

The impacts of sexual assault on women

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Rape is not just physical violence, it is also mental violence. It is not easily forgotten. (Unnamed victim/survivor in Easteal, 1994, p. 99)

This resource sheet gathers together the findings from a wide range of research into the impacts of sexual assault on adult women. Sexual assault can include a diverse range of experiences and, as such, the effects of sexual assault on the victim/survivor and the community at large are also diverse.

The effect of sexual assault is not only psychological or emotional but also impacts upon physical, social, interpersonal and financial domains. These are all considered in this resource.

Key issues in understanding impacts

In presenting this information we are mindful of a number of points: women may experience none, some or many of the possible impacts of sexual assault at different times; there are likely to be impacts of sexual assault that researchers have yet to identify; there is no single way a sexual assault victim should look and act; impacts are not signs of illness, deficiencies or weakness, nor are they characteristics of the individual—rather, they are normal responses to traumatic events.

A range of factors can influence the impact of sexual assault, including:

- the victim/survivor's relationship to the perpetrator;
- the extent and severity of any accompanying psychological or physical abuse;
- the severity of the abuse;
- the extent of physical harm;
- the length of time over which the abuse occurred;
- the responses of family and friends of the victim/survivor;
- the woman's experience of the various systems (health, police, courts etc.) with which she may have contact following the assault; and
- the personal history of the victim/survivor (Daane, 2005).

Psychological and emotional impacts

Sense of a foreshortened future was for me the most terrifying symptom of trauma, I was obsessed with the thought that I was going to die ... even though he was gone, my psyche still behaved as if it expected a disaster to happen. (“Rachel”, in Eastal & McCormond-Plummer, 2006, p. 140)

A range of short- and long-term psychological and emotional impacts have been associated with sexual assault.

Immediate and short-term impacts

During the attack itself, it is common to experience reactions such as an intense fear of death and dissociation. These are natural physical responses. Being paralysed by fear does not mean the victim/survivor wanted the assault to happen. Even if the victim/survivor “decides” that it is safest not to physically resist in the situation, this does not mean she wanted it to happen or gave consent.

I said no but he didn't care. He was nearly three times my size so when it became clear he was probably going to do what he was going to do, I quit fighting and probably dissociated through the rest of it. (“Jill”, in Eastal & McCormond-Plummer, 2006, p.26)

Research indicates that fear is a common immediate and short-term impact:

- Anxiety and intense fear are the primary responses following rape. Some research has found that this peaks at around three weeks after the rape (Peterson, Olasov & Foa, 1987, cited in Petrak, 2002); however, it can last for more than a year for a significant number of survivors.
- Ongoing fears can be related to reminders of the attack (e.g., legal proceedings or medical examinations, being with men, or being in a location that reminds the person of the assault).
- Fear of contracting HIV/STIs and/or becoming pregnant as a result of sexual assault is common (Holmes et al., 1996, and Resnick, Acierno, & Kilpatrick, 1997, both cited in Astbury, 2006).
- Fears of future attacks and other harm can follow sexual assault. If the victim/survivor had previously experienced the world as basically a safe place, this assumption is shattered. She may now experience the world as inherently untrustworthy and unsafe. This can lead to the restriction of social activities, including work and community involvement. This may be particularly profound when the perpetrator is an intimate partner (Crome & McCabe, 1995).
- For some women, particularly those from marginalised communities, sexual assault can reaffirm assumptions about themselves as devalued persons (“insidious trauma”), and about the world being unsafe and dangerous (Wasco, 2003).

Medium-to-long-term impacts

Research suggests victim/survivors may experience a range of medium-to-long-term impacts:

- Feelings of low self-esteem, self-blame and guilt can endure for months and years after the assault.
- It is common for survivors to forget or deny aspects of their experience. This can be a defence against overwhelming feelings of confusion, shock and bewilderment. This may be especially powerful in partner rape (Crome & McCabe, 1995).

I've done such a good job of blocking it all out. I can't remember very much. I hated all of it. (“Kate”, in Eastal & McCormond-Plummer, 2006, p. 3)

- Suicidal ideation is more common among victim/survivors of sexual assault than the general population (Stepakoff, 1998). Younger victim/survivors may be at particular risk of actually attempting suicide following rape (Petrak, 2002).

Trauma and post-traumatic stress disorder (PTSD)

The trauma response model and clinical diagnosis of post-traumatic stress disorder (PTSD) has helped to acknowledge the significance of the harm caused to people who have been sexually assaulted, and the extent of the violation they have experienced. PTSD is a psychiatric label for a collection of psychological symptoms following a traumatic event (see DSM-IV for full clinical definition and criteria; American Psychiatric Association Task Force on DSM-IV, 1994). However, the concept of trauma has some limitations:

- Various measures of trauma are not always adequately sensitive to diversity.
- 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.
- Some trauma measures reflect dominant views about the world that many people do not share.
- Certain symptoms of trauma, rather than being viewed as problems to be treated, need to be viewed in a more positive light—that is, as “coping mechanisms” an individual has adopted for protection and other purposes.
- Trauma conditions such as PTSD do not encompass all the individual effects of sexual assault (Morrison, Quadara, & Boyd, 2007).

Symptoms of PTSD can include:

- intrusive thoughts and distressing recollections of the violence;
- nightmares and other sleep disturbances—these may be the norm rather than the exception (Roberts, 1996, Choquet et al., 1997, Krakow et al., 2000, and Krakow et al., 2002, all cited in Astbury, 2006);
- depression (which can persist for 3 years or more)—Frank and Stewart (1984, cited in Petrak, 2002) found a 43% prevalence rate of depression among women who had experienced sexual violence;
- mood or anxiety disorders—Boudreaux et al. (1998, cited in Littleton & Breitkopf, 2006) found that 39% of women with a sexual assault history met criteria for a mood or anxiety disorder; and
- avoidance behaviours.

Depression followed, as did lack of any self-care or self-worth. Though I am ashamed to admit this, yes, suicide did enter my mind on many occasions and thankfully I was blessed in my life by daughters because they were my reason for surviving and pressing on even when I could barely stand my existence. I am still frequented by many of these emotions and am now just beginning, through therapy and strong support system, to work through them. (“Summer” in Eastale & McCormond-Plummer, 2006, pp. 143–144)

Women who have experienced sexual violence may constitute the single largest group of people affected by PTSD (Calhoun & Resnick, 1993, cited in Astbury, 2006). For example:

- a range of US studies have found that between 35% and 57% of community-based samples of rape victims suffer from PTSD at some point in their lifetime (Littleton & Breitkopf, 2006; Kilpatrick et al., 1987, and Kilpatrick & Resnick, 1993, both cited in Petrak, 2002); and
- up to 16.5% of survivors meet PTSD criteria an average of 17 years post-assault (Kilpatrick et al., 1987, cited in Petrak, 2002).

PTSD “stresses the abnormal nature of the stressor that causes the mental health symptoms, not individual pathology” (Walker, 1991, p. 22, cited in Bennice, Resick, Mechanic, & Astin, 2003). In other words, PTSD symptoms are “normal” or typical responses to sexual assault (Valentiner, Foa, Riggs, & Gershuny, 1996).

Some authors are critical of PTSD as a concept for understanding victim/survivors (e.g., Wasco, 2003). The primary reason for this is that PTSD, as a psychiatric diagnosis, implies that the individual survivor suffers from a medical problem, and that her “symptoms” are signs of a disorder, rather than reasonable responses to a lived experience. Also, the symptoms included in the diagnosis of PTSD do not include all the effects of sexual assault on women’s lives.

PTSD is also criticised for seeing the *event* of rape as the cause of trauma, thereby not fully accounting for the gendered and cultured context in which rape occurs (Wasco, 2003).

Physical impacts

To this day I will never know whether my back problem was actually caused by the force of the rape or me trying to push him off me. I have permanent damage to my back. (Unnamed victim/survivor in Easteal, 1994, p. 75)

I bled for weeks and future sexual experiences were extremely painful and caused more bleeding. (Unnamed victim/survivor in Easteal, 1994, p. 99)

Not all women who are sexually assaulted experience physical injuries or medical problems. However, a range of physical injuries and health consequences *can* be associated with sexual assault. Injuries can be sustained as a direct result of the assault itself, from later complications, or from its psychological impact.

Physical impacts can include:

- damage to the urethra, vagina and anus (for some victims of penetrative sexual assault);
- gastrointestinal, sexual and reproductive health problems; pain syndromes and eating disorders, especially bulimia nervosa (Astbury, 2006);
- increased risk of contracting sexually transmissible infections, including HIV/AIDS (Holmes et al., 1996, and Resnick, Acierno & Kilpatrick, 1997, both cited in Astbury, 2006);
- unwanted pregnancy and decisions regarding abortion (Wasco, 2003);
- pelvic pain (Walling et al., 1994, cited in Stein & Barrett-Connor, 2000);
- irritable bowel syndrome (Drossman et al., 1995, and Walker et al., 1993, both cited in Stein & Barrett-Connor, 2000);
- chronic diseases such as diabetes and arthritis (Golding, 1994, cited in Stein & Barrett-Connor, 2000);
- headaches (Golding, 1999, cited in Stein & Barrett-Connor, 2000); and
- gynaecologic symptoms; for example, dysmenorrhea (severe pain or cramps in the lower abdomen during menstruation), menorrhagia (abnormally heavy or prolonged bleeding during menstruation) and problems associated with sex (Golding, Wilsnack & Learmen, 1998, cited in Stein & Barrett-Connor, 2000).

The on-going violence throughout my years of marriage was mental and sexual. My urethra was so battered I became incontinent; my psyche was so battered I became a mental cripple. I finally got out and changed my name and city, and found myself again. (Unnamed victim/survivor in Easteal, 1994, p. 67)

Additionally:

- people with a sexual abuse history tend to self-rate their overall wellbeing as lower than those with no sexual abuse history (Golding, Cooper, & George, 1997, cited in Stein & Barrett-Connor, 2000);
- sexual assault can be associated with an increased dependence on alcohol (Ullman, Filipas, Townsend, & Starzynski, 2005), prescription medication (Sturza & Campbell, 2005) and other drugs as way of coping; and
- for older women, a sexual assault history has been associated with an increased risk of arthritis and breast cancer, with the risk increasing with the number of assaults experienced (Stein & Barrett-Connor, 2000).

Social and community impacts

Sexual assault can impact on the way the victim/survivor interacts with those close to them and the community as a whole.

- Interpersonal relationships with intimate partners, as well as friendships and family relationships, can all be affected following sexual assault. Difficulties with communication, intimacy, trust, sexual relations and enjoyment of social activities can all be adversely affected. Over-protectiveness of the victim may also be an issue (Crome & McCabe, 1995).
- Women may particularly avoid social situations with men, due to a heightened awareness of the potential for violence that some men are capable of.

I can't stand men. I live alone and don't go out. I hate them. You don't have to believe me, though. But it's true. I wish I was dead. (Unnamed victim/survivor in Easteal, 1994, p. 79)

Most male behaviour when I go out—the way men openly stare and leer at women—makes me feel very threatened. (Unnamed victim/survivor in Easteal, 1994, p. 137)

- Research has shown that women regularly feel vulnerable 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).
- Work life may also be disrupted, due to avoidance of social situations and feelings of low self-worth and self-doubt (Morrison, Quadara, & Boyd, 2007).
- The reactions of family, friends and partners can help or hinder the recovery of the victim/survivor. Negative reactions can lead to avoidant coping styles associated with less successful recovery, while supportive reactions can assist with recovery and healing (Littleton & Breitkopf, 2006).

Women have to be made aware that they are not to blame ... I wish I was able to report this at the time it happened. Dealing with 7 years of emotions almost sent me insane. I am very lucky that I had the support of family and friends when I felt I was able to deal with this. (Unnamed victim/survivor in Easteal, 1994, p. 123)

- The criminal justice system and health service providers (including counsellors) can also contribute to what has been termed “the second rape”. This is when victim/survivors receive victim-blaming, disbelieving and/or minimising responses to their disclosure, or do not receive the services they need (Ahrens, 2006). Such victimisation is likely to exacerbate existing psychological distress and delay recovery from the initial trauma (Campbell & Raja, 1999, cited in Astbury, 2006).

I was emotionally distraught, but was made to feel it was unimportant by male police. (Unnamed victim/survivor in Easteal, 1994, p. 80)

- In Victoria, the cumulative effects of intimate partner violence (of which sexual assault is a part) make it the leading risk factor contributing to death for women between the ages of 15 and 44, outweighing smoking, obesity, alcohol and drug use (VicHealth, 2004). Death, physical injuries and adverse impacts on reproductive health, mental health and general wellbeing all contribute the burden of disease from intimate partner violence. Poor mental health account for almost two-thirds (60%) of this burden of disease (VicHealth, 2004).

Sexual assault also affects partners, children, family and friends of the victim/survivor, as well as the wider community:

- Non-perpetrator family members, partners, friends and children of victim/survivors can be affected by a sexual assault and its aftermath; these people are sometimes referred to as “secondary victims”. Secondary victims often experience the effects of trauma as well, sometimes with similar symptoms to those of primary victims, while knowledge of a traumatising event experienced by a significant other is itself traumatic—this is secondary trauma (Morrison et al., 2007).

Financial impacts

It is difficult to place a monetary value on the harm caused by sexual assault, but it is important to recognise that there are financial costs to the victim/survivor and to the wider community (Mayhew & Adkins, 2003). These include:

- loss of actual earnings;
- loss of future earning capacity;
- medical expenses;
- intangible costs (loss of quality of life, pain and suffering); and
- counselling expenses.

Such expenses and costs are often borne by the victim/survivor herself; however, the wider community also suffers the costs (financial and other) of sexual assault. (Financial compensation may be available through the appropriate body in each state and territory. See details, links and information at <<http://www.aifs.gov.au/acssa/links.html>>.)

Sexual assault also has an effect on economic issues at a national level. For example, a study in Australia found the economic costs of intimate partner violence (of which sexual assault is a part) for 2002–03 to be \$8.1 billion (Access Economics, 2004; see also Laing & Bobic, 2002). Lost productivity, lost quality of life and mental health care are considered by researchers to be the most costly impacts of sexual assault in financial terms (Morrison, Quadara & Boyd, 2007).

Resilience and recovery

Victim/survivors possess significant resilience in the face of these negative impacts and the negative reactions of others. Resilience and healing for victim/survivors are multidimensional processes; survivors are both “suffering and surviving” (Harvey, 2007, p. 9). The following can promote resilience and the healing process:

- positive reactions of support (empathy, belief, understanding);
- speaking out about sexual assault;
- social acknowledgement of the impacts of sexual assault; and
- strong, empathetic social networks (Connor & Higgins, 2008).

Summary

Survivors experience diverse negative impacts of sexual assault; there is no list of typical “symptoms” they should exhibit. What is shared is that such impacts are profound, affecting the physical and mental health of victim/survivors, and their interpersonal relationships with family, friends, partners, colleagues and so on. More than this, the impacts of sexual assault go beyond the individual, to have a collective impact on the social wellbeing of our communities.

Further reading

- Astbury, J. (2006). *Services for victim/survivors of sexual assault: Identifying needs, interventions and provision of services in Australia* (ACSSA Issues No. 6). Melbourne: AIFS. Available from <<http://www.aifs.gov.au/acssa/pubs/issue/i6.html>>.
- Easteal, P. (1994). *Voices of the survivors*. North Melbourne: Spinifex Press.
- Easteal, P., & McCormond-Plummer, L. (2006). *Real rape, real pain: Help for women sexually assaulted by male partners*. Melbourne: Hybrid Publishers.
- Morrison, Z., Quadara, A., & Boyd, C. (2007). “Ripple effects” of sexual assault (ACSSA Issues No. 7). Melbourne: AIFS. Available from <<http://www.aifs.gov.au/acssa/pubs/issue/i7.html>>.

References

- Access Economics (2004). The cost of domestic violence to the Australian economy: Part 1 & 2. Australian Governments Office for the Status of Women.
- Ahrens, C. (2006). Being silenced: The impact of negative social reactions on the disclosure of rape. *American Journal of Community Psychology*, 38(3–4), 263.
- American Psychiatric Association Task Force on DSM-IV. (1994). *Diagnostic and statistical manual of mental disorders, 4th edition*. Washington D.C.: American Psychiatric Association.
- Astbury, J. (2006). *Services for victim/survivors of sexual assault: Identifying needs, interventions and provision of services in Australia* (ACSSA Issues No. 6). Melbourne: AIFS. Available from <<http://www.aifs.gov.au/acssa/pubs/issue/i6.html>>.
- Bennice, J. A., Resick, P. A., Mechanic, M., & Astin, M. (2003). The relative effects of intimate partner physical and sexual violence on post-traumatic stress disorder symptomology. *Violence and Victims*, 18(1), 87–94.
- Brownmiller, S. (1979). *Against our will: Men, women and rape*. London: Secker and Wallburg.
- Connor, P. K., & Higgins, D. (2008). The “HEALTH” model. Part 1: treatment program guidelines for Complex PTSD. *Sexual and Relationship Therapy*, 23(4) 293–303.
- Crome, S., & McCabe, M. P. (1995). The impact of rape on individual, interpersonal, and family functioning. *Journal of Family Studies*, 1(1), 58–70.
- Daane, D. M. (2005). The ripple effects: Secondary sexual assault survivors. In F. P. Reddington & B. W. Kreisel (Eds.), *Sexual assault: The victims, the perpetrators and the criminal justice system* (pp. 113–131). Durham, NC: Carolina Academic Press.
- Easteal, P. (1994). *Voices of the survivors*. North Melbourne: Spinifex Press.
- Easteal, P., & McCormond-Plummer, L. (2006). *Real rape, real pain: help for women sexually assaulted by male partners*. Melbourne: Hybrid Publishers.
- Ferraro, K. (1996). Women’s Fear of Victimization: Shadow of Sexual Assault. *Social Forces*, 75(2), 667-690.
- Gordon, M., & Riger, S. (1989). *The female fear*. New York: Free Press.
- Harvey, M. R. (2007). Towards an ecological understanding of resilience in trauma survivors: Implications for theory, research and practice. *Journal of Aggression, Maltreatment and Trauma*, 14(1–2), 9–32.
- Koskela, H., & Pain, R. (2000). Revisiting fear and place: Women’s fear of attack and the built environment. *Geoforum*, 31, 269–280.
- Laing, L., & Bobic, N. (2002). Economic costs of domestic violence: Literature review. Sydney: University of New South Wales.
- Littleton, H., & Breitkopf, C. R. (2006). Coping with the experience of rape. *Psychology of Women Quarterly*, 30, 106–116.
- Mayhew, P., & Adkins, G. (2003). *Counting the costs of crime in Australia* (Trends & Issues Paper No. 247). Canberra: Australian Institute of Criminology. Retrieved from <<http://www.aic.gov.au/publications/tandi/tandi247.html>>.
- Morrison, Z., Quadara, A., & Boyd, C. (2007). “Ripple effects” of sexual assault (ACSSA Issues No. 7). Melbourne: AIFS. Available from <<http://www.aifs.gov.au/acssa/pubs/issue/i7.html>>.

- Pain, R. (1991). Space, sexual violence and social control: Integrating geographical and feminist analyses of women's fear of crime. *Progress in Human Geography*, 15(4), 415–31.
- Petrak, J. (2002). The psychological impact of sexual assault. In J. Petrak & B. Hedge (Eds.), *The trauma of sexual assault: Treatment, prevention and practice*. West Sussex: John Wiley & Sons.
- Stanko, E. (1985). *Intimate Intrusions: Women's Experiences of Male Violence*, Unwim Hyman, London.
- Stanko, E. (1990). *Everyday violence: How women and men experience sexual and physical danger*. London, Pandora.
- Stein, M. B., & Barrett-Connor, E. (2000). Sexual assault and physical health: Findings from a population-based study of older adults. *Psychosomatic Medicine*, 62, 838–843.
- Stepakoff, S. (1998). *Effects of sexual victimization on suicidal ideation and behaviour in U.S. college women*. *Suicide and Life-Threatening Behavior*, 28(1), 107–126.
- Sturza, M. L., & Campbell, R. (2005). An exploratory study of rape survivors' prescription drug use as a means of coping with sexual assault. *Psychology of Women Quarterly*, 29, 353–363.
- Ullman, S. E., Filipas, H. H., Townsend, S. M., & Starzynski, L. L. (2005). Trauma exposure, post-traumatic stress disorder and problem drinking in sexual assault survivors. *Journal of Studies on Alcohol*, 66, 610–619.
- Valentine, G. (1989). The geography of women's fear. *Area* 21, 4, 385–90.
- Valentiner, D. P., Foa, E. B., Riggs, D. S., & Gershuny, B. S. (1996). Coping strategies and post-traumatic stress disorder in female victims of sexual and nonsexual assault. *Journal of Abnormal Psychology*, 105(3), 455–458.
- VicHealth. (2004). *The health costs of violence: Measuring the burden of disease caused by intimate partner violence. A summary of findings*. Melbourne: Department of Human Services. Retrieved from <<http://www.vichealth.vic.gov.au/~media/ResourceCentre/PublicationsandResources/Mental%20health/IPV%20BOD%20web%20version.ashx>>
- Warr, M. (1985). Fear of rape amongst urban women. *Social Problems*, 32, 238–250.
- Wasco, S. (2003). Conceptualizing the harm done by rape: Applications of trauma theory to experiences of sexual assault. *Violence, Trauma & Abuse*, 4(4), 309–322.



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