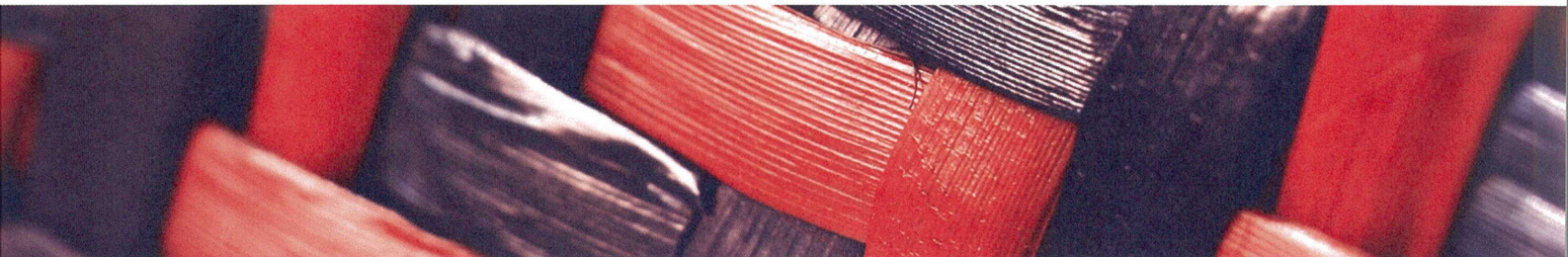# Lightning Does Strike Twice:

preventing sexual revictimisation

Author: **Ministry of Women's Affairs**
September 2012

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Disclaimer: The views, opinions and conclusions expressed in this paper are intended to inform and stimulate wider debate. They do not represent government policy.

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Executive summary

In 2009, the Ministry of Women's Affairs (MWA) published the findings from a cross-departmental research project on effective interventions for adult victim/survivors of sexual violence. The prevalence and impacts of repeat sexual victimisation (or sexual revictimisation) emerged as an issue of critical importance: preventing it could go a long way to addressing the costs of violence against women to individuals and society.

On the basis of that evidence, MWA undertook some early discussions with government agencies and non-government organisations (NGOs), about their understandings of and responses to sexual revictimisation. The discussions indicated that understanding varied and that responses tend to focus on mitigating the impacts of sexual violence, rather than preventing it from happening again. Agencies also indicated that they would welcome an accessible summary of the research literature on sexual revictimisation.

This report establishes a platform for identifying the policy and practice implications of sexual revictimisation and other forms of gender-based violence. It summarises key themes in the research literature on sexual revictimisation and includes insights and feedback obtained from workshops to discuss the research findings with representatives of key government agencies and NGOs in the sexual and family violence sectors.

Overall the report presents a complex picture of sexual violence and revictimisation, as experienced by many women across the life course. It strengthens our understanding of the profound and far-reaching impacts of sexual victimisation in childhood, adolescence or adulthood. While sexual revictimisation of women is the main focus, the evidence highlights the links between sexual violence and other forms of gender-based violence, including men's violence against their female intimate partners (IPV), childhood sexual abuse (CSA) and other types of child maltreatment. It underscores the importance of early identification of repeat victim/survivors, the need to break the cycle of repeat victimisation, and to provide consistent and appropriate support for survivors and their families and whānau, at a systemic level.

Sexual revictimisation is common

The literature reviewed for this report confirmed that a substantial proportion of sexual violence survivors experience repeated sexual victimisation, often beginning in childhood or adolescence and continuing across the life course. Repeated incidents of sexual violence are not necessarily due to the same perpetrator. On the basis of the New Zealand and international literature reviewed, we estimate that:

- at least 50 percent of girls and women who are sexually assaulted are likely to be sexually revictimised

- victim/survivors of childhood sexual abuse are twice as likely as non-victims to be sexually assaulted later in life.

Sexual revictimisation often co-occurs with other forms of violence

The literature also confirmed that many survivors of sexual revictimisation experience multiple forms of violence (or multiple victimisation), during a specific life stage, and/or at different ages and developmental stages. As a form of child maltreatment, sexual abuse

remains largely hidden, and delayed disclosure and non-disclosure are common. Regardless of the type of violence experienced, survivors of child maltreatment are more vulnerable than non-victims to violence at later points in their development and have a greater likelihood of psychological and health problems in adulthood.

There is a small amount of literature on intimate partner sexual violence (IPSV). IPSV is likely to be more frequent, severe and traumatic than sexual violence by other perpetrators. There is emerging evidence that it is a risk factor for lethality, with a higher risk of women being killed by partners who physically and sexually assault them; of women victims of IPSV killing their abusive partners; and of suicidal thoughts and attempts among victims of IPSV.

The cumulative impacts of sexual and multiple victimisation are profound

Sexual revictimisation is a severe outcome of sexual violence. It compounds the negative physical, mental, cognitive and emotional effects of the initial experience, and potentially creates new ones. Survivors of sexual revictimisation and multiple victimisation are a particularly vulnerable group who may be bearing the bulk of the social and health burden of these crimes. Sexual revictimisation is likely to be a hidden but over-represented factor in groups where other forms of vulnerability cluster, including Māori; victims of child maltreatment or intimate partner violence; women with disabilities, psychiatric, drug and alcohol problems, or who self-harm or attempt suicide; lone mothers; beneficiaries; and women in prison.

Co-occurring risk factors work together to increase vulnerability

While a history of sexual violence is a key predictor of sexual victimisation in adulthood and of multiple victimisation, no single factor leads to further or ongoing victimisation. Explanations for why only some survivors experience revictimisation often focus on victim-related risk factors at the individual level, such as psychological or behavioural changes that result from the initial trauma. There are benefits from addressing these factors, but it is also crucial to address variables at other levels of the social ecology. Moving beyond a victim focus means that families, whānau and communities need to be involved in efforts to prevent revictimisation, as well sexual offending and reoffending. Sex offenders often make deliberate choices to offend and target vulnerable victims, including those with prior victimisation histories, who are unlikely to disclose or to be believed if they do.

There is a need to further trial and evaluate promising practices to prevent sexual revictimisation

Internationally, relatively little attention has been given to designing and evaluating interventions to prevent sexual revictimisation. The few interventions that have been evaluated have reduced some forms of sexual revictimisation, such as rape, in some samples, but have not been effective in preventing sexual revictimisation overall. There are other gaps in knowledge about preventing revictimisation. An important element of strengthening the evidence base is to establish how particular interventions could be more effective, and/or the specific mechanisms that contribute to effectiveness.

We did not find any studies that looked at preventing sexual revictimisation among children and adolescents. There are indications that family- or whānau-centred therapy could have

promise. Some parenting intervention programmes have been successful in reducing child abuse generally, and may have some promise for preventing further sexual abuse.

Police initiatives have shown some success in reducing repeat intimate partner violence. While these initiatives only reach survivors who come to the attention of police, and their impact on preventing IPSV is not altogether clear, this is a key area of intervention.

Practitioners at our workshops said there are risks associated with raising the issue of sexual revictimisation with survivors. They were particularly concerned that survivors could become fatalistic about the inevitability of sexual revictimisation. They suggested that strengths-based approaches to supporting recovery could reduce revictimisation, for example, by building survivors' understanding of what healthy sexual relating looks like. We were also told that kaupapa Māori services implicitly address the complexity and sensitivity of sexual violence, including revictimisation. These approaches appear to be promising, but we are left with the question of how to establish whether they are preventing revictimisation and, if they are, how they could be modified to produce better results.

Action areas for change

There are strong social and economic imperatives to integrate revictimisation and its impacts into our understanding of violence against women and girls. This is not a task for a single agency or sector. Change can best be achieved by embedding the issue at a systemic level.

Sexual violence often sets up a trajectory of negative outcomes across the life course. Early identification of at-risk and repeat victim/survivors is fundamental to preventing further violence. Crucial foundations for preventing sexual revictimisation, then, include raising awareness of the nature, extent and impacts of the problem so that agencies can identify vulnerable women and girls; preventing sexual offending and reoffending; encouraging survivors to seek help from formal agencies; and, when they do, ensuring that they have consistent support, underpinned by strong inter-agency linkages.

Survivors and their families and whānau need access to evidence-based interventions to address the harms and minimise the likelihood of sexual revictimisation. Evidence-based interventions need to be built on consideration of factors and processes that can bring about changes in contexts and attitudes across the social ecology, including ways of decreasing perpetrators' opportunities to offend and providing effective support to women when violence does, particularly support that draws on women's strengths. This must be premised on a comprehensive overview of the way that gender shapes power in relationships, families and society.

Effective interventions for sexual revictimisation are based on an understanding of the connections between different forms of gender-based violence, how violence overlaps with other forms of disadvantage and discrimination, and the profound impacts of cumulative trauma. They are targeted towards early intervention for vulnerable groups, such as Māori, girls and adolescents and young women, and women with disabilities. In the case of girls who are exposed to CSA, interventions are potentially delivered again at high-risk periods such as adolescence, to empower young women before they begin adult sexual relationships.

Because many victim/survivors have contact with multiple agencies, interventions must be part of a systemic response, integrated into health, social, legal, educational and community services. They are developed and delivered by practitioners with specialised knowledge of sexual violence, including specialised cultural knowledge. Ideally, they would be based on an approach, such as an investment model, that would identify high-risk, high-cost groups, where early investment is likely to yield long-term benefits.

The paucity of existing evidence on effective practice for preventing revictimisation suggests that interventions will have to be developed on the basis of approaches that are currently identified as promising practice, with a view to building the evidence base and ongoing improvement. Evaluating programmes or approaches for evidence of effectiveness will not only ensure high-quality services, but will also broaden knowledge of the particular elements of interventions that work well for different groups of victim/survivors.

It is imperative to prevent sexual violence, particularly in childhood and adolescence

By definition, preventing revictimisation involves secondary and tertiary-level interventions. However, the damaging and potentially life-long consequences of sexual violence highlight the need to implement responses across different levels of prevention and intervention, including preventing sexual violence before it occurs, particularly among children and adolescents.

Internationally, increasing attention is being given to primary prevention of violence against women. It is increasingly seen as a public health problem that can be reduced and prevented, and there is a growing evidence base about what works to prevent it. New Zealand's Campaign for Action on Family Violence (the *It's Not OK* campaign) has been very successful in raising awareness of family violence. There may be value in exploring community readiness for similar messages, focusing on sexual violence.

1   Introduction: why focus on revictimisation?

The Ministry of Women's Affairs (MWA) has a clear priority to enable women to lead secure lives, safe from violence, and threats and fear of violence, and to mitigate the effects of violence, including restoring women to well-being. Within this broad priority, we have identified the need to reduce the risk of further harm experienced by many women and girls subsequent to their initial experience of sexual violence.

In 2009, MWA published the findings of a cross-departmental research project on effective interventions for adult victim/survivors of sexual violence.[1] The prevalence of repeat sexual victimisation emerged as an issue of critical importance. The findings showed how a history of sexual revictimisation, often beginning at a young age, was frequently associated with other forms of violent victimisation, and with the presence of other factors that heightened the risk of sexual violence (Kingi and Jordan, 2009; Ministry of Women's Affairs, 2009).

The research also indicated that repeat sexual victimisation is likely to be an important factor in understanding which survivors are likely to have high and complex medical, mental health and social support needs. Preventing it could, therefore, go a long way to addressing the costs of violence against women to individuals and society.

Objective, scope and structure of the report

This report is aimed at:

- establishing a platform for identifying the implications of sexual and other forms of revictimisation for policy and practice

- providing government agencies and non-government organisations (NGOs) working in the area of violence against women with accessible information on the prevalence, nature and impacts of sexual revictimisation and its links with other forms of gender-based violence

- identifying gaps in knowledge as well as action areas for change.

As a step towards ensuring that research, policy and practice inform each other, the report incorporates expert knowledge from research and practice.

Method

This report summarises key themes in the research literature on sexual revictimisation, as well as insights and feedback obtained from workshops held to discuss the research findings with representatives of key government and non-government agencies.

Review of research literature on sexual revictimisation

The report presents a comprehensive overview of key themes about sexual revictimisation in the New Zealand and international literature: it was not intended to provide an exhaustive

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[1] MWA led the project, in partnership with the Ministry of Justice and New Zealand Police. The project was supported by the Accident Compensation Corporation, the Ministries of Health, Social Development and Pacific Island Affairs, and Te Puni Kōkiri.

review of the literature. We began by looking at literature reviews, published in English, since 2000. We then incorporated primary research findings as required, to add to our understanding of emerging themes. We included all relevant New Zealand material. The draft report was peer reviewed and the reviewer's comments incorporated.

Workshops with officials and NGO practitioners

We then presented the high-level findings and opened the floor to discussion, at five workshops with a total of around 60 representatives of key government and non-government agencies that respond to sexual violence and violence within families, and research experts in this area. Key insights from NGO practitioners have been incorporated into relevant sections of the report.

There was good representation from organisations that lead responses for the sexual and family violence sectors. This included members of Ngā Kaitiaki Mauri (Māori) caucus and Tauiwi (non-Māori) caucus of Te Ohaakii a Hine – National Network Ending Sexual Violence Together, and the NGO Alliance, which is part of the Taskforce for Action on Violence within Families. There was also representation from Pacific service providers, women with disabilities, and male survivors of sexual abuse.

The discussions tended to centre on topics such as: how the evidence fits with practitioners' experience; practitioners' knowledge about effective interventions for or approaches to preventing sexual revictimisation, including kaupapa Māori and other culturally appropriate approaches; and ideas about practical steps for improving outcomes for this group of survivors.

There was a high degree of consistency among views expressed by NGOs. While we cannot claim that these views are representative of all community stakeholders, we are confident that they are relatively widespread, given the collective experience and expertise held by practitioners in these organisations.

In scope

The report's initial focus was on sexual revictimisation of women. This remains its primary focus – and this is the focus of most of the literature on revictimisation. However, because sexual revictimisation often co-occurs with other forms of gender-based violence, including violence within families and whānau, the report includes an overview of intimate partner violence (IPV), childhood sexual abuse (CSA) of girls, and child maltreatment more generally.

> The report's main focus is sexual revictimisation of women. It includes an overview of the links with intimate partner violence, childhood sexual abuse and child maltreatment.

The report also focuses on the role of formal or professional support agencies, such as counsellors, refuges, and health and criminal justice agencies in responding to and preventing revictimisation. Help from formal agencies is often crucial for recovery and ending the violence, because survivors' family, whānau and friends often have a limited ability to respond to the complex nature of these incidents. At the same time, we acknowledge that community ownership of the issue is essential for preventing sexual revictimisation.

Out of scope

The report does not specifically deal with sub-groups of women who are more vulnerable to revictimisation, such as Māori, women with disabilities, chronic victims, and 'hard to reach' groups. The literature has little to say about revictimisation among these groups.

Nor does it deal with men's and boy's experiences as victim/survivors of sexual violence, and women as perpetrators. While there are gaps in knowledge about these issues, there are clear gender differences in the dynamics and experiences of sexual violence. Girls are more likely than boys to be sexually abused by a family member, while boys are more likely to be victims of extra-familial abusers (Crome, 2006). The nature and closeness of the victim/offender relationship has implications for the repeated nature of CSA, as well as the severity of the impacts. Intra-familial abusers have more frequent access to their victims, and there is evidence that factors such as the frequency, duration and severity of CSA tend to predict the severity of impacts (Fergusson et al., 1996).

The report does not address secondary victimisation (sometimes also referred to as revictimisation), or the complexities associated with the victim to victimiser cycle.

Structure of the report

The report begins with a brief consideration of why revictimisation warrants a distinct approach within responses to violence against women, before giving an overview of New Zealand and international knowledge on the nature and prevalence of adult sexual violence and CSA, and the prevalence of sexual revictimisation among women and girls. The paper then draws on data from the New Zealand Violence Against Women Survey, to demonstrate the links between CSA, sexual revictimisation, and multiple forms of victimisation across the life course, including intimate partner violence. This is followed by an overview of risk factors associated with sexual revictimisation and how they fit into the ecological approach to revictimisation, which informs current work on preventing violence against women and children. Later sections summarise information on promising practices for preventing sexual revictimisation and intimate partner revictimisation. The final section discusses the paper's implications and action areas for change.

Insights and feedback from workshops with NGOs are incorporated into relevant sections.

Workshop feedback: a note on language

In this report we mostly refer to adults or adolescents who commit sexual violence as 'perpetrators'. Following feedback from practitioners, we considered using terms such as 'children with concerning or problematic sexual behaviour', or 'adolescents/adults with harmful sexual behaviour'. 'Perpetrator' and 'offender' are seen as labelling people rather than behaviours, and as legal terms. Many individuals with whom practitioners work have not been charged with an offence and not all forms of sexual violence are criminal acts.

We decided to retain 'perpetrator', both for consistency with the wider literature and for brevity. We regard 'perpetrator' as a fairly neutral term. It does not reflect whether or not a given behaviour constitutes a criminal offence or whether a person has come to the attention of the criminal justice system: in this case, terms such as 'accused', 'suspect',

'defendant' or 'offender' are more appropriate. Definitions of other key terms are in the glossary at the end of the report.

Why focus on revictimisation?

Violence against women is a serious crime and an infringement of human rights. It is also a major social and public health problem that exacts enormous direct and indirect costs associated with ill health, disability and premature death among women.

> Sexual violence and intimate partner violence have the highest revictimisation rates of any crimes.

Revictimisation is a feature of crime generally, but sexual violence and intimate partner violence have the highest revictimisation rates of any crimes (Davis et al., 2006). At the same time, rates of disclosure of these offences to formal support sources are low and many victim/survivors delay disclosing their experiences, sometimes for many years.

Sexual revictimisation warrants a distinct approach within responses to violence against women. It is a severe outcome of sexual violence, which compounds the negative effects of the initial experience, and potentially creates new ones (Tusher and Cook, 2010). As a result, it substantially escalates the costs of sexual violence to individuals and society, including the health, justice and social sectors.

Despite its prevalence and impacts, there is a lack of understanding about the factors connected to sexual revictimisation. Beyond this, the repetitive nature of sexual violence seems to be less well understood than other forms of gender-based violence, such as IPV: with the caveat that there is a relative silence around (IPSV) (Heenan, 2004). This means that survivors who are sexually revictimised may not be receiving adequate or appropriate responses.

By preventing sexual revictimisation, we reduce the impacts on women and girls, their families and whānau, and the community; we save money; and, not least, we save lives.

2 What we know about the nature, prevalence and impacts of adult sexual violence and childhood sexual abuse

The international literature is unequivocal that both adult sexual violence and CSA are common and that they occur primarily within family and social contexts. Most perpetrators are males with whom victim/survivors could expect to have a relationship of trust.

Girls are at greatest risk of sexual abuse from male family members. Older women, who are more likely to be partnered than younger women, are at greatest risk from current and ex-partners. Younger women and single women (and there is an overlap between these groups) are more likely than older women and partnered women to be sexually violated by 'other known men', such as friends and colleagues, by men they have just met, and by strangers.

Prevalence of adult sexual violence and childhood sexual abuse

New Zealand prevalence estimates are drawn from a small number of studies, which use different methods, samples and definitions, and often result in widely varying estimates. Our estimates are drawn from studies published since 2000 (Appendix A).

We estimate that at least 20 percent of girls in New Zealand are sexually abused. Recent New Zealand research has produced prevalence estimates ranging from 20 percent to 30 percent (Clark et al., 2009; Fanslow et al., 2007; van Roode et al., 2009). They are within the range of international findings, which put the mean lifetime prevalence of sexual abuse of girls at around 20 percent.

> At least 20 percent of girls in New Zealand are sexually abused.
>
> More than a quarter of New Zealand women are sexually victimised in their lifetime.

There is some variation in lifetime estimates of sexual violence against women. The 2006 New Zealand Crime and Safety Survey (NZCASS) found that more than a quarter (29 percent) of New Zealand women experience sexual violence once or more in their lifetime. This is in line with estimates from comparable surveys conducted in Australia, Canada and Britain (Families Commission, 2009).

High-risk population groups

Overarching estimates can obscure different risks among population groups. The 2006 NZCASS found that the risk of sexual victimisation was two to three times higher for young women (aged 15 to 24 years), Māori women, sole mothers, and welfare recipients. Many of these risk factors are related. For example, young women are likely to be single; sole parents are often beneficiaries, Māori, and economically deprived. Other groups at high risk of sexual violence include:

- women in prison – as many as 90 percent have been sexually revictimised before entering prison, most from a very young age and in adulthood (Australian Centre for

the Study of Sexual Assault, 2005; Gilfus, 2002; Tusher and Cook, 2010). Evidence on the extent of sexual violence within prisons is scarce and inconsistent: it is likely that it is rarely reported to authorities (Lievore, 2003)

- women with disabilities – international evidence suggests that between 50 and 90 percent of people with disabilities experience sexual violence in their lifetimes. Women are at higher risk than men (Blyth, 2002; Murray and Powell, 2008)

- girls in alternative education[2] – in a national survey of secondary school students 52 percent of girls in alternative education reported unwanted sexual contact, compared to 22 percent of female secondary school students overall (Denny et al., 2004)

- lesbian and bisexual women – the same survey found that rates of unwanted sexual contact were higher among students attracted to the same sex or both sexes (32 percent) (Le Brun et al., 2004)[3]

- refugee women – some authors suggest that most refugee women and children experience repeated sexual violence (Pittaway and Rees, 2005-06, cited in Allimant and Ostapiej-Piatkowski, 2011). They may have a reduced ability to deal with day-to-day challenges such as settlement, adjustment, education and family.

Information gaps about the extent of sexual violence and revictimisation among these high-risk groups reinforce the need to initiate discussions about the issue.

Sexual violence has widespread impacts

The impacts of sexual violence are widespread and well-documented. There is clear evidence of a dose-response gradient. For example, factors such as the frequency, duration and severity of CSA tend to predict the magnitude and extent of health outcomes. Data from the Christchurch Health and Development Study showed that:

> those exposed to severe CSA had odds of [poor psychiatric] outcomes that were 2.7 to 11.9 times higher than those of young people not exposed to CSA ... In general the risk of disorder appears to increase with increasing CSA severity. These results are generally consistent with the view that exposure to CSA may act as a risk factor that increases later vulnerability to psychiatric disorder. (Fergusson et al., 1996)

Impacts of childhood sexual abuse

CSA can have profound impacts on child development, including the child's sense of identity and her coping and interpersonal skills. The effects can be mediated by variables such as caregivers' support for the child, family environment, and bio-psychological factors (McGregor, 2003).

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[2] Alternative education programmes are available for 13 to 15 year-olds who have become alienated from school. Alternative education delivers education in a different setting, using different methods.

[3] The survey did not provide information on perpetrators' gender. Other studies have found high rates of sexual violence and revictimisation among gay, lesbian and bisexual women and men. It is not always clear whether these are actual differences, or associated with characteristics of particular samples. Findings that gay men and bisexual women and men are more likely than lesbians to be sexually revictimised partly reflect that they have male sexual partners (Heidt et al., 2005).

Frequent consequences include drug and alcohol abuse, self-harm, suicidal ideation, relationship disturbances, running away from home, flashbacks, dissociation or psychological numbing, and hypervigilance. Trauma at early developmental stages can alter brain chemistry and cognitive functioning, and interfere with concentration, school performance and the ability to interpret environmental cues regarding danger and risk (Gilfus, 2002).

There are complex associations between CSA and subsequent sexual health decision-making. CSA significantly increases the likelihood of victims engaging in unprotected sex, having multiple sexual partners,[4] being under the influence of alcohol or drugs during sex, and engaging in sex work.[5] These factors can directly or indirectly increase the risk of sexual revictimisation and poorer sexual health outcomes.

Many negative sexual health outcomes associated with CSA are thought to be a result of psychological factors, such as low-self esteem, negative sexual self-images, and feelings of powerlessness, that influence survivors' ability to negotiate sexual relationships (Mosack et al., 2010). The risk for revictimisation and engagement in 'high-risk' sexual behaviours is heightened by more severe forms of CSA and the co-existence of physical abuse. The link between CSA, multiple victimisation, and risky sexual behaviours adds to the complexity of understanding and addressing sexual revictimisation (Lalor and McElvaney, 2010).

Appendix B presents a case study from MWA's 2009 research. It shows how a history of sexual violence affected one woman throughout her life. It also touches on secondary victimisation through engagement with the criminal justice system.

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[4] Multiple sexual relationships are not risky *per se*, although researchers have found that a higher number of sexual partners may mediate the relationship between early and subsequent sexual victimisation.

[5] Sex work is typically described in the literature as a high-risk sexual health behaviour. However, the the link between CSA and sex work is mediated by factors such as IPV, drug addiction, or socioeconomic factors, including homelessness and the need for subsistence. Seen in this light, sex work can be described as an economic survival behaviour.

Impacts of adult sexual violence

Survivors of adult sexual violence who participated in MWA's research highlighted the widespread nature of the sequelae (below).

Social, health, economic and interpersonal impacts of adult sexual violence

Social impacts

Many survivors said that sexual violence affected every aspect of their lives and well-being, including leaving them vulnerable to later sexual and physical assault and abusive relationships: they felt their lives had been ruined. Many withdrew socially, becoming isolated and reclusive. Some spoke of the pain of being alone, as if no one understood or was there for them. Others tried to project an outer confidence, while burying their feelings and closing up inside.

Health impacts

Physical impacts included sleep disruptions, such as insomnia and nightmares, and ailments such as migraines, auto-immune diseases, and gynaecological, digestive and eating problems.

Fear and anxiety were common mental health impacts, from generalised feelings of fear, to specific fears, such as fear of the perpetrator returning. Other impacts included depression, flashbacks, anger, dissociation, self-harming behaviours, and post-traumatic stress disorder.

Employment and economic impacts

Disruptions to work and study, loss of motivation, or reduced concentration often resulted in a limited ability to work, which affected some survivors' financial status. Others used work as a distraction, becoming almost workaholic as a way of escaping their feelings.

Interpersonal impacts

Sexual violence led to a loss of trust in men, and a decreased willingness to interact socially and enter into intimate relationships. Some survivors spoke about engaging in risky sexual behaviours. Feelings around loss of safety sometimes extended into a general discomfort about being touched by anyone, which affected everyday relationships and communication. Sexual violence had a major impact on the way survivors thought about themselves, including loss of self-esteem and confidence, increased self-doubt, self-blame and self-hatred, and changes in personality.

Sexual violence rippled out to affect women's partners, children, family, whānau and friends. People close to the survivor became distressed through exposure to the survivor's trauma.

Source: Kingi and Jordan, 2009

Cost to the New Zealand economy

At just under one percent of all recorded crime, sexual violence is one of the smallest categories of recorded crime in New Zealand. In 2006, the Treasury estimated that sexual violence costs the New Zealand economy $1.2 billion per year. At $72,130 per incident, it is New Zealand's most costly crime (Roper and Thompson, 2004).

Workshop feedback: violence against Māori women

Much of the research literature draws on Western understandings of sexual and family violence and impacts. Understanding the impact of violence on Māori women requires a much broader conceptualisation that includes consideration of issues such as the impact of

colonisation; the interconnectedness of individuals and their whānau, hapū and iwi; differences between 'family' and 'whānau'; and the implications of sexual violence, in particular, for whakapapa (genealogy and ancestral ties) and mana (personal power) (Hamilton-Katene, 2009; New Zealand Family Violence Clearinghouse 2012).

It is beyond the scope of this report to address these concepts in any depth but we can touch on a small number of points raised by kaupapa Māori practitioners.

In traditional Māori society, women and men had complementary roles and responsibilities. Acts of violence were a public matter. Violence against an individual woman was seen as an assault not only against her, but also against her whakapapa, and perpetrators were held accountable to her whānau (Te Kupenga Whakaoti Mahi Patunga National Network of Stopping Violence, 2011).

> A Māori definition of sexual abuse based on cultural values is defined as the trampling of a person's mana or personal power and identity by others' sexual comments or behaviours. This definition is grounded in the Māori value of relationships, which Māori view as important and sacred engagements. (Hippolite-Wright, 2002, cited in New Zealand Family Violence Clearinghouse, 2012: 8)

Higher rates of sexual victimisation among contemporary indigenous women are not unique to New Zealand, but are also observed among American Indian and Alaskan Native women, and indigenous Australian communities. Violence against indigenous women occurs within the context of colonisation and has "additional layers of cultural oppression and racism" (Mossman et al., 2009: 15). In New Zealand, colonisation – and the patriarchal gender relations that came with it – fundamentally reshaped the foundations of Māori society and had a drastic impact on women's status and gender roles.

Higher rates of sexual violence against Māori women can lead to the mistaken assumption it is primarily perpetrated by Māori men. Many Māori women have non-Māori partners and New Zealand has a high intermarriage rate between ethnic groups, with 47 percent of Māori identifying as having multiple ethnicities (Statistics New Zealand, 2007). In the 1996 Women's Safety Survey, around a third of the Māori women who reported physical or sexual partner violence described their partners as non-Māori (Morris, 1997).

3   Prevalence and impacts of sexual revictimisation

There is no universally accepted definition of sexual revictimisation. We have defined it as the link between sexual abuse in childhood or adolescence and sexual victimisation in adulthood, or between repeated sexual victimisations in adulthood. There are also variations in how it is conceptualised and measured and in resulting prevalence estimates.[6]

Prevalence estimates can differ according to the composition of the sample

Rates of sexual revictimisation tend to be very high in studies of known victim/survivors. MWA's research found that 85 percent of a sample of adult sexual violence survivors had been sexually assaulted more than once, either as adults or as children (Kingi and Jordan, 2009). Almost half of adult sexual assault complainants who reported to New Zealand Police had made previous allegations of violent victimisation: around a quarter of the prior complaints related to sexual violence, 70 percent to physical violence (Triggs et al., 2009).

Rates of revictimisation are often lower in community samples but, on the whole, are still high. We found five New Zealand studies with estimates of sexual revictimisation in different community samples. The studies used different methods and definitions of sexual violence, and measured revictimisation over different time periods. Table 1 presents the estimates of sexual violence and sexual revictimisation (see Appendix A for more details).

Table 1   New Zealand estimates of sexual violence and sexual revictimisation

Study/sample	Prevalence of sexual violence	Prevalence of sexual revictimisation
Survey of women aged 18 and older residing in the 14 census enumeration districts across New Zealand (Flett et al., 2012)	13% reported having been sexually abused during childhood	76% said the indexed abuse incident was one in a series by the same assailant
National survey of children aged 9 to 13 years (Carroll-Lind et al., 2011)	11% said they had directly experienced sexual violence (ever)	15% said it happened 'lots'
2006 NZCASS (Families Commission, 2009)	4% of women said they were sexually victimised in 2005	43% said it happened two or more times in 2005
New Zealand Violence Against Women Survey (Fanslow et al., 2007)	25% said they experienced CSA before the age of 15	50% said it happened a few times or many times
Dunedin Multidisciplinary Health and Development Study (van Roode et al., 2009)	30% of women reported contact CSA prior to age 16	70% said it happened on multiple occasions

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[6] Some studies measure revictimisation in relation to a continuum of sexual offences, from non-contact offences, through sexual coercion, to rape. It is likely that the revictimisation rate is higher for less severe but more prevalent forms of sexual violence, such as unwanted sexual touching, than for less prevalent and more severe offences such as rape.

The lowest estimate of sexual revictimisation in Table 1 could reflect the young age of the study's participants. The highest estimate is within the range of an international review of empirical literature, which found that as many as two-thirds of people who are sexually victimised are revictimised (Classen et. al., 2005).

> CSA victims are at least twice as likely as non-victims to be revictimised in later life.

Given the difficulty of comparing results from different studies, we have settled on a relatively conservative estimate of revictimisation, which is nevertheless broadly consistent with international findings. Based on our review of New Zealand and international literature we conclude that:

- CSA victims, or victims who are raped before the age of 18, are at least twice as likely as non-victims to be sexually assaulted later in life (Black et al., 2011; Classen et al., 2005; Fanslow et al., 2007; Noll et al., 2003)

- at least 50 percent of girls and women who are sexually assaulted are likely to be sexually revictimised.

Surveys rarely tell us about sexual revictimisation over time

Most research on sexual revictimisation is cross-sectional and retrospective, and does not necessarily give information on whether the risk of sexual revictimisation varies over time. The NZCASS, for example, only measures revictimisation in the year before the survey. Findings from the 2006 NZCASS indicate that sexual violence, as with other crimes, is concentrated in a relatively small group of victims. Relative to the general population, a small proportion of women were victimised repeatedly in 2005, and they accounted for the majority of sexual offences measured in the survey. However, it is not clear whether this picture would hold true if longitudinal data were available, or if cross-sectional, quantitative data were supplemented by qualitative information.

> At least 50 percent of girls and women who are sexually victimised are likely to be revictimised.

Impacts of sexual revictimisation

While sexual revictimisation is common, it is also under-recognised and not well understood. Sexual revictimisation – which can be seen as an *outcome* of the initial victimisation – compounds the negative impacts of the earlier experience and has profound impacts across a variety of outcomes. However, many reports describe the impacts of CSA or adult sexual violence for a given sample as a whole, rather than considering the prevalence of sexual revictimisation, or differential impacts according to victimisation history. This can make it difficult to describe and assess the effects of sexual revictimisation *per se*.

Taking into consideration the range of negative consequences of sexual violence outlined earlier in this paper, it is clear that survivors of sexual revictimisation are a particularly vulnerable group who are bearing the majority of the social and health burden of sexual crimes. They are also likely to have high levels of service use, across an array of services.

Sexual revictimisation is likely to be a hidden but over-represented factor in groups where other forms of vulnerability cluster, including Māori; victims of child abuse and neglect or IPV; women with disabilities, psychiatric, drug and alcohol problems, or who self-harm or attempt suicide; lone mothers; and beneficiaries (Butterworth, 2004; Fanslow et al., 2007; 2010; Fanslow and Robinson, 2004; Noll et al., 2003).

Survivors of child sexual and/or physical abuse who are revictimised as adults have been found to have higher rates of unemployment, greater residential mobility and lower socioeconomic status than those who are non-victimised (Coid et al., 2001; Seth-Purdie, 2000).

Cumulative exposure to trauma over time has profound impacts on survivors' long-term outcomes. Compared to women who are singly victimised or non-victimised, women who are sexually revictimised (and particularly those with histories of CSA) have a much greater risk of developing adult mental health problems, significantly poorer long-term psychological and health outcomes, a greater number of lifetime traumas (non-sexual), higher levels of drug use, and more interpersonal problems (Casey and Nurius, 2005; Kimerling et al., 2007). Sexual revictimisation has been associated with unwanted pregnancies, severe psychiatric morbidity, and use of psychiatric services (Coid et al., 2001). Although little research has examined the specific long-term impacts of sexual revictimisation on women's health, it seems to be associated with poorer physical health, just as CSA is associated with increased somatic complaints and higher use of health-care services (Casey and Nurius, 2005).

> Survivors of sexual revictimisation are a particularly vulnerable group who are likely to be bearing the majority of the social and health burden of sexual crimes.

Women who are sexually revictimised take longer to recover from subsequent assaults, use less effective coping methods, and experience more post-traumatic stress disorder (PTSD) symptomatology.
The psychological impacts are greater among women who are revictimised by different perpetrators at different points, compared to child-only or adult-only victims, or those who experience ongoing abuse by the same perpetrator (Casey and Nurius, 2005).

Sexual revictimisation is also associated with negative outcomes in the criminal justice area, in two distinct ways. Firstly, sexual revictimisation is often part of the trajectory that leads to women's involvement in criminal activity and incarceration. The compounding impacts of revictimisation, such as drug and alcohol use, mental health problems, and homelessness, mean that these girls and women have limited resources for surviving abuse. Those who depend on illegal activities for income have an increased likelihood of coming into contact with the criminal justice system as offenders (Gilfus, 2002). A recent report indicated that there may be a higher rate of homicide perpetration among victims of CSA than the general population, and that female victims may be as likely to be charged with homicide as male victims (Ogloff et al., 2012). This is consistent with emerging evidence of intimate partner sexual violence as a risk factor for women killing an intimate partner (see later section of this report).

Secondly, there is evidence of a link between revictimisation and attrition of sexual offence cases that enter the criminal justice system. New Zealand data show that there is a lower likelihood of sexual offence cases proceeding through the criminal justice system or resulting in a conviction for women who have made previous allegations of physical or

sexual violence (Triggs et al., 2009). It is possible that the impacts of revictimisation, such as mental health problems and drug and alcohol abuse, affect the perceived credibility of women who report sexual offences to police.

Workshop feedback: sexual revictimisation is common

Practitioners were not surprised by research findings on the prevalence of sexual revictimisation. They said the findings are consistent with and validate their experience. They indicated that sexual revictimisation is also common among male survivors of sexual violence. They also raised the complex issue of the victim to victimiser cycle.

Since the workshops, we have accessed a report looking at subsequent offending and victimisation among CSA victims; this is the largest prospective study of its kind (Ogloff et al., 2012). Compared to a comparison group drawn from the electoral role and matched by gender and age:

- male CSA victims were significantly more likely than males in the comparison group to be sexually revictimised, but significantly less so than their female counterparts

- both male and female CSA victims were more likely to come into contact with police for any matter, including being a victim of crime and being charged with offences, including sexual offences

- the majority of CSA victims did not perpetuate the cycle of violence by perpetrating sexual offences

- even so, adolescent males who experience serious sexual abuse are a high-risk group for subsequent sexual offending and require active intervention.

The study did not find a significant difference in overall rates of sexual revictimisation reported to police by CSA victims and the comparison group. However, we would not necessarily expect to see particularly high rates of sexual victimisation or revictimisation in the comparison group, given the very high levels of under-reporting of these offences.

4 The New Zealand Violence Against Women Survey draws attention to repeat and multiple victimisation across the life course

Sexual revictimisation is not a random event: victimisations tend to accumulate for certain individuals and in certain environments. For many women, sexual victimisation begins at a young age and continues into adulthood.

Internationally, there is strong evidence that a substantial number of female survivors of sexual violence also experience other forms of violence, such as physical violence. Different forms of violence might occur in the same incident, during a particular life stage, or at different periods over the life course.

The New Zealand Violence Against Women Survey

The New Zealand Violence Against Women Survey (NZVAWS) replicated the WHO Multi-Country Study on Women's Health and Domestic Violence Against Women (Garcia-Moreno et al., 2005). The NZVAWS asked 2,855 Auckland and Waikato women, aged 18 to 64, about their experiences of CSA before 15 years of age, partner and non-partner violence as adults, and the health impacts of IPV. The findings can be generalised to the population.

The survey was consistent with other research showing higher rates of CSA and partner violence among Māori (Fanslow and Robinson, 2004; Fanslow et al., 2007; Fanslow et al., 2010).

CSA can set a trajectory to further victimisation

The NZVAWS provides the best picture we have seen of the link between CSA, sexual revictimisation, and victims' increased risk of multiple victimisation across the life course. The findings underscore the frequent co-occurrence of sexual violence and other forms of violence within families, whānau and intimate relationships, particularly the issue of intra-familial sexual abuse of girls. In summary:

- a quarter of the women said they were victims of CSA before the age of 15
- half of those said it happened a few times or many times
- the median age of victims at the first incident of CSA was nine years
- most perpetrators were male family members, a median 21 years older than the victims.

Other research has found that much intra-familial CSA is perpetrated by adolescents, particularly brothers (e.g. Grant et al., 2009). Either way, the findings underscore the problematical nature of differential responses to sexual violence and 'family' violence.

We have developed a diagram, using NZVAWS data, showing how CSA is associated with a higher risk of partner and non-partner physical and sexual violence, across the life course.

Figure 1 compares outcomes for victims of CSA to those of non-victims, in relation to experiences of first intercourse, lifetime partner violence and lifetime non-partner physical and sexual violence.

Overall, CSA victims were twice as likely as non-victims to experience sexual and/or physical violence as adults, perpetrated by partners and non-partners.
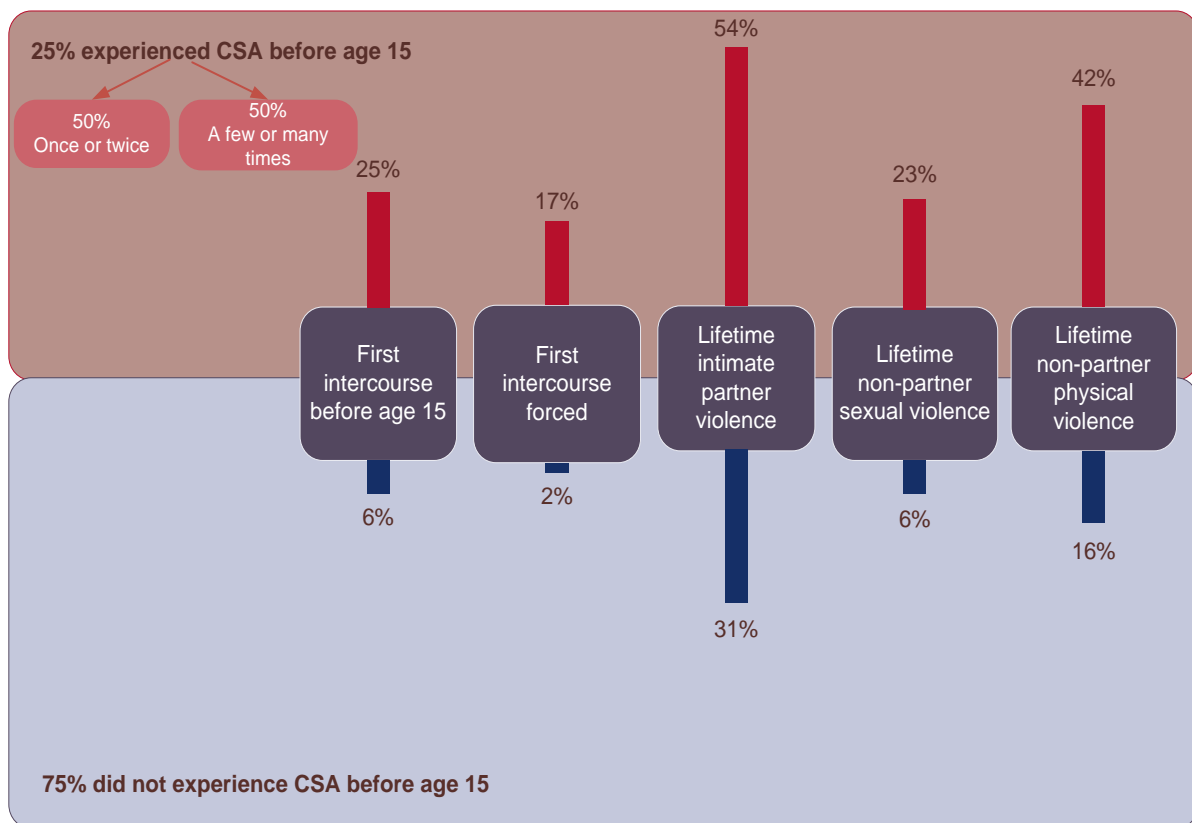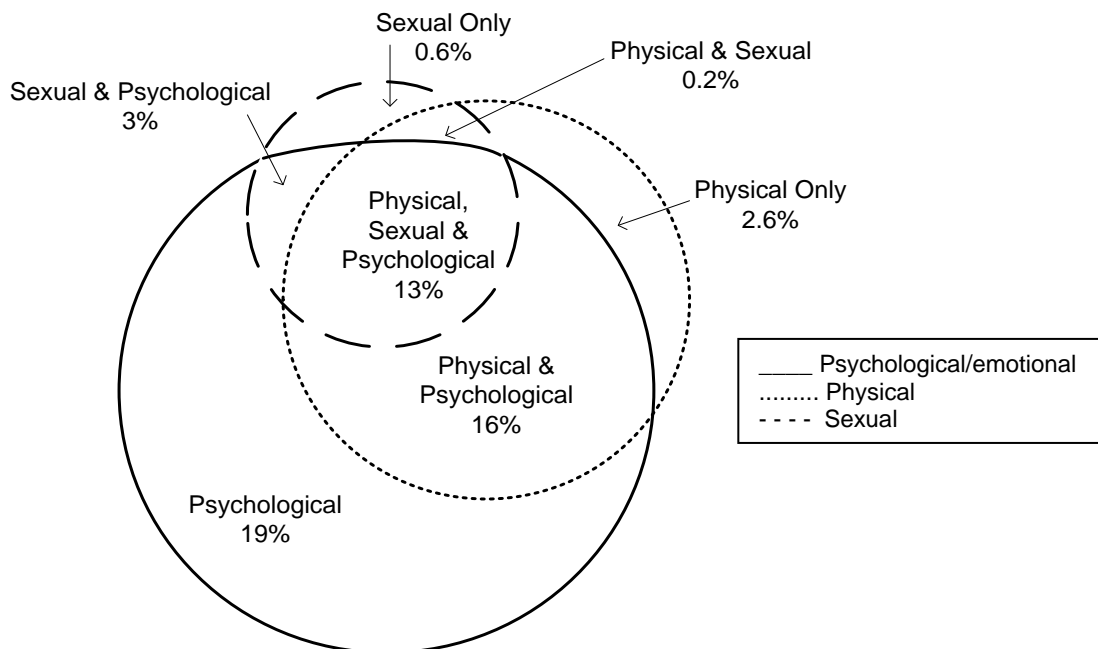

Source: Fanslow et al., 2007

Figure 1   Association between childhood sexual abuse, sexual revictimisation and multiple victimisation across the life course

Sexual violence and multiple victimisation in adult relationships

The survey also showed that many women experienced multiple forms of violence in their intimate relationships, including psychological or emotional violence (Figure 2).

Sexual Only
0.6%

Physical & Sexual
0.2%

Sexual & Psychological
3%

Physical,
Sexual &
Psychological
13%

Physical Only
2.6%

Physical &
Psychological
16%

Psychological
19%

_____ Psychological/emotional
.... Physical
- - - - Sexual

Source: Fanslow & Robinson, 2011: 748

Figure 2   Overlap of types of lifetime intimate partner violence

Around 42 percent of women who experienced moderate or severe physical IPV in the year before the survey were also sexually victimised by an intimate partner. Figure 3 shows that lifetime rates of both forms of IPV were highest among Māori women and there is a considerable degree of overlap between the two forms of violence.
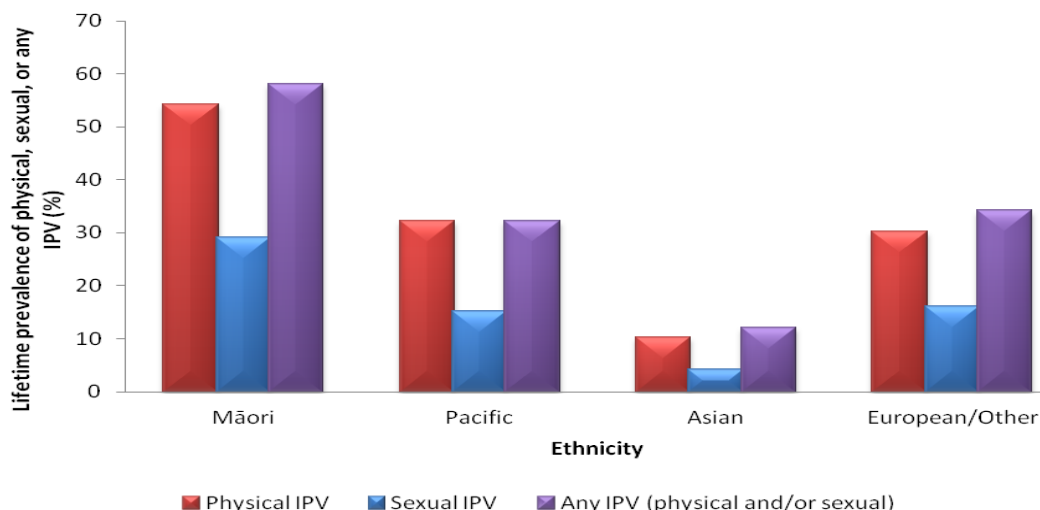
Source: Fanslow et al., 2010

Figure 3   Co-occurrence of lifetime sexual and physical IPV, by ethnicity

Workshop feedback: multiple victimisation is common

Practitioners confirmed that the women with whom they work have often experienced multiple forms of violence. In their experience, sexual violence commonly occurs within the context of IPV and clients in refuges often have histories of sexual violence, either in childhood or adulthood.

While they noted the need for specialist services to respond to sexual violence-related trauma, some practitioners expressed a concern that family violence and sexual violence are often treated as separate issues by government agencies. This can lead to interventions that fail to recognise or reflect the reality of women's experience.

5 What we know about childhood sexual abuse and links with other forms of child maltreatment

It is difficult to establish the actual extent of child maltreatment, largely because of varying definitions and difficulties associated with identifying different forms of child abuse.

> Although it is useful to distinguish between the different subtypes of child maltreatment in order to understand and identify them ... it is misleading if it creates the impression that there are always strong lines of demarcation between the different abuse subtypes, or that abuse subtypes usually occur in isolation ... When parents subject their children to sexual or physical abuse, how can the emotional harm and betrayal of trust implicit in these acts not also be thought of as a form of emotional maltreatment? (Price-Robertson and Bromfield, 2009: 4-5.)

Prevalence of child maltreatment and multiple victimisation of children

International research (Asmussen, 2010; Bromfield et al., 2010; McCloskey, 2011) shows that at least 16 percent of children in Western cultures experience some serious form of maltreatment. A substantial proportion of child victims – if not the majority– experience multiple forms of abuse. Children whose mothers experience IPV are at risk of child abuse, as men who assault women are more likely to abuse their children. Child maltreatment is likely to occur in families with chronic and inter-related problems, including IPV, substance abuse, and mental health issues, which themselves occur in a wider context of social exclusion and disadvantage, such as low income and education, and lower financial and social resources.

> A New Zealand community study found that at least one in seven girls who experienced CSA also experienced physical violence.

Knowledge about the frequent co-occurrence of IPV and child maltreatment, and the intergenerational transmission of violence and disadvantage, is not new. Children growing up in such families will benefit from early interventions for at-risk women, and longer-term interventions to promote women's recovery and prevent violence from re-occurring.

Exploratory research from the United States suggests that 8 percent of youth in a nationally representative survey were polyvictimised in the previous year. That is, they had experienced seven or more different kinds of victimisation or exposure to violence, crime and abuse, and had a disproportionate share of the most serious forms of victimisation, such as sexual abuse and parental maltreatment (Finkelhor et al., 2011).

New Zealand research also shows that there is often a high degree of association between different forms of violence during childhood (Fleming et al., 2006). One New Zealand community study found that at least one in seven girls who experienced CSA also experienced physical violence (Mullen et al., 1996; Romans et al., 2002).

Studies of CSA survivors can yield much higher rates of multiple and repeat victimisation. A postal survey of 191 New Zealand women who were survivors of CSA found that 80 percent experienced other forms of child abuse and/or neglect, from emotional abuse and witnessing violence in the family, to attempted murder. Most of the women experienced

different levels of CSA, from non-contact abuse such as flashing or being forced to watch pornography, to penetration. The mean age at the first incident of CSA was six years. On average, the 191 women were sexually abused over a period of around six years, by a total of around 450 perpetrators, mostly male family members, followed by non-related males (McGregor, 2003).

Within child maltreatment, CSA remains largely hidden, and delayed disclosure and non-disclosure are common. Some studies have found that less than half of all victims disclosed the abuse at the time it occurred, with a large proportion not telling anyone until they were asked by researchers (Tyler, 2002).

Impacts of child maltreatment and multiple victimisation of children

Victim/survivors of child maltreatment are more vulnerable to revictimisation at later points in their development. New Zealand surveys have shown that children who witness or are victims of violence in one context (home, school or community environment) are more likely to both instigate and be victims of violence in other contexts (Clark et al., 2009).

There is conclusive evidence that a history of child maltreatment is linked with a greater likelihood of psychological and health problems in adulthood. Children who experience

> Children who are victims of any form of violence should be assessed for a broader range of victimisations and adversities.

multiple forms of victimisation from multiple sources (including polyvictimisation) tend to experience a greater number of victimisations, more types of victimisation and more serious forms of victimisation than those who experience a single event or a single form of abuse. They also have a greater level of other lifetime adversities[7] and are much more vulnerable to severe and enduring forms of psychological distress (Asmussen, 2010; Finkelhor et al., 2011).[8]

> Having multiple sexual victimizations, for example, was not associated with nearly as much distress as having any sexual victimization in combination with several other different kinds of victimization. This suggests that among children identified with a single kind of victimization (such as sexual assault), the ones with the most distress will generally be those with other kinds of victimization as well. This may be because these children have no or few environments in which they feel truly safe. (Finkelhor et al., 2011)

Taken together, the findings highlight the importance of early intervention, particularly for girls and young women at risk of multiple forms of violence or trauma. Multiple victimisation, or polyvictimisation, appears to signal a more generalised vulnerability than repeat episodes of the same kind of victimisation. Children who are identified as victims of any form of violence should be assessed for a broader range of victimisations and adversities.

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[7] Other lifetime adversities include illness, accidents, family unemployment, parental substance abuse, and mental illness.

[8] Also see the Adverse Childhood Experiences (ACE) Study http://www.acestudy.org/

Workshop feedback: we could do better for victims of CSA

Practitioners raised a range of issues in relation to CSA.

- In their experience most child clients are revictimised by multiple perpetrators.

- There is little research on CSA, let alone on revictimisation among children.

- Few resources are available for children who are identified as having experienced CSA, including specialist services, or the capacity to work with families.

- CSA is not being identified as early as it could be.

- Sibling sexual abuse presents particular challenges both for families and for practitioners:
  - particularly for family and whānau members (often mothers) who are trying to support both the victim and the child or adolescent with concerning sexual behaviour
  - and/or when the child with concerning sexual behaviour is also a victim of CSA or other forms of violence within the family or whānau.

This feedback highlights the need for holistic and flexible policy responses and interventions that can conceptualise individuals being both victims and 'perpetrators' at the same time.

> Because of its intergenerational nature, the sexual abuse of children cannot be viewed as a tragedy that is visited solely upon an individual. Part of the difficulty in seeing the problem in its entirety is that we are unwilling or unable to hold the notion of an individual being both a victim and an offender simultaneously. However, this is exactly the task that is required. It is this dual 'role' that is at the heart of the cycle of abuse. It is now well understood that a propensity for domestic violence is 'transmitted' generation to generation ... However, perhaps because of understandable sensitivities, sexual abuse, particularly that perpetrated by a young person, is yet to be seen in the same light. (Grant et al., 2009: 5)

6   What we know about intimate partner violence and intimate partner sexual violence

Recent data from the NZCASS indicate that over a quarter of New Zealand women experience 'confrontational partner offences' at least once in their lifetime.[9] Women are more likely than men to be repeat victims of these offences (Ministry of Justice, 2011a).[10]

Prevalence of intimate partner sexual violence

In 2005, around 39 percent of sexual offences against New Zealand women were perpetrated by current or ex-partners (Families Commission, 2009). The prevalence of sexual offending by current and ex-partners, considered together with the dynamics and impacts of IPV, suggests that a woman's risk of future sexual violence is likely to be linked to her risk of physical (or other forms of) violence, at the hands of the same man (Robinson, 2003).

> Perpetrators with previous domestic violence complaints [against them] were much more likely to inflict sexual abuse on an intimate partner. Specifically, about 1 in 3 perpetrators who had previous domestic violence complaints sexually abused their partners, compared to 1 in 10 perpetrators without previous domestic complaints. (Robinson, 2006: 776-777)

In 2005, around 39 percent of sexual offences against New Zealand women were perpetrated by current or ex-partners.

Relatively few studies have examined the prevalence, nature or impact of intimate partner sexual violence (IPSV). There is emerging evidence that substantial numbers of women experience IPSV, either as a distinct form of IPV, or co-occurring with other forms, and that it is less likely than other forms to be reported to the police, or disclosed to other support sources (Braaf, 2011; Heenan, 2004; Temple et al., 2007).

The National Intimate Partner and Sexual Violence Survey found that nearly one in ten women in the United States has been raped by an intimate partner in her lifetime, and one in six has experienced other forms of IPSV (Black et al., 2011).[11] There were also overlaps among different forms of IPV: 9 percent of women victims of IPV experienced both rape and physical violence; 14 percent experienced physical violence and stalking. Around 9 percent reported ever having an intimate partner who tried to get them pregnant when they did not want to or who refused to use a condom.

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[9] In the NZCASS, 'confrontational partner offences' are narrowly defined as assaults or threats to an individual, or threats to their property.

[10] In 2008, 5 percent of women and 3 percent of men were victims of partner offences, but there were 18 partner offences per 100 women, compared to 11 partner offences per 100 men.

[11] Other forms of sexual violence measured in the survey included sexual coercion, unwanted sexual contact and non-contact unwanted sexual experiences.

Nature and impacts of intimate partner sexual violence

Overseas research has shown that IPSV is unpredictable, is ongoing and often escalates (Duncan and Western, 2011). It may be more frequent, severe and traumatic than sexual violence by other perpetrators.

Women report that they often 'give in' to abusive partners' demands for sex to 'keep the peace', or to avoid physical violence and 'rape', or harm to others. Women raped in marriage may be 10 times more likely to sustain multiple sexual assaults than women raped by strangers (Heenan, 2004; MacLeod, 2009; Temple et al., 2007).

IPSV compounds the health burden of intimate partner physical violence

The NZVAWS confirmed that physical IPV was significantly associated with a range of poorer health outcomes, and with increased use of healthcare. Victims of IPV were twice as likely as non-victims to have visited a healthcare provider in the four weeks before the survey and more than twice as likely to have been hospitalised in the last 12 months. IPV was significantly associated with current health impacts, including mental health problems (emotional distress, suicide attempts; memory or concentration problems), physical problems (pain, inability to perform usual activities), and self-perceived poor health. It was also significantly associated with higher use of medication to relieve physical or mental symptoms (Fanslow and Robinson, 2004).

A dose-response effect[12] was evident: the risk of current ill-health was higher for women who experienced severe IPV, compared to those who experienced moderate or no IPV. Beyond this, suicide attempts were up to eight times more likely among survivors of physical IPV than for non-victims (Fanslow and Robinson, 2004). These findings are consistent with the WHO multi-country study, which found significantly higher levels of emotional distress, and suicidal thoughts and attempts among victims of physical or sexual IPV, compared to non-victims (Garcia-Moreno et al., 2005).

The NZVAWS also looked at physical injuries resulting from IPV, although it did not differentiate between outcomes caused by physical and sexual IPV. New Zealand women had relatively high rates of physical injury among IPV victims compared to women in other countries in the WHO Multi-Country Study, and more frequently experienced injuries on multiple occasions. Even so, the percentage of New Zealand women needing healthcare as a result of IPV was at the low end of the range (Fanslow and Robinson, 2011).

Women who are sexually and physically assaulted by male partners carry a much greater health burden than women who are victims of physical IPV only. IPSV may result in more severe impacts on women's mental health, including severe PTSD and depression, and a decreased ability to trust. These women also find it hard to heal emotionally (Braaf, 2011; Heenan, 2004; Howard et al., 2003). Sexual violence in relationships also affects women's sexuality, including their confidence to communicate about sex and their capacity to negotiate contraception and consent (Duncan and Western, 2011).

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[12] The dose-response effect means that the frequency, duration and severity of violence (the dose) tend to predict the severity and scale of health outcomes (the response).

IPSV is a risk factor for lethality

Women may be more vulnerable to sexual assault, and sometimes murder, at the time of or soon after initiating a separation from a violent partner. Women who are sexually assaulted by their partners also experience a greater number of risk factors for murder, such as strangulation and threats to kill the woman and her children, compared to women who experience physical IPV only (Braaf, 2011).

IPSV is a risk factor for lethality in three different scenarios (Braaf, 2011).

- Women are at higher risk of being killed by partners who physically and sexually assault them.

- Women victims of IPSV are more likely to have suicidal thoughts, or to threaten or attempt suicide, than women who experience physical IPV only.

- Women who experience IPSV may be more likely to kill their abusive partners than those who experience physical violence only.

Frontline workers may be reluctant to ask about IPSV

Victims of IPSV may experience different service responses from those of other survivors of sexual violence, or survivors of other forms of IPV. Police, health, and domestic violence workers often do not ask about IPSV and may feel ill-equipped to respond (Braaf, 2011). There is a risk that survivors could be inadequately supported by both domestic violence and rape crisis services, if workers in each type of service consider IPSV to be 'a different kind of problem' (Heenan, 2004).

> Women are at higher risk of being killed by partners who physically and sexually assault them.

There are also negative implications for survivors who report IPSV to police. Sexual assault in general is seen as difficult to prosecute and conviction rates are low. A common finding in the international literature and recent New Zealand research is that cases involving partners have lower conviction rates than those with other victim-offender relationships (Triggs et al., 2009). It is beyond the scope of this report to explore the various reasons for this. These cases almost invariably involve a challenge to the victim's credibility, character and recall. Some of the behavioural and mental health impacts of sexual revictimisation, such as drug and alcohol use, emotional problems, or inarticulateness, can be seen as undermining the survivor's credibility and so contribute to case attrition (Lievore, 2004).

7   What we know about factors associated with sexual revictimisation

The international literature points to a range of factors that might increase the risk of sexual revictimisation among adults. One of the most robust findings is that a history of sexual victimisation, particularly in childhood or adolescence, but also in adulthood, is a key predictor of sexual revictimisation and other forms of interpersonal violence *among adults*. However, the underlying mechanisms that explain why some, but not all, women experience revictimisation, are not well understood.

> A history of sexual victimisation is the best single predictor of further victimisation.

No single factor leads to revictimisation, but co-occurring risk factors can work together to increase victim/survivors' vulnerability. They include factors that are both related to and external to victims, such as the impacts and characteristics of the initial abuse, the actions of perpetrators, and family and whānau contexts, or the degree of social support given to victim/survivors.

Victim-focused models of revictimisation

Many of the theories or explanations of revictimisation in the literature focus on victim-related factors, such as their abuse history, or the behavioural and psychological changes that result from the initial sexual violence. For example:

> Browne and Finkelhor developed a comprehensive "traumogenic" model to explain how early sexual abuse may increase the odds of abuse later in life through four dynamics. First, [they] postulate that through "traumatic sexualization," child sexual abuse results in the association of sex with affection or attention, thereby promoting promiscuity or compulsive sexual behavior. Second, [they] hypothesize that feelings of betrayal lead to a strong need to re-establish trust in others but poor judgment about which individuals are trustworthy. Third, they believe that abuse leads to powerlessness ... [which] inhibits victims from asserting themselves in rebuffing unwanted sexual advances. Fourth, in a process that Browne and Finkelhor term "stigmatization," victims of sexual abuse develop a negative self-image that may lead to substance abuse, risky sexual behavior, or even criminal activity. (Davis et al., 2006: 5)

Table 2 lists a number of factors that have been found to be associated with sexual revictimisation. In the main, they seem to be more applicable to adults than to children. Beyond this, the direction or nature of the association is not always clear. In particular, it is often difficult to distinguish between factors that:

- increase the risk of sexual revictimisation (have a causal link)

- are correlates of revictimisation but do not have a causal link with it

- are consequences of revictimisation.

Table 2   Sexual revictimisation: risk factors, correlates or consequences?

Individual-level factors	
Prior sexual victimisation	Key predictor of sexual revictimisation and other victimisation
CSA, adolescent, lifetime	CSA associated with a higher risk of victimisation in adolescence
	Victimisation in adolescence a stronger predictor than CSA of sexual revictimisation in adults
	Victimisation in childhood *and* adolescence has highest risk of revictimisation in adulthood
	Women raped before the age of 18 have double the risk of being raped as adults than women with no history of rape
Characteristics of prior sexual victimisation	Severity
	Age of onset
	Longer duration
	Frequency
	Closeness of victim/offender relationship
Recent victimisation	Highest risk following recent victimisation
Cumulative trauma	Multiple victimisation, including witnessing violence in the home
	Additive effect of CSA and child physical abuse
Psychological factors	Behavioural and characterological attributions
	Knowledge of risk factors
	Self-efficacy (self- and other-representations)
	More severe psychological distress/poorer psychological health
	Information processing e.g. take longer to recognise risk
	Shame, self-blame, powerlessness
	Poor coping strategies e.g. addiction/substance use and multiple partners may reflect avoidant, maladaptive coping strategies
Behavioural changes	Alcohol/substance abuse can be an independent risk factor for revictimisation and/or a consequence of revictimisation
Dating behaviour, alcohol use, sexual behaviour	Alcohol use before sex
	Interpersonal problems: risk increases for women who are overly responsible, nurturant, sociable/intimate, controlling, non-assertive
	Multiple consensual sexual partners, more frequent sex, brief sexual relationships, sex work, more sexual problems, unintended pregnancies, abortions, reproductive problems

Situational / contextual factors	
Offenders	Motivated offenders identify and target vulnerable women
Family environment	Reports of CSA increase with socioeconomic disadvantage
Lack of social support	Negative social reactions to disclosures lead to negative outcomes for victim/survivors and may increase revictimisation risk

Source: Classen et al., 2005.; Davis et al., 2006; Kearns & Calhoun, 2010; Macy, 2006; Mason et al., 2008; Mouilso et al., 2010; van Roode et al., 2009

Limitations of the evidence base on factors associated with revictimisation

The risk factors in Table 2 reflect the limitations of the empirical evidence base, particularly the heavy emphasis on victim-related factors. The table *does not* provide a comprehensive list of factors for preventing or responding to revictimisation and should not be used as a check list for assessing the risk of future sexual victimisation. While individual-level analyses are important, on their own they offer inadequate explanations of sexual revictimisation.

> Most explanations focus exclusively on individualistic factors, a few have explored interactional dynamics, but virtually none has considered sociocultural factors despite the likely importance of these factors ... The result ... is that most available research encourages a victim-blame interpretation. (Grauerholz, 2000: 5)

There are various theoretical models of women's pathways to revictimisation (for example, see Fargo, 2008; Macy, 2006; Grauerholz, 2000). It is beyond the scope of this paper to explore them, but research has identified that there are multiple social and behavioural mediators between instances of sexual victimisation across the life course. There are benefits in addressing risk factors such as problematic alcohol use or risk-taking behaviour – although these are clearly not useful for thinking about preventing sexual revictimisation of children. However, efforts to prevent sexual revictimisation also need to be built on consideration of the wider range of variables that mediate or moderate susceptibility to revictimisation, as well as the complex relationships among them.

Moving beyond victim-focused models of revictimisation

Listing specific types or combinations of risk factors does not necessarily help our understanding of how to prevent sexual revictimisation. To comprehend the range of experiences, processes and situations that affect survivors' vulnerability, we need to shift our focus to the social and systemic contexts that enable sexual revictimisation to occur.

The following sections of the paper focus on adult male perpetrators of sexual violence. This is in keeping with our primary focus on the sexual revictimisation of women. It is beyond the scope of this report to consider additional factors relating to boys and adolescents who display harmful sexual behaviours. We acknowledge that theoretical models that apply to adults are not appropriate for children, particularly in relation to the sexual revictimisation of girls by siblings or other young family or whānau members.

The predator-context-victim model, for example, hypothesises that sexual revictimisation of women is the product of victim vulnerability, perpetrator characteristics, and situational factors. Some victim/survivors use drugs or alcohol to cope with the trauma. Alcohol and drugs are associated with an elevated risk of sexual violence, and can increase survivors' likelihood of crossing paths with potential perpetrators. Motivated predators are experienced at picking up on and manipulating survivors' psychological and social vulnerabilities. They may gain survivors' trust and use it to isolate survivors from help. Survivors' previous experiences can affect their ability to recognise, avoid and end risky encounters safely (Davis et al., 2006). This model implicitly raises the issue of reoffending and the nature of its links with revictimisation, an issue that has not been well explored in the literature.

Revictimisation and reoffending occur in everyday contexts

> The link between repeated victimisations is not necessarily due to revictimisation by the same person.

The link between prior and subsequent victimisations is not necessarily due to revictimisation by the same person (Classen et al., 2005). Rather, sexual victimisation is a facet of everyday interpersonal contexts – family, work and social situations – which give perpetrators access to victims and opportunities for sexual offending (Clark and Quadara, 2010).

Many perpetrators never come to the attention of the criminal justice system: some researchers estimate that less than 5 percent are ever apprehended (McAlinden, 2006). A substantial number of convicted rapists,[13] as well as undetected rapists, commit a very high number of unreported rapes, as well as other forms of interpersonal violence, including other types of sexual violence, physical IPV, and child sexual and physical abuse (Lisak and Miller, 2002).

Undetected perpetrators may avoid the criminal justice system by targeting victims who are vulnerable, unlikely to report an offence, and/or unlikely to be believed if they do report: characteristics that heighten survivors' vulnerability to revictimisation, and enable perpetrators to reoffend with impunity.

Undetected perpetrators target vulnerable women in social contexts

Repeat perpetrators often make deliberate choices to offend and they are experienced at identifying and targeting vulnerable women. Perpetrators who are aware of a survivor's previous victimisation history can use this knowledge to establish a high level of trust, to isolate and dominate her and control the situation. They use social norms about masculinity and femininity, sex, and 'seduction', to force compliance, to reinterpret the assault as consensual, and to silence their victims (Clark and Quadara, 2010).

The social use of alcohol is another common and important factor in sexual violence and sexual revictimisation. Alcohol is seen as an aid to flirtation and seduction. It diminishes perpetrators' sense of accountability and allows them to reframe the situation, but affects survivors' memories of the incident and increases victim-blaming and disbelief (Clark and Quadara, 2010). A study of undetected repeat rapists found that they often chose victims from within their social networks and/or who were incapacitated by alcohol or drugs. The authors of that study concluded that 'these rapists create "cases" that victims are least likely to report, and that prosecutors are less likely to prosecute' (Lisak and Miller, 2002: 81).

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[13] The term rapist refers to perpetrators whose victims are adults.

Undetected perpetrators in institutional or care contexts

Beyond this, undetected perpetrators may actively target women who are perceived as vulnerable in other ways, perhaps because they have a disability, or mental illness, or are in aged care. For example:

> perpetrators of sexual abuse may be especially keen to exploit women with cognitive disabilities because abusers perceive these women as those that will not tell or will not be believed ... [Disabilities] that are cognitive (i.e., limited learning behavior, limited social skills, limited understanding of social cueing, limited intellect) can interfere with procedures of investigation and criminal prosecution ... Perpetrators frequently select their victims for their perceived powerlessness and vulnerability – and for their seeming limitations. (Elman, 2005)

Women in these situations often have a high degree of contact with paid service providers, from doctors and psychiatrists to orderlies and volunteers, on whom they rely for physical care, emotional support and companionship. There is evidence that some perpetrators target sites that give them access to vulnerable women. As a result of the silence, disbelief and lack of awareness that often surround these survivors, particularly in institutional settings, they have an increased risk of exposure to potential abusers and to ongoing and repeated sexual violation, but a decreased ability to avoid repeated violation (Elman, 2005).

Initiatives to address revictimisation must, therefore, consider perpetrators' behaviours and strategies, and acknowledge that some will be chronic offenders (Hanmer et al., 1999), with well-established ways of legitimising, justifying and hiding their offending.

Workshop feedback: repeat perpetrators in institutional contexts

Practitioners confirmed that, in their experience, women living in institutional settings are at higher risk of sexual revictimisation and particularly of being targeted by predatory perpetrators. They also noted that these women's fears and trauma symptoms can be triggered by the presence of male workers who are not abusive.

8   An ecological approach to revictimisation

Explanations at the individual and interpersonal levels have gone some way towards enhancing our understandings of sexual revictimisation. At the same time, some theorists have begun to apply the ecological framework to the issue. This approach focuses on the determinants of violence against women. It considers the complex interplay among a range of factors, spanning five levels, which are likely to play a role in revictimisation.
These factors are associated with individuals (victims and those who display concerning or harmful sexual behaviours), their family, whānau and interpersonal relationships, and institutional, community and societal contexts.

A recent review found that the key drivers of violence against women are unequal power relations between women and men, adherence to rigid gender stereotypes, and broader cultures of violence (VicHealth, 2007). By taking a more holistic view of sexual revictimisation, the ecological approach helps us to:

- understand factors related to victims and perpetrators, and their family and whānau contexts, that allow sexual revictimisation to occur

- take into account the institutional, community and societal contexts that are likely to play a role in supporting or preventing revictimisation

- think about how the strengths of victims, their families, whānau, and communities can act as protective factors, or be utilised to prevent sexual revictimisation

- consider the range and types of interventions that could be implemented at a systemic level, to help prevent sexual revictimisation.

Figure 4 builds on the only ecological model of revictimisation that we have located (Grauerholz, 2000). The text at the top of the diagram identifies factors that are likely to contribute to sexual revictimisation. The text below it identifies potential interventions to prevent it. The model is not intended to be a complete picture of causes and interventions, nor is it the only model that could be used. We include it here to stimulate thought and discussion, and because it is familiar to many people working in the sexual violence field. We would welcome further elaboration of this model, and the development of other models to promote understanding of revictimisation.

The ecological model has also been used to explain the severity of the consequences of revictimisation.

> For victims of childhood sexual abuse, their postassault distress would be determined by aspects of the child, the assault sustained, informal support, formal systems, and sociocultural factors. If victims of childhood sexual abuse are then revictimized in adolescence, the postassault sequelae from that victimisation would include the experiential vestiges of the prior victimization (and multilevel factors that contributed to postassault distress at that time …). In addition, the model would "repeat" itself in the context of the new victimization – new interactions in the ecology would shape the distress experience from the most recent assault … Women's victimization is cumulative, and so it is little wonder then that the mental health consequences of revictimisation are so severe. (Campbell et al., 2009)

Other theoretical frameworks might be better suited to thinking about the drivers of and opportunities for perpetration (Clark and Quadara, 2010).

Potential contributory or causal factors

Individual
Victims
- Negative emotional, psychological, behavioural impacts of initial victimisation result in higher risk of exposure, less able to recognise/escape from sexual violence
- Abuse history
- Cumulative trauma
- Characteristics of prior victimisation
- Recent victimisation
- Unaware of risk factors
- Failure to seek help
Perpetrators
- History of violent offending
- Attitudes to women
- Motivated to identify and target vulnerable women

Family/relationship
- Victim/offender relationship
- Dysfunctional family relationships
- Family dysfunction in childhood extends to lack of support in adulthood

Institutional
- Social, health, justice systems fail to identify and protect repeat victims
- Interventions focus on mitigating impacts, rather than preventing revictimisation
- Lack of evidence about effective interventions
- Agency policies and practices allow violence to continue
- Agency staff do not understand revictimisation: attitudes result in secondary victimisation and deter further help-seeking
- Agency policies and practices reproduce dynamics of power and control

Community
- Victims lack social power and resources e.g. CSA victims more likely to be socially disadvantaged, isolated or detached
- Victims less likely to have alternative sources of support or the means to gain resources
- Negative responses to initial disclosures deter help-seeking, reinforce self-blame

Societal
- Widespread cultural beliefs and social attitudes e.g. victim-blaming justifies perpetrators' actions; victims internalise attitudes, beliefs, shame and self-blame
- Rape myths obscure nature of sexual violence e.g. 'lightning doesn't strike twice'
- Constructions of femininity e.g. 'damaged goods' cannot be violated again
- Constructions of masculinity normalise coercion

INDIVIDUAL — FAMILY/RELATIONSHIP — INSTITUTIONAL — COMMUNITY — SOCIETAL
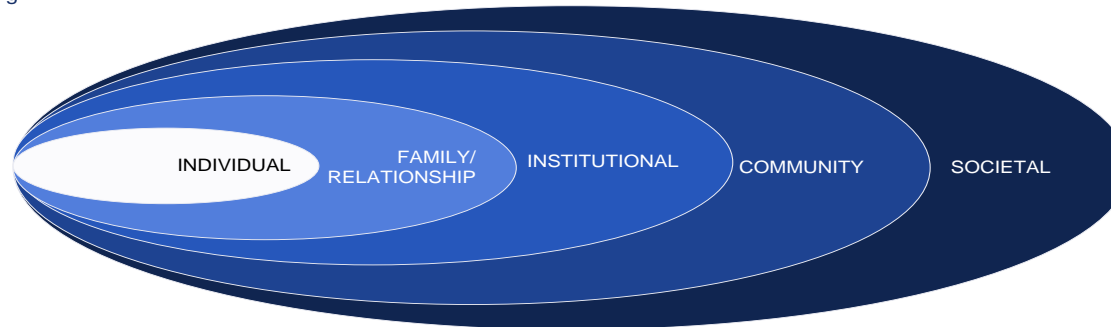
Potential interventions

Individual
Victims
- Psychological interventions to mitigate impacts, promote resilience
- Skills and awareness training, including increased knowledge about revictimisation
Perpetrators
- Early intervention

Family/relationship
- Build family and whānau resilience
- Family/whānau-centred therapy
- Interventions that take a gendered approach

Institutional
- Training for agency staff
- Systemic response to identify and protect women at risk and/or identify and deter repeat offenders
- Develop and evaluate interventions to prevent revictimisation

Community
- Link women into social networks and resources
- Bystander intervention programmes

Societal
- Counter rape myths e.g. through public education or media campaigns
- Legislation and policies that support gender equality

Figure 4   Ecological model of sexual revictimisation: some underlying contributory factors and potential interventions

Workshop feedback

Māori and Pacific models for addressing sexual and family violence

The ecological approach might have limited usefulness for Māori, Pacific, and other collectivist cultures. This is mainly because there are important conceptual differences between Western and indigenous worldviews and understandings of sexual violence, its impacts, and ways to address it. For example, while the ecological approach recognises links between risk and protective factors at various levels in the social environment, it implicitly places the individual at the centre of the analysis, unlike Māori, Pacific and other collectivist world views. However, some kaupapa Māori service providers told us that the model is not necessarily completely at odds with their frameworks.

We are mindful that there are several Māori and ethnic-specific Pacific frameworks for addressing violence. We cannot do justice to them in this report. We also want to avoid homogenising different cultural beliefs, values and practices, particularly in relation to Pacific cultures.

At a very high level, there are some common elements among Māori and ethnic-specific Pacific worldviews, and these are quite distinct from Western worldviews. They include, for example, concepts of gender that see women and men as separate but complementary; concepts of well-being or hauora that incorporate social, relational and spiritual aspects; the fundamental interconnectedness and interdependence of people and their environments; and strengths-based, family or whānau-centred approaches to healing (Hamilton-Katene, 2009; Percival et al., 2010; Taskforce for Action on Sexual Violence, 2009; Taskforce for Action on Violence within Families, 2012).

Whānau-centred approaches do not necessarily preclude practitioners from working with individual survivors. Rather, by working with survivors to identify whānau members with whom they feel safe, they can help survivors to re-establish positive whānau relationships and supportive social networks.

Impacts of societal attitudes to, and representation of, sexuality and gender

Practitioners talked about the damaging impact, on children and young people particularly, of a societal context that presents them with highly conflicting messages about sexuality, such as:

- an intense exposure to unreal sexualised imagery and stories

- the linking of 'coolness' with overt expressions of sexuality (e.g. through behaviour, dress or availability)

- a lack of engagement with, or talk about, how sexuality is expressed in the real world and what constitutes healthy sexual relating

- gender stereotypes that make it 'uncool' for boys and girls to say no, while also being socially risky for girls to say yes.

This all takes place against a societal backdrop that normalises the denigration of, and violence towards, girls and women.

9   Promising practice in preventing revictimisation

This section focuses primarily on therapeutic initiatives to prevent sexual revictimisation and justice/advocacy approaches to preventing repeat IPV, as there have been some evaluations in these areas. Internationally, relatively little attention has been given to designing and evaluating interventions to prevent sexual revictimisation. The few that have been piloted and evaluated offer encouraging results, although they have generally not been successful in preventing all forms of sexual revictimisation. They have also tended to have an individualistic focus on victims, and be delivered within a therapeutic or psychological framework, rather than addressing the different levels of the social ecology. There are good reasons to widen the focus of interventions:

> the victim as indicator of the repeat status of a crime is particularly relevant when the offender is unknown. However, in cases where the perpetrator is known, such as domestic violence, taking the victim's previous history as a sole means of identifying repeats would ignore a man's history of violence towards other women. (Hanmer et al., 1999: 6)

While there are actions that individual women can take to reduce their particular risk levels, accountability for sexual violence rests with perpetrators. Preventing sexual offending and reoffending are important areas for further exploration, but are beyond the scope of this paper. Many of the approaches discussed below aim to empower women. They are not appropriate for children, because children cannot control the risks of being sexually abused or revictimised. The adults around them are responsible for creating safe environments (Tauiwi Caucus of TOAH-NNEST, 2012).

> Some pilot studies have reduced some forms of sexual revictimisation in some samples. They have also reduced some psychological symptoms among women who were sexually revictimised.

Beyond this, multi-level, collaborative, or whānau or family-focused efforts are likely to be more efficient and effective in reducing revictimisation than any singular, victim-focused intervention. We are not aware of any such interventions aimed at preventing sexual revictimisation specifically, although it may be implicit in kaupapa Māori frameworks.

Therapeutic approaches show promise in reducing sexual revictimisation of women

We located four pilot studies that assessed differing therapeutic approaches to preventing sexual revictimisation of women (Classen et al., 2001; Davis et al., 2006; Hill et al., 2011; Marx et al., 2001; see Appendix C).[14]

Taken together, the studies indicate that it is possible to reduce sexual revictimisation among this vulnerable population. While the programmes did not prevent sexual

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[14] Davies et al. (2006) discuss a series of non-therapeutic interventions, designed and evaluated by Christine Gidycz and colleagues, which had variable results, but overall did not reduce sexual revictimisation.

revictimisation overall, they reduced some forms of sexual revictimisation, such as rape, in some samples of women. They also had some success in reducing psychological symptoms among women who were sexually revictimised. Larger sample sizes and longer and more involved programmes might be needed to establish exactly how particular interventions might be more effective if they were modified in some way, or the specific mechanisms that contribute to effective interventions.

Another study showed that participation in a psycho-educational risk reduction programme (and particularly components that addressed attributions of self-blame and promoted adaptive coping) mitigated the severity of psychological distress, especially PTSD, among women who were later revictimised (Mouilso et al., 2010).

Beyond this, while MWA's research on effective interventions for adult victim/survivors did not specifically address revictimisation, it showed that survivors valued specialist sexual violence services and counselling as the most important factor in recovery (Kingi and Jordan, 2009). This suggests that there are likely to be opportunities to address sexual revictimisation within therapeutic contexts.

Absence of evidence on preventing sexual revictimisation of children

We did not find any studies that looked at reducing the risk of sexual revictimisation among children and adolescents. Therapeutic approaches in the CSA field seem to focus on alleviating the psychological impacts,[15] with little consideration of preventing revictimisation (Lalor and McElvaney, 2010). There are indications that therapy can contribute to preventing sexual revictimisation. In this respect, family- or whānau-focused therapy, or therapy delivered within the ecological framework, could have promise.

> Although an ecological approach is promoted in the area of prevention ... [there is a] need for such an approach in the area of therapy – with the child who has been abused, the family (which may or may not include the abuser), and the community. To date, such an approach has not been evident in practice or in the research literature. (Lalor and McElvaney, 2010: 172)

The high occurrence of CSA within family and whānau contexts suggests that family-oriented approaches that are not specifically focused on CSA might also have promise. For example, an evaluation of Early Start, a home visitation programme begun in Christchurch, found that the Early Start group had significantly lower rates of severe child abuse at age 36 months, compared to a control group (Fergusson et al., 2005). Internationally, other parenting intervention programmes[16] have shown positive effects on child abuse rates. Some have also had the secondary advantage of reducing IPV against women. At least one promising programme challenges fathers' gender stereotypes around childcare and alters sex-typed self-schemas (McCloskey, 2011).

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[15] There is evidence that cognitive-behavioural approaches may have a positive impact on the psychological sequelae of CSA (Macdonald et al., 2009). Given the paucity of evaluations of different forms of therapy, this does not necessarily mean that other approaches are not effective. Still, it is not clear that mitigating the impacts of CSA will, on its own, protect against revictimisation.

[16] Parenting interventions are designed to promote effective parenting among mothers and fathers at risk of abusive behaviour, or with a prior record of child maltreatment.

> Interventions that address power differences in abusive relationships are likely to reduce repeat IPV.

There is some information about preventing repeat intimate partner violence

There has been considerable evaluation of programmes aimed at reducing repeat IPV. However, interventions for IPV are grounded in diverse theories of causation and change; they make different assumptions about fundamental factors such as who or what needs to change (for example, victims, perpetrators, families, communities) and about the agents of change (victims, perpetrators, police, communities); and they are implemented in varying contexts (such as legal, social service, mental health, or therapeutic settings). Thus, while there is evidence of effectiveness for specific programmes:

> we lack solid, comparative research on most domestic violence interventions and the precise contours of the interventions and how they can or do contribute to specific intermediate and longer term outcomes. (Mears, 2003: 140)

A review of United States legal/justice, social service, and health-care interventions to reduce IPV revictimisation found variable evidence for effectiveness (Mears, 2003). The findings are summarised in Appendix D. Overall, we found evidence that the interventions listed below can be effective. It is not always clear whether, or how, broader community factors such as crime, poverty and residential mobility may moderate the effectiveness of a given intervention. Overall, evidence suggests that interventions are likely to be effective if they address power differences in violent relationships (Mears, 2003).

Police initiatives

Police projects have been successful in reducing repeat physical IPV. It is not clear whether they also reduce repeat IPSV.[17] While these initiatives only reach survivors who come to the attention of police, this is an important area of intervention: 'Crime prevention efforts focused on protecting repeat or multiple victims of personal offences are likely to have the greatest crime reduction impact' (Ministry of Justice, 2011b: 10).

Based on 2008 incidence rates, confrontational partner offences could be cut by 53 percent if action was taken to ensure that no individual was victimised more than twice (Ministry of Justice, 2011b). This is also a cost-effective focus for crime prevention, which can reduce demands on police time and result in a better service for victims.

> Confrontational partner offences could be halved if action was taken to ensure that no individual was victimised more than twice.

The following factors are likely to be important in reducing IPV revictimisation (Hanmer et al., 1999; Hester and Westmarland, 2005):

- a gendered approach to preventing repeat IPV, with an equal focus on victims and perpetrators

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[17] Details of one successful project, conducted by the West Yorkshire Police in the United Kingdom, are in Appendix E.

- measures of increased intensity for successive police attendances, aimed at constraining the perpetrator's future actions

- supporting women to speak out and seek help

- strong communication and co-ordination among agencies that work with victims and perpetrators

- extensive and accurate databases to identify repeat victims (and perpetrators)

- target hardening, such as improving the security of women's accommodation, and providing personal alarms or cell phones

- regular risk assessments for women and their children who have been identified as victims of male partner violence

- paying attention to perpetrators' tactic changes when target hardening or other safety measures are used: interventions can result in an escalation of violence due to reprisals, so police need to be trained to understand IPV and their role in reducing it.

Advocacy in justice settings

One advocacy service for victims of family violence in England says it has 'reduced by 25 percent the rate of repeated reports to police from victims of domestic violence; and increased the safety of survivors'.[18] Key elements in reducing repeat IPV include:

- intensive, proactive, tailored and holistic advocacy services

- support through civil and criminal justice processes, particularly the court process

- longer-term support that helps women cope with feelings of isolation and loneliness that result from leaving a partner or taking legal action

- support for the victim not to re-enter a violent relationship

- long-term safety planning.

Advocacy in other settings

Advocacy approaches are also used in healthcare and community settings, and women's refuges. Here, the aims of advocacy may extend beyond preventing revictimisation, to empowering women by helping them set and achieve goals, access services, and promote physical and psychosocial health.

A systematic review of trials evaluating advocacy interventions in refuges and healthcare settings found that intensive advocacy for women in refuges was associated with a decrease in physical abuse for more than one to two years after the intervention (Ramsay

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[18] Standing Together Against Domestic Violence Trust, 'Advocacy for Survivors' Project, London, http://www.standingtogether.org.uk/projects.html

International evaluations indicate that advocacy is also an effective means of supporting victims of IPV throughout the criminal justice system and helping to prevent attrition (Hester and Westmarland, 2005). Victim/survivors who receive support from specialised advocacy services are also more likely to give evidence and to be more satisfied with legal proceedings (Parmar and Sampson, 2005).

et al., 2009; and see Appendix C). Brief advocacy was associated with an increase in women's use of safety behaviours. The evidence was equivocal as to whether advocacy had a positive impact on depression, quality of life, and psychological distress, or whether it decreased emotional abuse. The review could not confirm whether less intensive interventions in healthcare settings are effective for women who still live with abusive partners (Ramsay et al., 2009).

The importance of collaborative interventions

Co-ordinated community responses have been found to reduce harm to high-risk domestic violence victims who take part in Multi-Agency Risk Assessment Conferences (Robinson, 2006). There are considerable methodological challenges involved in rigorously evaluating the effectiveness of these responses, as well as the critical elements that reduce revictimisation. There is value in systematically addressing those challenges, because:

> the importance of collaborative efforts lies in large part in their ability to create individual and community-level reductions in domestic violence revictimization and in a manner that is more effective and efficient than any one single intervention could be. (Mears, 2003: 136)

There is a need to establish whether strengths-based approaches and kaupapa Māori approaches are preventing sexual revictimisation.

Workshop feedback: ways of addressing revictimisation

We had conversations with sexual violence prevention educators, kaupapa and tikanga Māori, and non-Māori counsellors and service providers, about whether or how they address sexual revictimisation (or the possibility of it) with their respective client groups. They did not say that they were aware of or using any targeted interventions, but they did give us insights into the sensitivities around talking about sexual revictimisation and different ways they might address it. These discussions are summarised below.

These approaches appear to be promising, but we are still left with the question of how we might establish whether they are preventing revictimisation.

Strengths-based approaches to healthy sexual relating

Sexual violence prevention educators said they often receive disclosures about sexual victimisation from young people in their programmes, as well as enquiries about whether revictimisation is common. Counsellors said they do not necessarily ask their clients about victimisation histories, but they are aware of the high prevalence of revictimisation.

Both educators and counsellors said there are risks associated with raising the issue of sexual revictimisation directly with survivors. In particular, they were concerned that survivors could become fatalistic about or resigned to revictimisation as inevitable. They suggested that strengths-based approaches to supporting survivors' recovery have potential for reducing the risk of sexual revictimisation. This might involve a focus on building survivors' understanding of what healthy sexual relating looks like and their sense of entitlement to healthy and enjoyable sex.

Kaupapa and tikanga Māori responses to sexual violence and revictimisation

There are various models and good practice guidelines for kaupapa and tikanga Māori programmes aimed at preventing or responding to violence against women. Some fundamental aspects of these approaches to violence against women are that they:

- are based on Māori models of health, cultural values, beliefs and clinical practices

- comprise holistic responses to healing the individual within the context of the whānau, hapū and iwi

- are founded on an analysis of the historical and socio-political contexts affecting the position of Māori, including colonisation, assimilation, and Te Tiriti o Waitangi

- ensure that the whānau members accessing the service (often women and children) remain the priority

- recognise that the well-being and autonomy of women are central to whānau well-being (Hamilton-Katene, 2009; Te Kupenga Whakaoti Mahi Patunga National Network of Stopping Violence, 2011).

Practitioners told us that although these approaches might not distinguish between sexual victimisation and revictimisation, they implicitly address the complexity and sensitivity of violence-related issues. For example, Tiaki Tinana is a sexual violence primary prevention programme that combines expertise in preventing sexual violence, sexual perpetrator treatment, referrals to survivor services, and Māori clinical practice. It works across the different levels of prevention and has the capacity to create safe community environments. An evaluation of the project showed that it led to an increased demand for services and support for both survivors and perpetrators (Te Puni Kōkiri, 2010). The holistic approach of the programme is consistent with the ecological approach, suggested above, as a useful way of thinking about the drivers of and potential interventions for sexual revictimisation.

10   What needs to change?

Overall this report:

- shows us a complex picture of sexual violence and sexual revictimisation, experienced by many women across the life course

- strengthens our understanding of how profound and far-reaching the impacts of CSA and sexual victimisation in adolescence or adulthood can be

- emphasises the links between multiple forms of violence against women and girls

- highlights the importance of early identification of repeat victim/survivors and of providing consistent and appropriate support across a range of sectors

- underscores the need to break the cycle of repeat victimisation.

Sexual revictimisation can be prevented, but this is not a task for a single agency or sector. Change can best be achieved by embedding the issue at a systemic level, as reflected in the action areas outlined below.

### A system that is responsive to vulnerable groups of women

A systems approach to sexual violence provides a crucial framework for integrating the range of actions needed to prevent repeat victimisation and mitigate its impacts. Figure 5, below, shows an idealised system that spans government and community sectors, as well as responses to survivors and perpetrators.[19]

To increase women's safety and well-being, the system must both *prevent* violence and *respond* effectively when it does occur. As indicated by the dotted lines, the subsystems are not discrete: to have the greatest impact, prevention and response initiatives must be comprehensive and co-ordinated, span the social ecology, and take into consideration a range of interventions at the level of victims, perpetrators, communities, and government agencies.

The figure is also based on the understanding that the risk of violence is not evenly distributed across the population. Any work in this area must be underpinned by responsiveness to vulnerable population groups, particularly girls and young women, and Māori women. As the median age of Māori is younger than the overall population, this overlap in vulnerability factors is a concern. Women with disabilities also face substantially elevated risks of sexual violence and sexual revictimisation. Practitioners in our workshops raised concerns that there is a paucity of appropriate services to respond to these vulnerable population groups.

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[19] The model is based on the ecological approach. MWA developed it in consultation with other government agencies as part of our 2009 research (Ministry of Women's Affairs, 2009).
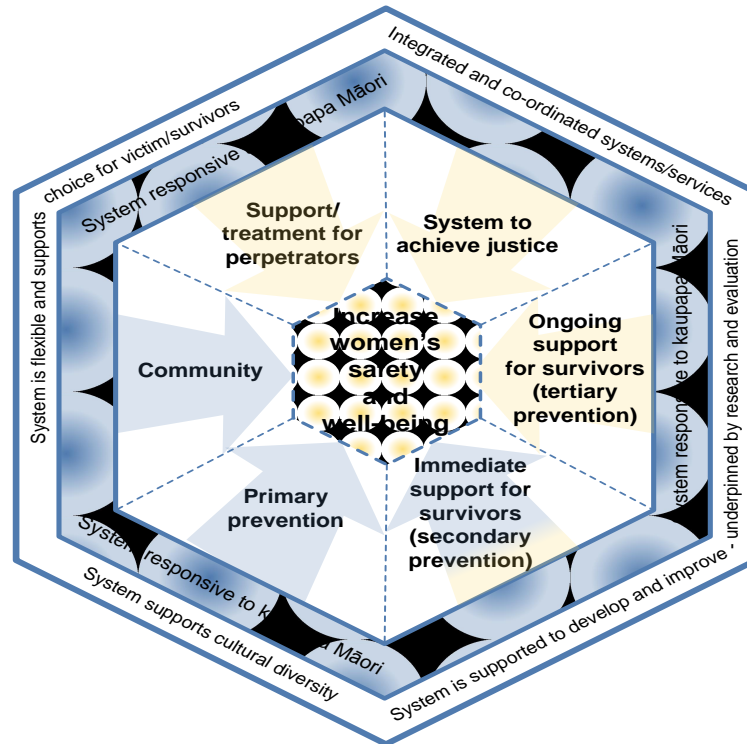
Figure 5: Sexual violence prevention and response system

Increase understanding and awareness of sexual revictimisation

There are strong social, cultural and economic imperatives to integrate sexual revictimisation into our understandings of violence against women. Our discussions with community and government stakeholders indicate that awareness of the issue varies across agencies. There also seems to be a greater focus on mitigating the impacts of sexual violence than on preventing it from happening again. Practitioners in our workshops noted that health, justice and education professionals often lack knowledge about issues such as the dynamics of sexual violence, how to identify it, and how to respond to disclosures.

Therefore, it is crucial to embed understanding of the complexity of sexual violence, revictimisation, and multiple victimisation, in policy and operational responses to violence against women and girls. This can be achieved in various ways, such as training or developing resource sheets to help frontline staff ask their female clients about their histories of sexual violence and/or assess the likely risk of revictimisation.

Early identification and protection of at-risk and repeat victim/survivors

This report has made it clear that sexual violence often sets up a trajectory of negative outcomes across the life course. Early identification of at-risk and repeat victim/survivors – particularly children who have experienced CSA – is fundamental to preventing further violence. This needs to include an assessment of the likelihood and imminence of future violence, risk factors for violence, and ways of protecting vulnerable survivors from further harm.

This report highlights the fundamental interconnectedness of different forms of violence against women and girls, as well as the prevalence of multiple victimisation. Victim/survivors

Extensive and accurate databases are needed to identify repeat victims.

often seek help from multiple agencies, either because of escalating violence and/or because of the complexity of their revictimisation-related needs. Repeat victims could potentially be identified through a range of agencies, including but not limited to justice, health, social/welfare, disability, educational, workplace and community settings.

However, agency responses tend not to reflect the frequent co-occurrence of different forms of gender-based violence, either within life stages or across the life course. Siloed responses perpetuate the hidden nature of sexual violence within intimate relationships, or CSA within other forms of child maltreatment, and may actually increase the likelihood of repeat and multiple victimisation. At the very least, extensive and accurate databases are needed to identify high-risk and repeat victims. Integrated or collaborative approaches offer the best prospect of early identification of and appropriate responses to vulnerable women and girls (see below).

Despite high levels of service use among repeat victims, rates of reporting and disclosure are low. There are numerous barriers to disclosure, including the inability of some survivors to name their experiences as sexual violence. If survivors' victimisation histories are not identified, they will not be given an opportunity to consider whether their past experiences are connected with their present difficulties (McGregor, 2003).

This suggests that the onus is on frontline personnel to identify repeat and at-risk victim/survivors by directly asking about their histories. Research has shown that rates of CSA in clinical samples increase dramatically when outpatients and female psychiatric emergency room patients are asked about previous violence. However, repeat victims are not systematically identified by service providers. Clinicians, for example, do not always ask about prior violence, because patients' immediate needs and concerns are often more pressing and because they are concerned that asking about it could adversely affect patients' psychological state (McGregor, 2003).

Effective secondary and tertiary interventions

When sexual violence does occur, victim/survivors and their families and whānau, need access to evidence-based interventions to address the harms and minimise the likelihood that it will happen again.

Research shows that crisis intervention during the initial stages immediately after rape is crucial to the health and wellbeing of victim/survivors and that early and appropriate post-crisis intervention can mitigate the longer-term impacts of sexual violence (Mossman et al., 2009). As such, effective specialist crisis intervention has the potential to reduce the ongoing costs of sexual victimisation to survivors and to society.

Ideally, these interventions would be based on an approach, such as an investment model, that would identify high-risk, high-cost groups, such as Māori, and children and adolescents exposed to CSA, where early investment is likely to yield long-term benefits by preventing the damaging consequences of revictimisation. In the case of girls who are victims of CSA, interventions would potentially be delivered again at high-risk periods, such as adolescence and young adulthood, to empower young women before they become involved in adult sexual relationships.

Encouraging help-seeking from specialist sexual violence services

Previous New Zealand research has shown that survivors rate counselling and specialist sexual violence services as the most important services contributing to their recovery, followed by informal support systems, and well ahead of generic or community services. It indicated that survivors in New Zealand cannot be guaranteed timely access to services, or to services that are of a consistently high standard, and able to address the needs of diverse population groups (Ministry of Women's Affairs, 2009). The literature reviewed for this report demonstrates that therapeutic approaches do not always prevent sexual revictimisation. A useful area of work would be to identify what is working to prevent it and how these approaches could be used more widely.

Supporting families, whānau and communities to prevent revictimisation

For most victim/survivors, the first step in the help-seeking process is to tell someone in their social network about the sexual violence. Their reactions to disclosures play a strong role in shaping subsequent help-seeking decisions. Negative reactions, including disbelief, can deter further help-seeking and increase survivors' vulnerability to revictimisation. Positive reactions can encourage survivors to seek help from specialist sexual violence services, but informal support sources often do not know how to access these services. Efforts to prevent revictimisation will be more effective if they go hand-in-hand with initiatives to:

- inform the wider community about the nature and dynamics of sexual violence

- dispel commonly held myths about sexual violence and revictimisation that can lead to victim-blaming and disbelief

- help families and whānau know what to do and where to get the professional help that survivors need

- encourage families and whānau to intervene when they suspect or know that sexual violence has occurred.

Collaboration between agencies

Survivors of sexual revictimisation often present to a number of helping agencies, which have a range of generic and specialised knowledge and skills. Survivors' complex needs can only be effectively addressed through collaborative and co-operative approaches, underpinned by strong inter-agency linkages. Mental health workers who work with IPV survivors, for example, should consider the effects of sexual violence as potential contributors to psychological symptoms (Temple et al., 2007). This is especially important considering that survivors of IPSV might not disclose sexual violence to refuge workers, but would benefit from referral to specialist sexual violence service providers.

Supporting 'secondary victims'

Families, whānau and friends can be traumatised by being exposed to the harm caused to a loved one who has been sexually violated. These 'secondary victims' have legitimate support needs in their own right, particularly because they may experience symptoms

similar to those of the primary victim, and their responses can hinder the survivor's recovery.

Identifying and responding to perpetrators

In this report we have noted the importance of preventing sexual (re)offending. We hope the report will provide an impetus for promoting evidence-based, effective approaches to preventing sexual offending and sexual recidivism. It was outside the scope of the report to look at this literature and we note that the term 'perpetrator' could be applied to a heterogeneous group, ranging from boys and adolescents with concerning sexual behaviours (who might themselves be victims of CSA) to repeat rapists who deliberately target vulnerable victims. At the very least, treatment services must be available and accessible for boys and adolescent males who display harmful sexual behaviours, and for men who want to change their harmful behaviours.

Building the evidence base about what works to prevent revictimisation

There is a limited evidence base on what works to prevent sexual revictimisation, although this report does give examples of promising practice, sourced from both the international research evidence and local practitioner knowledge. This suggests that we are in a position to build the evidence base on effective practice.

Evidence-based interventions for victims (and perpetrators) need to be built on theoretical understandings of revictimisation that consider factors and processes that:

- are strengths-based, and do not simply focus on women's vulnerabilities

- decrease perpetrators' opportunities to offend

- bring about changes in contexts and attitudes that support gender-based violence

- span the levels of the social ecology.

These interventions should be developed and delivered by practitioners with specialised knowledge of sexual violence and/or specialised cultural knowledge to respond to Māori survivors and their whānau. They should be open to evaluation – possibly along the lines of a formative evaluation – to establish evidence of effectiveness, including specific mechanisms that contribute to effectiveness and how promising practices could be more effective.

Preventing sexual violence

The high costs of sexual violence, together with the increased likelihood of multiple victimisation, underscore the importance of preventing sexual violence and other forms of gender-based violence, particularly in childhood and adolescence. Violence prevention occurs across three levels:

- primary prevention, or preventing violence before it occurs – including universal strategies, and strategies targeted at individuals and groups who exhibit early signs of perpetrating or being subject to violence

- secondary prevention – interventions for victims and perpetrators that prevent revictimisation or further offending

- tertiary prevention – intervening after violence has occurred, providing longer-term support and treatment to women and children who are affected by violence or to men who use violence, preventing future victimisation and/or the escalation of violence.

By definition, preventing revictimisation involves secondary and tertiary-level interventions. However, when it came to analysing the association between child maltreatment and repeat and multiple victimisation across the life course, and the intergenerational transfer of violence, it was difficult to think about preventing revictimisation without considering the imperative of primary prevention.

Internationally, violence against women is increasingly seen as a public health problem that can be reduced and prevented. There is a strong move towards developing integrated strategies that address all forms of violence against women and children. Within this, increasing attention is being given to primary prevention, and there is a growing evidence base about what works to prevent violence before it begins (Australian Government, 2009; Loots et al., 2011).

New Zealand's Campaign for Action on Family Violence (the *It's Not OK* campaign) has been very successful in raising awareness of family violence. Evaluations indicate that more people are seeking help since the campaign's launch and more people believe they can help others to change. Community ownership has been integral to the campaign's success. There may be value in exploring community readiness for similar messages, focusing on sexual violence.

Opportunities to enhance understanding and address gaps in knowledge

This report highlights a number of gaps in our knowledge base about preventing revictimisation. The evidence base is limited by:

- the lack of a universally accepted definition of revictimisation, along with variations in how it is conceptualised and measured

- the lack of a comprehensive and nuanced understanding of revictimisation among different groups of victim/survivors, such as revictimised women with multiple perpetrators versus those with only one perpetrator; women from diverse ethnic or cultural backgrounds; women and girls whose initial sexual assault occurs at different life stages; women with disabilities; boys and men; and lesbian, gay, bisexual, transgender and intersex people

- poor understanding of ways that psychological processes vary across situations and individuals, and how they combine with a range of risk factors to increase vulnerability

- poor understanding of protective factors and resilient life trajectories and of how such concepts can inform social policy and the design of effective interventions

- inadequate attention to and evaluation of what works to prevent sexual revictimisation, including kaupapa Māori approaches, and how promising practices could yield better outcomes if modified in some way

- the absence of multi-level or ecological analyses to help understanding about how programme or community-level characteristics moderate programme effectiveness.

While some police initiatives have been successful in reducing IPV, it is unlikely that they could be generalised to (most) non-partner sexual offences. It is also not clear to what extent initiatives aimed at preventing repeated, non-sexual forms of violence in dating, intimate and family relationships, will be effective in reducing sexual revictimisation. While there are common drivers, risk factors, and dynamics across different forms of violence against women and girls, some are specific to sexual (re)victimisation, and must be addressed through targeted programmes.

There are also gaps in other areas. For example, screening in healthcare settings aims to identify victim/survivors of IPV and child maltreatment in order to offer interventions that can lead to better health outcomes.[20] However, international research suggests that there is no clear evidence that screening leads to better outcomes for women, or whether it is more effective for different population groups (Taft et al., 2008). Beyond this, screening will be most effective when health professionals have a good knowledge of sexual violence and strong links with local providers, to whom they can refer repeat victims. It is not clear that health practitioners across New Zealand have this level of knowledge, or are linked in to specialist sexual violence services.

Summary

In summary, effective interventions for sexual revictimisation are:

- based on a comprehensive overview of gender inequality, including the way that gender shapes power in relationships, families and society

- based on a sound understanding of the connections between different forms of violence against women and girls, including repeat and multiple victimisation

- cognisant of the profound impacts of revictimisation across the life course, the high and complex needs of many survivors, and their involvement with multiple agencies

- part of a systemic response, integrated into health, social, legal, educational and community services

- developed and delivered by practitioners with specialised knowledge of sexual violence, including practitioners with specialised cultural knowledge, such as kaupapa and tikanga Māori service providers

- implemented across all three levels of prevention – on the basis that primary prevention educators often receive disclosures about sexual violence

- targeted towards children and adolescents exposed to CSA, to prevent the damaging consequences of revictimisation, and potentially delivered again at high-risk periods, such as adolescence and young adulthood, to empower young women before they become involved in adult sexual relationships

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[20] The Ministry of Health's Violence Intervention Programme (VIP) seeks to reduce and prevent the health impacts of violence and abuse, through early identification, assessment and referral of victims presenting to health services. An evaluation of 27 hospitals across New Zealand found that the Partner Abuse and Child Abuse & Neglect Intervention Programmes made steady progress between 2004 and 2008 in identifying and supporting a multi-agency response to women and children at risk of family violence. However, it did not track outcomes for those women and children (Koziol-McLain et al., 2009).

- based on an approach, such as an investment model, that would identify high-risk, high-cost groups, where early investment is likely to yield long-term benefits

- evaluated for evidence of effectiveness.

Key terms

For the purposes of this report, an **adult** is defined as someone aged 16 years or older at the time they were sexually assaulted. This is based on the legal age of consent and is not entirely unproblematic. For example, the UN Convention on the Rights of the Child sets the upper boundary of childhood at 18 years.

Child abuse and neglect, or child maltreatment, is commonly defined in terms of children experiencing physical or psychological harm as a result of physical abuse, sexual abuse, emotional maltreatment, neglect, and witnessing family violence. Abusive and neglectful behaviours can differ in terms of severity, frequency and duration of occurrence, and their likelihood of causing harm. It can be the result of others inflicting harm on or failing to prevent harm to children (Asmussen, 2010; Price-Robertson and Bromfield, 2009).

Defining **childhood sexual abuse (CSA)** can be complicated. A general definition is 'the use of a child for sexual gratification by an adult or significantly older child/adolescent'. Some behaviours are unequivocally abusive e.g. any sexual behaviour between a child and a family member, or an adult in a position of power; between an adult and a child under the age of consent; any non-consensual or coercive sexual activity between minors, particularly when there are unequal power relations or developmental differences between the young people. Others are more equivocal e.g. consensual sex between a 19 year-old and a 15 year-old.

Chronic victim is a term used in the international literature to refer to people who experience five or more offences within a 12-month period (Ministry of Justice, 2011b).

Concentration of crime is a measure that shows how many times one person has been victimised. It is used to illustrate multiple and repeat victimisation (Ministry of Justice, 2010).

The **dose-response effect** (dose-response relationship or gradient) describes how the likelihood and severity of adverse health effects (the responses) are related to the amount and condition of exposure to an agent (the dose). In relation to violence, this means that the frequency, duration and severity of violence tend to predict the magnitude and extent of health outcomes.

The ecological model is a widely used public health framework that helps understand violence against women and how to reduce it. It focuses on the determinants of violence and looks at the interplay of factors, spanning five levels, that combine to cause it. These factors are associated with individual victims and offenders, their family, whānau and interpersonal relationships, and institutional, community and societal contexts.

Intimate partner violence (IPV) refers to behaviour in an intimate relationship, including current and ex-partners, and most often used by men, that causes physical, sexual or psychological harm. It includes threatened and actual physical violence and sexual violence; psychologically and emotionally abusive behaviours, including intimidation and humiliation, isolation, and monitoring a woman's movements; economic or financial abuse; and reproductive coercion (World Health Organization, no date; Branigan, no date). It is often cyclical and involves the systematic use of threats, isolation and coercion to instil fear and control intimate partners.

Multiple victimisation is a broader term than revictimisation. It is usually defined as someone being a victim more than once of any offence type, including different types of crimes, such as sexual and physical violence (Ministry of Justice, 2010; compare definition of polyvictimisation, below). We also refer to the co-occurrence of different forms of violence against women and girls.

Perpetrator refers to an individual who commits sexual violence. Some sectors prefer terms that do not label individuals, such as 'children with concerning or problematic sexual behaviour' or 'adolescents/adults with harmful sexual behaviour'.

Some researchers use the term **polyvictimisation** to refer to children exposed to multiple types of violence, crime and abuse, such as child maltreatment, victimisation by peers and siblings, sexual victimisation, witnessing violence and indirect victimisation (in the family or the community), school violence and threats, Internet victimisation, and other types of crimes. There is no consensus on the numerical threshold for polyvictimisation, although exploratory research has found a significantly greater level of distress among youth who experienced seven or more types of victimisations in a single year (Finkelhor et al., 2011).

Primary prevention interventions aim to prevent violence before it occurs. They can be targeted to the whole population or to particular groups that are at higher risk of being victims or perpetrators of violence.

Recovery relates to a restoration of well-being across a range of domains, including the physical, mental, emotional, spiritual and interpersonal spheres. Different sectors have different models of recovery. Recovery is a process, not an end, and people recover in different ways. Recovery is related to safety and well-being (see below).

Repeat victimisation – or **revictimisation** – is a feature of crime generally. It is usually defined as someone being a victim of the same offence, or the same offence type, more than once (Ministry of Justice, 2010).

Safety refers to freedom from the risk of, threats of, or actual further sexual victimisation, physical or psychological injury, or secondary victimisation. Potential sources of further risk include other people, risky or self-harming behaviours, or engagement with justice, health or other services. Safety is on a continuum with well-being (see below).

After an incident of sexual violence, the first priority is safety, or removing the victim from the risk of further harm. This is followed by the longer process of recovery or restoring well-being.

Secondary prevention (or early intervention) approaches focus on more immediate responses to violence, including crisis responses, and on preventing violence from recurring.

In some literature, the term 'revictimisation' refers to '**secondary victimisation**', in which victims of sexual violence are retraumatised as a result of the attitudes and actions of individuals, and/or institutional processes, which have been likened to a 'second rape'.

There is no standard definition of **sexual violence** (or sexual assault). It is a broad term that covers a continuum of behaviours, not all of which are criminal offences. Different jurisdictions, agencies and surveys use a wide range of terms, definitions, classification systems, counting procedures and behavioural definitions. The definition of sexual offences used by the New Zealand Crime and Safety Survey covers:

sexual violation/rape, and indecent assault ... The survey asked respondents about forced sexual intercourse, attempted forced sexual intercourse, distressing sexual touching, and other offences of sexual violence. (Ministry of Justice, 2010)

A Māori definition of sexual abuse based on cultural values is defined as the trampling of a person's mana or personal power and identity by others' sexual comments or behaviours. This definition is grounded in the Māori value of relationships, which Māori view as important and sacred engagements. (Hippolite-Wright, 2002, cited in New Zealand Family Violence Clearinghouse, 2012: 8)

Sexual revictimisation refers to the link between sexual abuse in childhood or adolescence and sexual victimisation in adulthood, or between repeated sexual victimisations in adulthood. It does not necessarily involve the same perpetrator.

Tertiary prevention interventions are longer-term responses that aim to prevent the consequences of violence, such as trauma for victims, restore victims to well-being, reintegrate or rehabilitate perpetrators, and ensure that violence does not escalate or happen again.

'Victim/survivor' is used interchangeably with 'victim' and 'survivor'. This terminology reflects that not all people who are raped assume the victim label, with its negative connotations. At the same time, 'survival is neither assured nor necessarily immediately apparent: some women may always deem it a "work in progress" (Mossman et al., 2009).

Well-being refers to physical, psychological and emotional welfare. Well-being can be promoted in many ways, including through the belief and support of others; access to therapeutic interventions that promote recovery; access to legal redress; the perception that justice has been done; knowledge about rights and choices; having one's needs met; and regaining a sense of control over one's body and life.

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Appendix A

New Zealand estimates of sexual abuse and sexual revictimisation of girls

Author	Method, sample, definition of sexual violence	Prevalence estimate
Boden et al., 2009	Longitudinal study of a birth cohort born in Christchurch in 1977. Information on CSA obtained at ages 18 and 21 years Interviews with 492 women (78% of original sample). Sample is not representative of New Zealand population CSA: before age 16, anyone ever attempted to involve them in any of a series of 15 unwanted sexual activities, including non-contact episodes; sexual contact; attempted or completed vaginal, oral or anal intercourse	14% experienced CSA prior to age 16
Carroll-Lind et al., 2011	National survey of children aged 9 to 13 years Representative sample of 2,077 children from 28 randomly selected schools Sexual violence: unwanted sexual touching or being asked to do unwanted sexual things; direct victimisation and witnessing sexual violence	11% directly experienced sexual violence Among those: 43% reported a single incident; 15% said it happened 'lots' 7% reported witnessing sexual violence against adults; 10% had observed other children being asked to perform unwanted sexual activities or having unwanted sexual touching. Most sexual violence witnessed was on television, videos or movies
Clark et al., 2009	Youth'07: national survey of 9,107 secondary school students. Findings are representative of young people attending mainstream secondary schools Unwanted sexual experiences: touched in a sexual way or made to do sexual things they didn't want to do	20% of females had unwanted sexual contact

Author	Method, sample, definition of sexual violence	Prevalence estimate		
Fanslow et al., 2007	New Zealand Violence Against Women Survey		**Auckland**	**Waikato**
	Random sample of 2,855 women aged 18 to 64 years from Auckland and north Waikato. Findings are generalisable to the population	**Prevalence of CSA prior to age 15 (%)**		
		All women	24	28
	CSA: before the age of 15, ever touched sexually, or made to do something sexual they didn't want to do	Māori	31	35
		Pacific	18	NA
	First experience of sex: wanted, coerced or forced	Asian	6	NA
		European & other	17	21
		Number of times abuse occurred (%)		
		Once or twice	51	50
		A few times	25	28
		Many times	24	22
Flett et al., 2012	Interviews with 961 women aged 18 and older, from an area probability sample across census districts	13% reported sexual abuse during childhood		
	CSA: during childhood, ever made to have sex by use of force or threats to harm you; involves all unwanted sexual activity	Among those, 76% said the indexed abuse incident was one in a series by the same perpetrator		
van Roode et al., 2009	Longitudinal study of a birth cohort born in Dunedin in 1972/73. Information on CSA sought at age 26	30% of women reported contact CSA prior to age 16: 42% of those experienced multiple types of CSA		
	Questionnaire completed by 465 women and 471 men (92% of surviving cohort)	An additional 3% of women experienced some other form of abuse		
	CSA: before the age of 16, someone touched genitals when they didn't want them to; forced to touch someone else's genitals; attempted intercourse; completed intercourse; any other unwanted sexual activity	70% of women who were abused said it happened on multiple occasions		

New Zealand estimates of sexual violence and sexual revictimisation of women

Author	Method, sample, definition of sexual violence	Prevalence estimate		
Fanslow and Robinson, 2004	New Zealand Violence Against Women Survey		**Auckland**	**Waikato**
	Random sample of 2,855 women aged 18-64 years from Auckland and north Waikato. Findings are generalisable to the population	**Lifetime sexual violence (%)**		
		Non-partner	9	12
	Adult sexual violence: physically forced to have sexual intercourse when they did not want to; having sexual intercourse because they were afraid of what their partner might do, or being forced to do something sexual that they found degrading or humiliating	Partner	14	20
		Partner physical and/or sexual	33	20
		12-month partner violence (%)		
		Sexual	2	2
		Physical and/or sexual	6	5
Mayhew and Reilly, 2006 and Families Commission, 2009	New Zealand Crime and Safety Survey, 2006 Nationally representative random sample of 4,229 people aged 15 and over, with a Māori booster sample of 1,187 (N=5,416) Lifetime and 12-month prevalence Sexual offences: Forced sexual intercourse as a result of threats, being held down, hurt in some way; attempted forced sexual intercourse as a result of threats, being held down, hurt in some way; distressing sexual touching; other sexual violence, including threats	29% of women were sexually victimised in their lifetime 4% of women were sexually victimised in 2005. Among those: • 57% said it happened once • 25% said it happened twice • 10% said it happened three or four times • 8% said it happened five or more times In comparison to the overall one-year prevalence rate, the rate was doubled for Māori women and sole mothers, three times higher for women aged 15 to 24, and women living with flatmates, and three and a half times higher for female students		
Morris et al., 2003	New Zealand National Survey of Crime Victims, 2001 National random sample of 5,300 persons aged 15 and over, with a Māori booster sample of 500 and a Pacific booster sample of 699 Unwanted sexual attention, lifetime and 12 month prevalence	19% of women sexually victimised in their lifetime 1% of women victimised in the 12 months before the survey Methodological differences likely to account for lower prevalence rates than the 2006 NZCASS: changes included differences in the way NZCASS measured sexual victimisation and increased number of screener questions.		

Appendix B

Case study: Victoria's story[21]

Victoria, a professional New Zealand European woman, has a lifelong history of different forms of abuse, beginning in childhood and continuing into adolescence and adulthood, and involving different perpetrators.

Victoria was brought up in a very religious family. Her father, a church elder, was physically abusive. As a child, Victoria was sexually abused by her friend's older brother. She did not tell her parents about it, because she believed they would blame her, and she was afraid of her father.

Teenage experience of sexual violence and involving the police

When Victoria was 16, she was raped in her bedroom by a stranger who broke into the house. Her parents were overseas and a couple from the church were caring for the children. She told them she had been raped, and they called in the church minister, who then called the police.

> *The minister told the police that I was a slut and that I probably got myself pregnant, and that I was not to be trusted. They took me back to the cells ... There were three burly policemen standing around ... and they were just at me and at me to tell the truth. They didn't believe me. They, in fact, threatened to make my life a misery.*

A few months later, the (serial) rapist returned ...

> *Everyone kept asking me why I didn't scream. When he came back the second time, I tried to scream, but I made a choking sound, which is what woke Dad ... Dad chased him ... but he got away ... Mum went to phone the police, but I threw the phone down, I didn't want to go through all that again. So Dad held me down while Mum phoned them. The police were right there on our doorstep with tracker dogs because he had just raped another girl around the corner and the dogs had tracked him to our house.*

This time the police believed Victoria ...

> *It sounds horrible, but it was good that he did come back the second time, because I was validated. It was the first time they believed me.*

Going to court

The rapist was eventually caught, and Victoria became crucial to the trial. She had to give evidence and found the whole process extremely traumatic.

> *It was very traumatic; it took me back to square one ... the defence lawyers twisted everything. And it was reported in the paper that I encouraged him to my bed ...*

The rapist was convicted and spent nine years in prison. Victoria was not offered counselling or support, and said she would have got over the experience more quickly if she had not interacted with the police or attended court.

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[21] Kingi and Jordan, 2009: 30-33.

I think it sounds bizarre, but the actual rape wasn't as bad because I'd been abused as a child and knew how to dissociate, so the rape wasn't as horrendous as all the treatment I got afterwards.

Surviving sexual violence

It was 10 years after the trial that Victoria first received counselling. She was married and carrying her first child when the rapist, who had been released from prison, began to make obscene phone calls to her home ... Victoria saw a photo of the rapist in the paper doing roadwork, and thought she recognised him working in a road gang in her street.

I had a brand new baby, and I was crawling around the floor of the house. I was too scared to go out and too scared to stay home. I sat in the wardrobe for about four days straight. So that is when I first got connected into counselling ...

Victoria did not find the counselling useful and was unable to stay alone in the house at night. It was not until her second child was born that she contacted a specialist sexual violence agency.

I went to a support group for a while. But it was down a back alley, and up some external fire stairs. It scared the shit out of me, because it was night meetings.

A further 10 years later, Victoria had a 'melt-down' and went to counselling with her husband.

But of course there was no diagnosis of [post-traumatic stress disorder], or what was going on with [my husband] ... I always thought the way I was with him was because [of] what happened previously. But now I know different. He had no respect for me, no never means no to him. With him, 'no' means 'yes'. It was rape.

Throughout her life Victoria did not get the support she needed. When she was being raped by her husband, she did not talk about what was happening because she felt 'quite stupid and ashamed'. Victoria and her husband split up in 2007. She had been through so much she did not want to report to the police; she just wanted to move on with her life.

Key recovery tools

It was not until Victoria was completing a counselling course at a polytechnic, when she was in her 40s, that she got the support she needed.

... We were discussing [post-traumatic stress disorder] in a personal development class, and I said 'Isn't that normal, doesn't everybody do that?'

Victoria does not feel that her healing is complete.

I don't think that anyone really does fully heal. It is so imprinted in you ... when you have something of that magnitude happen to you. I've come a long way, but I think it is like learning in life – it is never done.

Positive outcomes

Victoria now works as a counsellor, and believes she has found her vocation.
Her experiences have given her a lot more ... empathy for other people.

... [T]hroughout my life, I have had no knowledge and no power. Somebody said to me 'Victoria, you've got to reclaim your power'. I said 'I've never had it to begin with. How do you reclaim something you never had?' But it is learning to find it, and knowing that you are

entitled to it ... Believe in yourself and you will come through it. You know what is right and what is wrong. Rape victims need understanding, empathy and education ...

Appendix C

Pilot studies investigating prevention of sexual revictimisation

Hill, J.M., Vernig, P.M., Lee, J.K., Brown, C., and Orsillo, S.M. (2011) 'The development of a brief acceptance and mindfulness-based program aimed at reducing sexual revictimization among college women with a history of childhood sexual abuse', *Journal of Clinical Psychology, 67,* 1-12.

This two-session programme was based on a theoretical model that CSA survivors' coping strategies, such as alcohol and drug use, are often aimed at avoiding unpleasant thoughts, feelings and physical sensations, but can increase the risk of revictimisation. It was aimed at helping survivors accept and pay attention to internal sensations and did not include sexual assault-specific material. It did not reduce overall rates of sexual revictimisation among a group of college women with a history of CSA, but had a large-magnitude effect on the risk of rape at two-month follow-up. The programme seemed to be effective at increasing participants' ability to observe internal sensations. The researchers suggested that a longer and more involved programme might be needed to achieve the desired effects.

Davis, R., Guthrie, P., Ross, T., and O'Sullivan, C. (2006) *Reducing Sexual Revictimization: technical report. A field test with an urban sample.* New York: Vera Institute of Justice.

This brief workshop was based on the theory that psychological processes initiated by sexual violence can result in behaviours that increase victims' exposure and vulnerability to perpetrators. It aimed to reduce revictimisation among previously victimised women in an urban setting, primarily by increasing their knowledge of sexual assault risk factors and their confidence in handling high-risk situations, and changing their behaviour in dating situations. The workshop did not reduce revictimisation or increase awareness of high-risk situations or behaviours. The researchers noted that many participants were facing more immediate challenges, such as finding safety from an abusive relationship, while others were still traumatised from past assaults. They suggested that future pilots should consider a more holistic approach, addressing the multitude of psychological, emotional and practical challenges faced by many survivors of repeat sexual violence.

Classen, C., Koopman, C., Nevill-Manning, K., and Spiegel, D. (2001) 'A preliminary report comparing trauma-focused group therapy against a wait-listed condition among childhood sexual abuse survivors with PTSD', *Journal of Aggression, Maltreatment, and Trauma, 4,* 265-288.

This pilot study was conducted among CSA survivors who met the criteria for current PTSD as a result of that abuse. Participants were randomly assigned to one of three conditions: trauma-focused group psychotherapy; present-focused group psychotherapy; and a waiting list no-treatment control condition. Therapy had no effect on sexual revictimisation overall, but there was a 50 percent reduction in revictimisation among women in the treatment groups who had been sexually revictimised in the six months before the study, when compared to women in the wait-list condition. These differences were not statistically significant, but are clinically significant. Group therapy also resulted in a significant reduction in two kinds of trauma symptoms and two types of interpersonal problems.

The researchers suggested that further research with a larger sample of women is needed to confirm these findings and to test for differential effects of the two types of group therapy.

Marx, B.P., Calhoun, K., Wilson, A., and Meyerson, L. (2001) 'Sexual revictimization prevention: an outcome evaluation', *Journal of Counseling and Clinical Psychology*, *69(1)*, 25-32.

This study evaluated a two-session programme aimed at reducing the risk of sexual revictimisation among female college students who were sexually victimised as adolescents or adults. The programme combined psychoeducation with skills training. It aimed to increase victims' factual knowledge of sexual violence, including their understanding of social forces that foster a rape supportive environment; teach practical strategies for preventing unwanted sexual experiences; help them to alter dating behaviours; and foster effective risk recognition using education, discussion, videotapes and modelling. Overall levels of sexual revictimisation were not reduced, although the programme did reduce the incidence of rape revictimisation. In addition, participants in the intervention group displayed significant improvement in psychological adjustment and self-reported self-efficacy.

Appendix D

Findings from a review of literature on effectiveness of United States interventions to reduce intimate partner violence revictimisation

(Mears, D.P. (2003) 'Research and interventions to reduce domestic violence revictimization', *Trauma, Violence, & Abuse 4(2)*, 127-47.)

Type of intervention	Evidence the intervention prevents revictimisation
Legal interventions	
Mandatory reporting requirements for health-care professionals	No evaluations
Protective or restraining orders	Unclear
Arrest	Mixed results
Criminal prosecution	Insufficient to draw firm conclusions
Specialised courts	Few evaluations, insufficient evidence
Systemic approaches	Some evidence of improvement in process outcomes, but no evidence of impact on revictimisation outcomes
Criminal justice personnel training	No systematic or rigorous evaluation
Social service interventions	
Shelters	Reduction in revictimisation in the weeks immediately following women's stay
	Shelters may contribute to increased access to services that may, in turn, reduce revictimisation
Peer support groups	No evaluations
Advocacy services	No evidence of impact, but may be linked to increased self-esteem, empowerment and social support
Health care interventions	
Screening, identification and medical care	Screening may increase detection of IPV Unclear if it reduces revictimisation
Mental health services	Little strong evidence of effectiveness, including offender-victim couples counselling
Collaborative interventions	
Co-ordinated community responses; substance abuse and domestic violence treatment; battered women's shelters	May be effective, but require careful evaluation

Appendix E

West Yorkshire Police: The Domestic Violence and Repeat Victimisation Project

(Hanmer, J., Griffiths, S., and Jerwood, D. (1999) *Arresting Evidence: domestic violence and repeat victimisation.* Police Research Series Paper 104. London: Home Office.)

The Domestic Violence and Repeat Victimisation Project, conducted by the West Yorkshire Police in the United Kingdom, is an example of a successful police project. It reduced the number of repeat attendances at domestic violence incidents, increased the time interval between repeat attendances, and identified and reduced the number of chronic perpetrators and victims. The project:

- involved a three-tiered model of police interventions, comprising measures of increased intensity for successive police attendances, aimed at constraining perpetrators' future actions

- took a gendered approach to preventing repeat IPV, with an equal focus on victims and perpetrators, and required that they knew about actions taken in relation to each other

- acknowledged women's vulnerability and provided suitable support and information to help women protect themselves, including extending the network of people who were prepared to telephone police, because 'the single most important action a woman can take is to tell others about the attacks on her' (Hanmer et al., 1999: 6)

- prompted men to confront their own behaviour, by demonstrating the unacceptability of violence

- required continuing input from all police officers in implementing the policy and more training to instil attitudes and understandings necessary to make effective contact with women victims of IPV

- required strong inter-agency communication and co-ordination from agencies that work with victims and those that work with perpetrators

- highlighted the need for extensive and accurate databases to identify repeat victims.

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