

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

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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 Pearlman (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 & Maclan, 1995; Schauben & Frazier, 1995), and disruptions in basic cognitive schemas about trust in oneself and others and beliefs regarding safety (Johnson & Hunter, 1997; Pearlman & Maclan, 1995; Schauben & Frazier, 1995).

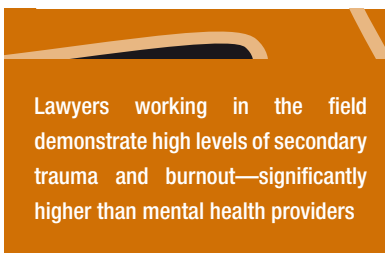
In fact, research has also found that working in the sexual assault field is particularly distressing when compared to other forms of trauma work. Cunningham (2003) found that clinicians who worked primarily with clients who were sexually abused reported more disruptions in cognitive schema than clinicians 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).



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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 MacLan (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).

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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 (Ilfie & 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 (Ilfie & 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]. (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 (Ilfie & 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