belief that the "recovery" of mothers was a key factor for the recovery of their children. This brief glance at some of the literature on the parents of child victims of sexual assault could suggest that mothers and fathers of adult victims of sexual assault would also be significantly affected, if not traumatised, by the rape of their adult child.

Clearly, large gaps in this literature still exist in relation to family members of adult victim/survivors. We have pointed out the small amount of literature on parents, while siblings of victim/survivors (both child and adult) hardly figure at all in any of this literature. Yet, it is important that these people are able to access services to support them in their recovery: "All too often the 'other' victims

of rape are overlooked during the acute and follow-up phases of intervention" (Cwik, 1996, p. 96). Researchers have also emphasised the importance of long-term (rather than short-term crisis) counselling in relation to families of victim/survivors of sexual assault, as well as victim/survivors themselves (Silverman, 1978; White & Rollins, 1981).

Secondary trauma and children of adult victim/survivors of sexual assault

We have not found any primary studies to date on the specific effects of sexual assault on the children of adult victim/survivors of rape. Mio and Foster (1991) stated that the lack of attention to children in the literature on secondary victims of sexual assault may be because many authors consider rape a "sexual" rather than a "violent" act. Thus, as sex is seen as an issue for adults, children are excluded from consideration.

However, it should be noted that there has been extensive national and international research on the impacts of domestic violence on children, and many perpetrators of domestic violence include sexual assault as part of their repertoire of controlling behaviour. We do not have the space to fully engage with this substantial body of literature here. Most recently, this research has found that the impact on children of witnessing family violence is so profound, it needs to be considered a form of children abuse within its own right (Victorian Law Reform Commission, 2006). Children who have been exposed to violence between parents often display similar reactions and developmental problems as children growing up in war zones (Berman, 2000). Children of all ages suffer emotional distress, psychological disturbance and behavioural difficulties as a result of witnessing family violence (Imbesi, 2005–2006; James, 1994). Research has also recognised a connection between family violence and direct child abuse (Tomison, 2000), including sexual abuse of children. One Australian study found domestic violence in the families of 40% of cases of child sexual assault presented to a city children's hospital (Goddard & Hiller, 1993, cited in Baker, 2004), and another identified domestic violence in at least 52% of families where children were abused or neglected (Tomison, 2000). This brief glance at some of the literature on children and family violence would suggest that the sexual assault of adults probably has a profound effect on the adults' child/ren.

Secondary trauma and friends of victim/survivors

Ahrens and Campbell (2000) surveyed 60 friends of adult female rape victims, collecting both quantitative and qualitative data. Of all the participants, 96.6% felt angry at the assailant, 71.7% felt shocked, and 68.3% wanted to get even. Ten per cent of friends had nightmares about the assault, 8.3% were afraid of what others would think, and 6.7% felt alone in dealing with it. Similarly, Davis et al. (1995), in their study of 138 "significant others", which included male partners, male and female friends, and family members of adult female sexual assault victims, found high levels of distress, particularly among female secondary victims.

Gender and secondary trauma

The literature on PTSD and other trauma suggests trauma is experienced differently by women and men (Gavranidou & Rosner, 2003): female partners, friends and

mothers appear to describe and/or experience sexual abuse–related secondary trauma differently to their male counterparts.

Davis et al. (1995) found that female significant others of victim/survivors displayed greater levels of distress than their male counterparts. Also, some female significant others had a heightened fear of rape following the assault of their friend/family member. Manion et al. (1996) found responses to sexual abuse of children correlated with the gender of the parent. However, they also suggested that fathers' lower levels of distress compared to mothers' does not necessarily imply that the fathers were less affected by the assault. Rather, there may be issues of measurement and gendered experiences of distress that are not best conceptualised as "more" traumatised or "less" traumatised.

McGuffey (2005) found that parents may not only respond in ways that are gendered, but also respond in ways that are traditionally "gender re-affirming". Gender re-affirmation represents an attempt to restore the "known" order through exaggerated recourse to traditional gender roles and identities, even among groups that are conventionally expected to hold "liberal" attitudes towards gender. Such actions may need to be viewed in the face of a traumatic event that potentially unsettles existing assumptions about the world, which people may want to restore. Such re-affirmation of traditional roles tends to assert men's position of power and be detrimental to women. Such responses may include "mother-blaming" for the abuse, and emphasise idealised child-caring expectations on mothers, while ignoring father's responsibilities in this area. While McGuffey found in this US study that both fathers and mothers (particularly white mothers) and some external others (such as service providers) engaged in this process, some mothers (especially black mothers) resisted such moves. Gender reaffirmation may be a useful concept for wider understanding of the reactions of some secondary victims of adult sexual assault.

Positive ripple effects for family and friends of victim/survivors of sexual assault

The process of supporting a victim/survivor of sexual assault can also be a rewarding experience for the supporter or secondary victim. Research on family members of victim/survivors has stated that the trauma of the rape may stimulate a total re-evaluation of the quality of the relationship, a new-found closeness and common sense of purpose in response to the external crisis the couple shares (Silverman, 1978). Research on friends of victim/survivors has found that the assault may often result in the establishment of a stronger relationship between the supporter and the primary victim/survivor (Ahrens & Campbell, 2000).

We discuss in more detail the positive ripple effects of supporting victim/survivors of sexual assault in the following section on professionals working in the field.

Ripple effects on sexual assault counsellor/advocates and other professionals working in the field

Both theorists and practitioners have recognised that working with traumatised clients and traumatic subject matter can trigger reactions in workers similar to those experienced by the client (Dunkley & Whelan, 2006). In this section, we discuss the issue of vicarious traumatisation as a ripple effect of sexual assault, and also positive ripple effects of working in the sexual assault field. (See also Morrison, in press, on this topic).

The concept of vicarious traumatisation

We witness or are exposed to some of the most cruel and horrific things that human beings can do.

The term "vicarious traumatisation" was coined by McCann and Pearlman (1990), and conceptualises the "risks" of working with trauma clients. It has been defined as "the transformation that occurs in the inner experience of the therapist [or other worker] that comes about as a result of empathic engagement with clients' trauma material" (Pearlman & Saakvitne, 1995, p. 31), and refers to a cumulative (rather than sudden) transformative effect.

The original research on vicarious traumatisation stated that, like non-perpetrator family members and friends, many of the effects of sexual assault experienced by a counsellor/advocate parallel those experienced by the victim/survivor. For example, as one writer put it:

> Those of us who work with sexual assault are constantly exposed to traumatic material. We witness or are exposed to some of the most cruel and horrific things that human beings can do. Essentially, we walk into hell every day to face the horror of sexual assault, either with those who are victimised or with those who cause the harm. It is vital that we understand this constant exposure to human cruelty, and the pain it engenders, will impact us, in our work and in our lives: it will profoundly change us. (McAllister, 2003, p. 1)

Vicarious traumatisation is related to secondary traumatisation (see above), and has been related to concepts such as "burnout", "counter-transference", "compassion fatigue", and even ripple effects, although key differences exist between these concepts. Some have suggested this variety of terms has led to confusion and uncertainty regarding key concepts (see Dunkley & Whelan, 2006).

Questioning the use of the term "risk" in relation to vicarious traumatisation

Some literature on this topic conceptualises vicarious trauma as a "risk" of working in the sexual assault field. For example: "Many professionals *risk* vicarious trauma through their contact with traumatized people or material" (Bell, Kulkarni, & Dalton, 2003, p. 464, our emphasis). While attempting to convey the distress experienced by many professionals in the field, such conceptualisations may unwittingly portray traumatised people in a negative light, implying they are somehow "contagious" or "diseased" and, by implication, to be avoided. Through conceptualising trauma symptoms as ways of surviving and coping after a trauma (see above)—with many of these being in fact helpful ways to avoid further trauma—our conceptualisation of victim/survivors changes to one of people who have wisdom about aspects of the world that others do not.

What does vicarious traumatisation involve?

Vicarious traumatisation may involve a change in the cognitive schema (important or fundamental beliefs) that people have about themselves, other people, and the world around them. They may feel the world is no longer a "safe place". They may feel helpless to take care of themselves and others. They may feel their personal freedom is limited. They may feel that working with clients or sexual assault sets them apart from others (see above for a discussion about this symptom).

Vicarious trauma can also result in physiological symptoms that resemble PTSD reactions, which may manifest themselves either in the form of "intrusive symptoms", such as flashbacks, nightmares and obsessive thoughts, or in the form of "constructive symptoms", such as numbing and disassociation (Beaton & Murphy, 1995, cited in Bell et al., 2003, p. 463). For example, Astin (1990) reported that her work with rape victims resulted in nightmares, extreme tension and feelings of irritability.

Workers may also experience having no energy or time for self or others, increased feelings of cynicism, sadness or seriousness. They may feel "overwhelmed" by emotions such as anger and fear (Wasco & Campbell, 2002), grief, despair, shame, guilt and irritability. They may develop an increased sensitivity to violence, for example, when watching television or a film. They may feel anxious and need to avoid situations now perceived as potentially dangerous. They may feel a profound distrust of other people and the world.

The occurrence of vicarious traumatisation in the sexual assault field

McCann and Pearlmann (1990) argued that vicarious traumatisation is an unavoidable result of trauma work. Research has found that working with traumatised clients is especially difficult, and can be distinguished from working with other "difficult populations" because of the exposure of workers to emotionally shocking images of horror and suffering (see Cunningham, 2003). Empirical research has demonstrated that female counsellors who work with sexual assault survivors report intrusive thoughts or memories, increased arousal, avoidance or numbness (Pearlman & MacIan, 1995; Schauben & Frazier, 1995), and disruptions in basic cognitive schemas about trust in oneself and others and beliefs regarding safety (Johnson & Hunter, 1997; Pearlman & MacIan, 1995; Schauben & Frazier, 1995).

In fact, research has also found that working in the sexual assault field is particularly distressing when compared to other forms of trauma work. Cunningham (2003) found that clinicians who worked primarily with clients who were sexually abused reported more disruptions in cognitive schema than clinicians who worked with clients who had cancer. Similarly, Johnson and Hunter (1997) compared sexual assault counsellors and counsellors from a range of other therapy areas and found that sexual assault counsellors experienced greater emotional exhaustion and used more escape/avoidance coping strategies than other counsellors. Most recently, Bober and Regehr (2006) found that working with victims of interpersonal violence such as "wife assault", child abuse, rape and torture was associated with higher traumatic stress scores, but of all these, working with victims of rape in particular was associated with greater "disruptive beliefs". Interestingly, Way, VanDeusen, Martin, Applegate, & Jandle (2004) found in their study that people who treated victim/survivors and people who treated offenders did not differ in their experience of vicarious traumatisation.

Vicarious traumatisation and other professionals working in the field

The vicarious traumatisation framework has been primarily applied to understanding how conducting therapy with rape victims affects professional counsellors (Wasco & Campbell, 2002). Less literature relates vicarious trauma to other professions within the sexual assault field. However, most recently, researchers have called for a widening of the conceptualisation to other professionals exposed

to traumatic material (Dunkley & Whelan, 2006), stating that anyone who has extended contact with trauma victims or material, including helping and legal professionals, researchers and educators, is at risk of vicarious traumatisation and other types of reactions (Wasco & Campbell, 2002).

Research has found that lawyers working in the field demonstrate high levels of secondary trauma and burnout—significantly higher than mental health providers (Levin & Greisberg, 2003). Police officers also reported significantly greater symptoms of psychological distress and PTSD symptoms than mental health professionals (Follette, Polusny, & Milbeck, 1994). Research has also found that researchers working in the field are negatively effected, even if they have no personal contact with victims or assailants (Alexander et al., 1989, cited in Wasco & Campbell, 2002).

Lawyers working in the field demonstrate high levels of secondary trauma and burnout—significantly higher than mental health providers

These findings suggest that working in fields dealing with traumatic subject matter in ways that are not generally perceived to be "traumatising" may fare worse than, say, therapists. In contrast to the counselling and therapy field, where the concept of vicarious traumatisation has been recognised and addressed, recognition of the potential harm of other forms of work involving the trauma of sexual assault has been slow, and efforts to assist these workers are rare. Clearly, there needs to be wider recognition of these ripple effects of sexual assault.

What "predicts" experiencing vicarious traumatisation?

To predict whether therapists would experience vicarious traumatisation, early literature on vicarious traumatisation tended to focus on individual characteristics, and the organisations within which they worked. Later research on vicarious trauma emphasised the extent to which, regardless of personal or organisational characteristics, vicarious traumatisation is a natural and, to a certain extent, inevitable reaction of working with traumatic material. As McAllister puts it (2003), vicarious traumatisation is a "normal response to the repeated exposure to traumatic material" and it is "the nature of the trauma that causes it, not some weakness or failure in the provider or the organization" (p. 1).

Caseloads and trauma exposure

Within the sexual assault field, caseloads, or the extent of trauma exposure, appears to be a predictive factor of vicarious traumatisation. A study of 259 therapists by Bober and Regehr (2006) found that time spent counselling trauma victims was the best predictor of trauma scores. Schauben and Frazier (1995) found that counsellors who had a higher percentage of survivors of sexual assault in their caseload reported more "disrupted beliefs" about the goodness of other people, more symptoms of post-traumatic stress disorder, and more self-reported vicarious trauma. This has implications for occupational health and safety for sexual assault workers, particularly in regard to how many cases they see within a given period of time.

Level of experience

Level of experience also appears to be salient, yet existing research on this is contradictory. Way et al. (2004) found that providing sexual abuse treatment over a shorter length of time was a predictor of greater intrusions for those treating

survivors, but they also suggested that clinicians who had been most affected by vicarious traumatisation might have left the field prematurely and were therefore not represented in the study. Bober and Regehr (2006) found that the number of years of experience working in the field was associated with more disruptive beliefs regarding intimacy with others, which they said suggests that degree of exposure has an impact on intrusion and avoidance symptoms, but that altered beliefs do not appear to occur in the short run. Indeed, vicarious traumatisation is said to be cumulative. Some have suggested that symptoms may be recognised to a lesser extent over time, becoming normalised. For example, as one experienced domestic violence counsellor put it:

> When you do something that is difficult, you get used to it … it can seem to be having less of an effect on you, when in actual fact I don't think that is so … it can become even more important to get support because you can get out of touch with your own levels of stress. (Iliffe & Steed, 2000, p. 410).

Is a worker's own abuse history predictive of vicarious traumatisation?

Some research has suggested an association between personal history of abuse and experiencing vicarious traumatisation, but other researchers have not found personal history of abuse to be a predictive factor. For example, in an investigation of vicarious traumatisation in 188 self-identified trauma therapists, Pearlman and MacIan (1995) found that counsellors with a personal trauma history showed greater disruptions than those without such a history. However, Schauben and Frazier (1995) studied therapists who worked with sexual violence survivors, and found that vicarious traumatisation symptoms were not related to their personal trauma history (that is, whether they had experienced sexual assault themselves).

Similarly, Bober and Regehr (2006) found that personal histories of childhood or adult trauma were not associated with disrupted personal belief scores, except in individuals who sought treatment, suggesting that those who were distressed and unresolved about their personal histories were likely to appropriately seek assistance. In a study of those who work with maltreated children and their families, Stevens and Higgins (2002) found that a personal history of maltreatment (particularly psychological maltreatment and witnessing family violence) predicted current trauma symptoms, but not burnout.

Geography, rurality and vicarious traumatisation

The unique cultural characteristics of any community will potentially affect working in the sexual assault field in both positive and negative ways. Working in sexual assault in small or isolated communities, particularly in rural areas, can magnify and/or raise particular issues relevant to vicarious traumatisation. Accessing confidential professional support in small, isolated communities can be difficult, if not impossible. A lack of anonymity can exacerbate already stressful situations. For example, counsellors living in small communities may have unavoidable social interactions with offenders against the victim/survivors they have been counselling. As one worker put it, working in a small, isolated rural setting:

> Sometimes I may know an offender has been named, and he may never have been charged. I may know that there is not enough evidence to convict the guy—he's not going to be charged. So I'm left with this information. Probably 80 per cent of the time I'm going to run into [him] one way or another. (Caholic & Blackford, 2005, p. 48).

In an article focusing on sexual assault workers in Northern Ontario, Canada (Caholic & Blackford, 2005), the authors emphasised the impact of a lack of awareness of gender politics in the community—heightening the difficulties of working in the field. They drew a link between employment revolving around a resource-based industry, limited and traditional employment opportunities for women and the reinforcement of traditional gender roles, with greater difficulties working against sexual assault, and a less supportive community. However, on the other hand, they also pointed out strong relationships between workers and other members of the community, which helped defray trauma symptoms.

Coping strategies and their effectiveness

What are recommended coping strategies?

Many coping strategies are recommended by theorists and researchers in the area of vicarious traumatisation (Bober & Regher, 2006, p. 7), and research has found that when counsellors identify that they have been affected by their work, many have the ability to access positive coping strategies (McCann & Pearlman, 1990; Schauben & Frazier, 1995).

Many coping strategies are recommended by theorists and researchers … and research has found that when counsellors identify that they have been affected by their work, many have the ability to access positive coping strategies.

Researchers have variously suggested that changes in workplace practices and organisational culture, changes in workload, staff support, supervision, self-care, education, and work environment may help the prevention of vicarious traumatisation (Bell et al., 2003). Coping strategies such as de-briefing and peer support were identified in a study of domestic violence counsellors as the most important strategy for dealing with the after-effects of a difficult counselling session (Iliffe & Steed, 2000). Physical activity and self-care have been recommended. Self-care is said to involve monitoring levels of caseloads; identifying clients' levels of resilience and strength; clarifying boundaries; and socio-political involvement. Socio-political involvement has been found to enable people to positively channel their knowledge and feelings of anger and powerlessness regarding the insufficiently effective social and justice systems for victim/survivors of violence against women (Iliffe & Steed, 2000). For example, as two different workers remarked:

> There's a political reason why we have [this] problem in society, a problem with the way things are structured. And that's the reason to do the work that you do. (Caholic & Blackford, 2005, p. 55).

> I sort of had this passionate type of energy which I'm sure was some anger about what I was hearing … I wanted to try and channel this in a healthy way … so I got involved in a sort of a lobby component in the field so I

could channel some of that emotional energy into that area. (Caholic & Blackford, 2005, p. 55).

Are coping strategies effective?

Despite all the advice on coping strategies, however, little research has been done to assess their effectiveness (Bober & Regehr, 2006). Schauben and Frazier (1995) found that the use of positive coping strategies was associated with lower levels of PTSD symptoms in rape counsellors. However, recent research has found that the use of particular coping strategies, such as problem-focused coping, was not associated with the extent to which therapists experienced trauma, or symptoms or feelings of burnout (Stevens & Higgins, 2002).

For example, in a study of 259 therapists, it was found that for therapists who believed that recommended coping strategies (including leisure activities, self-care activities and supervision) would be useful in coping with workplace stress and vicarious traumatisation, these beliefs did not in fact translate into time devoted to engaging in these activities (Bober & Regehr, 2006). Most importantly, there was no association found between time devoted to coping strategies and traumatic stress levels. This has led Bober and Regehr to conclude that:

Intervention strategies for trauma counsellors that focus on education of therapists and augmenting coping skills unduly individualize the problem [of vicarious traumatization].

> Intervention strategies for trauma counsellors that focus on education of therapists and augmenting coping skills unduly individualize the problem [of vicarious traumatization]. (p. 1)

Indeed, Bober and Regehr (2006) argued that while mental health professionals have been strong in arguing that victim/survivors of violence should not be blamed for their victimisation or responses, when addressing the distress of colleagues, the focus has been on the actions of the distressed individual (their work/life balance, whether they engage in enough positive coping strategies, and so on). They argued that attention in this topic needs to shift from vicarious or secondary traumatisation intervention efforts to advocacy for improved and safer working conditions, particularly in regard to caseload and trauma exposure.

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Helpful aspects of work environments

The literature in this field contains suggestions for areas of advocacy in improved and safer work conditions. For example, as well as making sure caseloads are not too high, research has shown that having a more diverse caseload is associated with decreased vicarious trauma (Crestman, 1995, cited in Bell et al., 2003, p. 463). A safe, comfortable work environment has been found to be crucial for workers, particularly for those working in settings that may expose them to violence. Researchers have emphasised the importance of providing social support within the organisation, and staff opportunities to de-brief. Effective supervision is important, particularly in regard to creating a relationship of safety in which a worker is able to express his/her concerns. (See Morrison, in press, for more suggestions on helpful work environments).

Positive ripple effects of working in the sexual assault field

The concept of vicarious traumatisation is just one aspect of the ripple effects of sexual assault. In seeking to raise awareness about the significance of sexual assault as a social issue, it can be easy simply to focus on the negative effects. It is also important to point out positive ripple effects of working in the sexual assault field.

Firstly, apparently negative effects of this work may in fact assist therapists to do a better job. One study (Wasco & Campbell, 2002) points out that while work in the sexual assault field may engender negative emotions such as fear and anger, such emotional reactions are also found to be an important part of their work with rape victims. As the authors suggest:

> intense emotional reactions [to working with sexual assault victim/survivors], previously conceptualised within a vicarious trauma framework, may at times serve as resources for women working with rape survivors. (p. 120).

Also, besides an income, career progression for some, and other general benefits of paid work, research has found positive effects peculiar to the field of sexual assault. In another study (Iliffe & Steed, 2000), participants reported they felt privileged to share their clients' struggles and enjoyed seeing growth and change. As one worker put it, work in the sexual assault field can provide the opportunity for fulfilment and spiritual reflection, and greater appreciation of positive experiences:

> Like those of our clients, our spiritual questions are about evil, about the nature of humanity, about the nature of what is holy, about whether the universe is benign, or about existential angst and despair. Our questions emerge from the concrete realities of the stories we hear or see in the course of our daily work. … We cannot return to innocence, but perhaps because we know the worst, we can appreciate even more the delightful, playful surprises that awaits us. (Arms, 2003, p. 5)

Another writer discussed how witnessing "suffering provides a humbling and unrelenting experience of my own humanness" (Rankow, 2006, p. 96). A worker pointed out that working in this field meant you were "changing the world":

> [Workers are], one step at a time, changing the world. Each time we refuse to let the horror and pain of sexual assault define our lives, each time we can refuse to let it destroy another person, each time we transform the pain into greater knowledge, strength, compassion and wisdom we are one step closer to creating the world we want: a world free from sexual violence. (Rankow, 2006, p. 96)

Ripple effects on women's use of local and public space

The fear of sexual assault

The fear of sexual assault looms large in the minds of many women. Stanko (1995) argued that a generalised awareness of sexual assault permeates women's consciousness, leading women to disclose a fear of crime at levels three times that of men. Women fear the possibility of rape more than any other crime, and take greater efforts to avoid the possibility of rape than any other crime (Holgate, 1989). Individual women manage this threat in their daily lives, learning to avoid

situations perceived as "risky", which often translates into a fear of public areas, dark places and lonely streets. Research on the social geographies of fear has found that both individual sexual assaults in a local geographic community that receive specific media coverage, and the occurrence or phenomenon of sexual assault in general, has implications on the behaviour and autonomy of women within the public spaces they occupy.

A significant body of scholarship has examined women's feelings of vulnerability in their local communities and in public spaces as a consequence of the fear of rape (Brownmiller, 1975; Ferraro, 1996; Gordon & Riger, 1989; Koskela & Pain, 2000; Pain, 1991; Stanko, 1985, 1990; Valentine 1989; Warr 1985). However, much of this research is concerned with the impact of the fear of rape on women in the community. Little research proceeds from the question of how the fear and occurrence of sexual assault impacts on communities generally; that is, in terms of the health, wellbeing and even ideals of communities. While the costs of violence on communities are beginning to be considered, some of which are considered below, this understanding has yet to be extended specifically to sexual assault.

Women fear the possibility of rape more than any other crime, and take greater efforts to avoid the possibility of rape than any other crime

The effects of fear on women's lives

Research has found that the public realm has been defined as dangerous, unpredictable and unsafe for women (Day, 1999, 2001; Fisher & Sloan, 2003; Gardner, 1995; Hughes, Marshall, & Sherrill, 2003; Koskela, 1997; Pain, 2000, 2001; Stanko, 1992). This research also shows that women are most worried about sexual assault by a stranger, feel most unsafe outside at night time, regard certain areas such as underpasses and parks as frightening, and perceive neighbourhoods other than their own to be dangerous (Day, 1999 p. 307). Managing the threat involves strategies that minimise risk in public areas, such as carrying a personal alarm, not going out at night, not going out alone, or being accompanied by a male. These strategies are often couched as a "natural" or commonsense responses to the threat of victimisation.

Misattributed fear and the reality of sexual assault

Yet researchers have also noted that this generalised fear felt by women does not reflect actual forms of victimisation. Contrary to popularly held fears, perpetrators are usually known to victims (rather than strangers), violence against women occurs more often in private residences (rather than on dark alien streets), and does not usually involve the use of a weapon. Thus, the tendency to misattribute violence against women to strangers in a dangerous outside world glosses over the ways violence against women is part of the social structures of heterosexuality (that is, the meanings attached to romance, seduction and relationships) and social expectations about gender (that is, expectations about what it means to be a woman or a man). As a consequence, the extent of violence against women is minimised, since only one form of violence against women—that perpetrated by strangers in public spaces—is most collectively recognised (Haksell & Randall, 1998–1999, p. 115). The majority of violence against women, perpetrated by intimates and other known people, still remains a private, "domestic" matter rather than a political issue of women's rights to safety.

Some consequences of fear

This combination of fear and misattributed fear can have several consequences:

- *Impact on women's participation and presence in the public sphere*—It impacts on how women participate in the public domain, resulting in a restricted freedom of movement and participation in a range of forms of public life. Indeed, some strategies employed by women to maintain their safety result in the women disappearing from the public realm: "they avoid this space and are forced to reproduce the masculine domination over space" (Koskela, 1997, p. 121; see also Day, 2001).
- *Impact on women's presence in "the home"*—It ties women even more closely to the home, despite the fact that, as most empirical research indicates, this is the site of greatest danger for women.
- *Debates about women's safety are informed by problematic assumptions*—It becomes second nature, taken for granted and invisible in debates about women's safety for women to be in a state of fear, take precautions and restrict their movements, and to idealise the home as a safe place.
- *Sexual assault that does not fit the stereotype is not adequately recognised*—It encourages the response of "denying or minimising the reality of violence against women", through not naming certain experiences of rape that do not fit popular stereotypes of a stranger rape in a dark alleyway as sexual assault, while people in general "may believe that women who are victimised [in less stereotypical ways] are somehow responsible for what happened to them" (Haskell & Randall, 1998–1999, p. 120).

Impact of the fear of rape on wider community wellbeing

These impacts do not only affect individual women, but the wider community as a whole. Recently, researchers have started to think about community strength and wellbeing beyond economic indicators or neutral benefits such as "the greater good" (Broom, 2005). Freedom from violence and discrimination, economic participation and security, and social inclusion are regarded by many health promotion experts (VicHealth, 1999) as key determinants of mental health and overall community wellbeing. As this research suggested, levels of personal health and wellbeing, community connectedness, and personal and community safety tell us something about community health overall. Women's pervasive sense of fear and apprehension in public areas, in addition to the prevalence of sexual violence could suggest that these key areas of community wellbeing are yet to be realised (we discuss this in more detail below).

Ripple effects on diverse communities

Diverse communities exist within broader society. We are not able to discuss in this paper the many and different ripple effects of sexual assault in refugee communities, Indigenous communities, CALD communities, and among people with a disability. There are different issues and ripple effects for many of these groups that need to be the subject of future research. We hope that this paper will be the initiation of discussion and formation of these.

Ripple effects on wider society

If we only conceptualise sexual violence as an issue of private trauma, social costs of sexual assault, including the economic costs, are made invisible. Yet in countries such as Britain, the US, Canada and Australia, where researchers estimate between a fifth to a quarter of women will experience some form of sexual assault in their lifetime (ABS, 2006; Gannon & Mihorean, 2004; Myhill & Allen, 2002; Tjaden & Thoennes, 2000), sexual assault will inevitably have an effect on health and economic issues at a national level, as studies we discuss below have demonstrated.

Measuring the costs of intimate partner and sexual violence

Recent studies have measured both tangible and intangible costs of intimate partner and sexual violence. Tangible costs of sexual assault are taken to include direct costs (such as medical care, the use of mental health services, insurance, administration costs, police investigations, criminal prosecutions and costs associated with the correctional system), as well as indirect costs (such as loss of economic productivity). Intangible costs are taken to include the psychological pain and suffering of survivors, and a generalised, heightened fear of victimisation.

A recent study in Australia found the economic costs of intimate partner violence (of which sexual assault is a part) for 2002–2003 to be $8.1 billion (Access Economics, 2004; see also Laing & Bobic, 2002). In the US, the health-related costs of intimate partner violence were estimated to exceed US$5.8 billion (National Center for Injury Prevention and Control, 2003, p. 40), and US$67 billion when property damage and pain and suffering of intimate partner violence is included (Miller, Cohen, & Wiersema, 1996). Similar costs have been demonstrated in Jamaica, New Zealand and Britain.

Tangible costs of sexual assault are taken to include direct costs … as well as indirect costs …. Intangible costs are taken to include the psychological pain and suffering of survivors, and a generalised, heightened fear of victimisation.

In relation to sexual assault, some attempts have been made to determine economic costs. Working with figures that suggest about 93,000 sexual assaults took place in 2001, Mayhew & Adkins (2003) estimated that the cost of sexual assault totalled $230 million in Australia—about $2,500 per sexual assault. However, only a limited range of costs were included, and it did not, for instance, include the probably significant cost of mental health care, indicating it was likely to be an underestimate.

In other countries, a UK Home Office report showed sexual offences generated costs of £8.46 billion, and that it was the second most expensive interpersonal crime, followed only by homicide (Dubourg, Hamed, & Thorns, 2005). A study estimating the financial costs of sexual assault in the US state of Michigan showed that sexual assault cost Michigan US$108,447 per incident (including quality of life costs). Based on prevalence data, the study estimated the total cost of sexual assault to be US$6.7 billion (Post, Mezey, Maxwell, & Wibert, 2002). Across all these studies, lost productivity, lost quality of life and mental health care were consistently the most costly impacts.

Who bears the costs?

Research has found that the heaviest economic burden of sexual assault falls on victim/survivors themselves.

Research has found that the heaviest economic burden of sexual assault falls on victim/survivors themselves. For example, a US study on rape in intimate relationships found that not only did medical and mental health care contribute the largest proportion of costs (representing a half and a third of costs respectively), but that the primary methods of payment for medical and mental health care costs were through out-of-pocket payments by the victim/survivor or through private or group insurance (Max, Rice, Finkelstein, Bardwell, & Leadbetter, 2004).

By contrast, research has suggested that core agencies, such as those within the criminal justice system, bear little of these costs through their official responses. For example, research in the UK has found that, while sexual assault may be the second most costly interpersonal crime (following only homicide), this is not reflected in the response of the criminal justice system (Dubourg et al., 2005). This can be seen in Table 1, where the costs of sexual offences are compared with the costs of serious wounding.

Table 1: Breakdown of (financial) costs of offences of sexual offences and serious wounding, UK (selected cells highlighted)

Offence	Impact on victim (£)	Lost output (£)	Health services (£)	Criminal justice system (£)	Average total cost (£)
Sexual offences	£22,754	£4,430	£916	£3,298	£31,438
Serious wounding	£4,554	£1,166	£1,348	£14,345	£21,422

Source: Adapted from Dubourg et al. (2005).

Table 1 shows that although serious wounding cost £10,000 less per incident, and generated one-quarter of the cost in terms of impact on victim and lost output, the cost of this offence within the criminal justice system is more than four times that of sexual assault. Thus, while the bulk of the costs associated with serious wounding is generated by the criminal justice system in investigating, prosecuting and incarcerating offenders, in contrast, most of the cost of sexual offences is connected to the impact it has on the victim.

In a recent Australian study on violence against women more broadly, Access Economics (2004) found that the majority of costs associated with family violence were borne by the victims themselves. Of the total cost of $8.1 billion, victims as a single category bore half (49.9%) of the annual costs of domestic violence. The study found that the next largest group to bear the costs was "the community", bearing $1.2 billion of the costs (Access Economics, 2004, p. xi).

Measuring the international health costs of sexual assault and violence against women

Koss, Heise, and Russo (1994) compared international data on sexual violence in a range of sociocultural contexts, such as rape in war, acquaintance rape, partner rape, and rape occurring on college campuses. Numerous health impacts of sexual assault were identified, including psychological distress (e.g., major depression and PTSD), reproductive health consequences (such as unwanted pregnancies and

sexually transmitted infections), and loss of quality of life through poor general health.

Over the last decade, there has been growing interest by governments, researchers and health planners in the concept of the "burden of disease". This refers to estimating the impacts of health problems by taking into account illness, disability and death that result from injuries. There are few studies that specifically examine the health burden of sexual assault. However, numerous studies examine the health burden associated with violence against women in general, and intimate partner violence against women specifically, both of which encompass sexual violence and share other conceptual features.

At an international level, the estimates of the *World Development Report* (World Bank, 1993) have suggested that gender-based victimisation, including sexual assault, accounts for 1 in every 5 healthy years of life lost to women between 15 and 44. In Australia, VicHealth (2004) conducted research measuring the health burden of intimate partner violence, and found that the cumulative effects of intimate partner violence make it the leading risk factor contributing to death for women in Victoria between the ages of 15 and 44, outweighing smoking, obesity, alcohol and drug use. In part, this is related to the fatal impacts of intimate partner violence: 57% of deaths of women in this age group were the result of homicide or violence perpetrated by a violent partner. However, it is the range of non-fatal impacts that account for much of the health burden. Reviewing the available literature, the burden of disease report related physical injuries and adverse impacts on reproductive health, mental health and general wellbeing to experiences—past and current—of intimate partner violence. Poor mental health accounts for almost two-thirds (60%) of this burden of disease (VicHealth, 2004).

Gender-based victimisation, including sexual assault, accounts for 1 in every 5 healthy years of life lost to women between 15 and 44.

The relationship between mental illness and sexual violence

Research has indicated the close relationship between mental illness and sexual assault. Bryer, Nelson, Miller, and Krol (1987) found that almost three-quarters (72%) of a sample of patients admitted to a private psychiatric hospital had been physically and/or sexually abused at some point in their lives. More recently, Goodman et al. (2001) found in four US states that 68% of women with severe mental illness had been sexually assaulted in their lifetimes. However, despite the strong relationship between sexual assault and mental health, women's mental health and sexual trauma are usually viewed as unrelated. As one survivor stated:

> I have disclosed [the sexual assault] many times … but within the psychiatric system everyone seems to get the same thing. They put you on medication and it's a vicious circle. They talk about what has happened in the last week but they never talk about the underlying problem that makes you feel unhappy and depressed. (Graham, 1994, p. 90).

In this way, a woman's reaction to sexual violence is treated as an individual, medicalised problem that must be "fixed". As mentioned in the context of trauma, the individualising tendency of many branches of therapeutic sciences such as psychiatry and psychology, combined with a historical tradition of perceiving the words of women (particularly about violence) as untrue, irrational and hysterical, combine to make the structural and mutually constitutive relationship between poor mental health and sexual assault invisible.

Reflections on costing sexual assault

While costing sexual assault will inevitably leave many costs out, and while there are inherent problems in putting any monetary figure on some effects of sexual assault, those costs that have been measured are substantial. Costs of sexual assault in terms of many billions of dollars indicate the serious impact sexual assault has on victim/survivors and the communities within which they exist. On the basis of economics alone, sexual assault has collective costs. As the authors of the Michigan study concluded: "laws and public policy that ignore the economic burden sexual violence places on society at large, as well as on individual survivors, are laws and public policy that misunderstand and underestimate the nature and cost of sexual violence" (Post et al., 2002, p. 780). Burden of disease methodology shows the effects of violence against women are cumulative and persistent, and violence against women is the major factor in premature death, poor reproductive health and poor mental health among women. Sexual assault should no longer be thought of as private burden and experience, but rather as a significant social cost in urgent need of reduction. Some writers have asked: who benefits economically from violence against women? For example, Stanko (cited in Laing & Bobic, 2002) wrote:

> If studies showing the economic costs of violence against women are not effective in directing government and business efforts towards reducing male violence, it may be because the economic costs revealed in such studies are less than the unspoken economic benefits of maintaining male dominance in social institutions. The millions of pounds in costs resulting from male violence may be a small price for men to pay in exchange for their continued control of political and economic power, resources and status. (p. 11)

Certainly, however, it needs also to be emphasised that, in the end, violence hurts all of society, not only certain groups within it. Overall, it is important to raise awareness of the ripple effects of sexual assault, and draw attention to how these may harm many members of society, as well as society itself.

Conclusion

Sexual assault and violence against women in general have often been only characterised as "private experiences". This means that sexual assault and other violence remain hidden and taboo, and are believed by many to be rare events. It also renders the ripple effects of sexual assault and other violence invisible. This paper has recognised that sexual assault affects many individuals in profound ways, and has demonstrated that the effects of sexual assault spread out into the community in a ripple effect among those close to the victim/survivor, those who work with her or him, and the communities and wider societies within which the violence of sexual assault exists. A number of implications flow from this.

- *In relation to family members and friends*—If we acknowledge that many family members and friends will also be profoundly harmed by the sexual assault of a significant other, then specialist services will need to be adequately funded to formalise and expand already existing services for these people. These people's "wounds" must be validated, and their recovery assisted.
- *In relation to people working in the sexual assault field*—Given that the latest research suggests vicarious traumatisation is at least to some degree inevitable

when working in this field, and that individual coping strategies are not necessarily correlated with reduced levels of vicarious trauma, better efforts must be made to recognise vicarious traumatisation in the whole range of professions dealing with sexual assault. Occupational health and safety measures need to be put in place to protect workers from harm. This should not result in a stigmatisation of these professions, but rather the recognition of the extraordinary efforts of these workers and the wisdom they hold about an important yet under-recognised aspect of our society. Increased prestige should be given to these workers and mechanisms created to politically and culturally mobilise them as a group.

Overall, this paper has documented the profound harm and sheer costs of sexual assault. While people and communities do and will recover from sexual assault, sexual assault is a trauma that is preventable, and significantly more effort needs to be made in this direction. It is simply not good enough for sexual assault to continue to be largely privatised and a taboo topic. Awareness-raising about these issues needs to be such that talking about sexual assault becomes commonplace. Strategies to prevent sexual assault need to be increased, including strategies that focus on creating greater respect for women and other disempowered people, and on communicating the social unacceptability of all violence. Non-violence should be promoted as a fundamental social and community value.

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