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COPING WITH VICTIMIZATION: THE SHORT- AND LONG-TERM IMPACT OF RAPE UPON SURVIVORS

The Ohio State University

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COPING WITH VICTIMIZATION: THE SHORT- AND LONG-TERM
IMPACT OF RAPE UPON SURVIVORS

DISSertation

Presented in Partial Fulfillment of the Requirements
for the Degree Doctor of Philosophy in the Graduate School
of Ohio State University

By
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The Ohio State University
1985

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DEDICATION

This study would not have been possible without the willingness of survivors to share their experiences for the benefit of others.

This study is dedicated to survivors of sexual assault. Their victimization represents the danger present to each and every one of us; their struggle, the remarkable strength of people in their will to change and survive. As each survivor knows, recovery is not possible without the support of others. This study, then, also is dedicated to those who have shared themselves with survivors and eased the pain, while bearing their own.

As a survivor, I owe much to my parents for their financial and emotional support and encouragement, even when they did not agree with some of my choices. To my father for his advice, support and, at times, his silence. To my mother, whose willingness to listen, share and encourage me have brought us closer than before.
ACKNOWLEDGEMENTS

This project represents the collective efforts of many individuals who have given of their time, expertise, and energy.

It is with gratitude that the investigator acknowledges the contributions of:

The Ohio Department of Mental Health, Office of Program Evaluation and Research, for their interest and financial support of this study.

Henry Saeman, Managing Editor of The Ohio Psychologist, who paved the way for the financial backing of this project.

Dr. Ellen Hock, Advisor, for her willingness to help with special needs, and for her thoughtful suggestions regarding human subjects issues and methodological problems.

Dr. Patrick McKenry, for his unfailing support of me throughout my academic experience, and for his consistent availability to me when I needed assistance.

Dr. Verta Taylor, for her enthusiasm and encouragement, and her sharing of resources and expertise in the area of feminist methodology.

Drs. Meg Metts, Pat Semmelman and Mary Koss for their encouragement and sharing of their professional experiences as consultants in this study.

Sue Waugh, for her tireless persistence in transcribing lengthy interviews without complaint, and for her friendship.

Carla Davis, for her technical assistance, and great sense of humor.
VITA

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CHAPTER I

INTRODUCTION

Pervasiveness of Sexual Assault

According to the Uniform Crime Reports, the numbers of rapes per 100,000 women has increased from 3.7 in 1933 to 29.1 in 1977, an increase of almost 700 percent. The FBI Uniform Crime Index states that every six minutes, a woman is raped.

These statistics are considered to be underestimates of the number of victims of rape since a substantial number of victims of stranger rape do not report the crime. According to a survey by the Law Enforcement Assistance Administration (LEAA) (1979b; 72), even larger numbers of victims of "acquaintance rape" may not report the crime because they consider it too personal a matter or believe nothing would be accomplished by reporting the crime.

Other instances of sexual assault, such as marital rape, remain inaccurately estimated since many states have not yet legally recognized this form of assault as a crime (Dean & DeBruyn-Kops, 1982). Given the large percentage of our population that has or will suffer sexual assault, the view (or perhaps wish) on the part of the public that rape is an uncommon experience is not warranted. Thus rape is only slowly becoming acknowledged as a crime of violence rather than as an act of uncontrolled lust.
Perspectives on Rape

Many normative (developmental events that most people can expect to occur over the life cycle, e.g., death) and non-normative (other events which are not predictable or common occurrences, e.g., disabling illnesses, rape) stressors occur in life which are frequently perceived as traumatic and are difficult to deal with and to integrate in meaningful ways. Particular events which may be perceived this way are death, permanently disabling accidents, illnesses, and acts of violence. Generally in our society, individuals are not taught specifically how to cope with serious non-normative stressors. Lack of preparedness and unpredictability add to the painfulness of the experience and sense of tragedy when they do occur.

As a non-normative stressor, rape carries a negative stigma which increases the painfulness of its occurrence and difficulty in recovery. Historically, rape has been viewed as a crime against property; the person was not considered as primary, but as damaged property of the husband or father (Brownmiller, 1975). According to this perspective, the law saw the man as victim. Also, women throughout history have frequently been seen as precipitating the rape—either consciously or unconsciously. Being selected as victim implied there was some defect in character, or that the victim was from a lower-socioeconomic group where rape behavior was seen as a symptom of that group's lack of adherence to social mores and conduct (Brownmiller, 1975; Burgess, 1976).

From this socio-historical perspective arises the issue of responsibility, or its negative connotation, blame. "Rape is the only crime which involves a role reversal between the accused and the accuser, thereby placing the victim on trial" (Hartwig & Sandler, 1975, p. 508). Common experience still suggests that people are inclined to think that individuals get what they deserve and that good people
receive only good things in life (Lerner & Simmon, 1966). Lerner (1970) has hypothesized that people desire to believe the world is just, and that such belief in a just world would be seriously damaged should an innocent person be seen to suffer. It follows that there will be a tendency to blame innocent victims for their underserved fate as a means of maintaining the belief that the world is fair and just. Maintaining this belief in a just world may also serve to give people a false sense of protection from being raped.

Yet once victimized, the belief that the world is fair is shattered, and many victims then find the cause for the rape within their own character or behavior. Burgess and Holstrom (1974) found in their study that victims themselves often believe they deserved to be raped, and that these guilt feelings must be resolved for recovery to be complete, regardless of whether the victim imposed her own guilt or others blamed her for the attack.

Rape typically effects more than just the victim; family, friends, and neighbors may also react to the crisis, which they often perceive as a stressor to themselves. In fact, increasingly rape is viewed as a crisis shared among the significant others in the life of the victim (White & Rollins, 1981). It is thus important to understand how rape affects others close to the victim. Burgess and Holstrom (1979) and Rodkin, Hunt and Cown (1982) report that nearly half the men in their studies viewed themselves as the primary victim rather than the rape victim herself. These men needed to hold the survivor as somehow responsible for the assault. Although some men did believe that they were to blame for the rape having occurred, many placed blame on the victim. These attributions of blame upon anyone besides the rapist constitute serious possible obstacles to the recovery process for the victim.
The definition that one gives to rape greatly affects the support given a rape victim. Rape is usually defined as either sex or violence. Clearly, where rape is seen as sexual activity, social standards of behavior dictate that the woman have ultimate control. The comment, "If you are going to be raped, relax and enjoy it," accentuates the belief of many men and women that rape is sex, and sex is pleasurable regardless of whether it is consensual. (This statement, however, should not be confused with advice that rape prevention groups give to women regarding resistance to an assault.) "If a woman cannot successfully fend off an attacker, resistance may cause more severe injury." Burgess and Holstrom (1979) and Rodkin et al. (1982) reported that many men still view rape as a sex act and therefore are not as supportive of the survivor as would otherwise be expected.

Underlying relationship problems between the victim and male significant other may also affect the interpretation of the rape. Pre-existing stresses in a relationship and ineffective attempts to resolve interpersonal problems may leave the couple much more vulnerable to the impact of new stresses following the rape. Problems with intimacy and attribution of blame for the assault may emerge within the relationship context if the male views rape as sex and/or the victim reacts following the rape with lowered sexual satisfaction as Orlando & Koss (1983) report. Burgess et al. (1979) found that sexual problems in the relationship prior to the rape increase the likelihood of less understanding and less sympathetic reactions following the rape.

Other factors besides cultural norms and definitions of rape may affect the desire and inability of significant others to function as support for the survivor. If the survivor cannot provide and care for herself or perform daily tasks, a great burden is placed on those close to her, and the relationship between them is strained. Women most often turn to significant others for support in times of
crisis, and their support system has been found to be the most important resource in their recovery process (Webb, 1980). Yet what effects rape has upon significant others, particularly male partners, in terms of their ability to cope with such a crisis themselves, and their ability to support the victim, remains largely unknown.

Major Investigations of Rape

Chappel, Gels, and Fogarty (1974) note that most rape studies prior to 1969 have concentrated on offenders rather than victims. Rape research in the 1970's focused on identifying and describing the common resultant symptoms and reactions victims experienced following sexual assault. Both early and recent studies of rape have typically consisted of single case, or very small sample studies (e.g., Factor, 1954; Symonds, 1976) and/or exploratory, rather unsystematic investigations (e.g., Burgess et al., 1974, 1976, 1979; Notman & Nadelson, 1976; Sutherland & Scherl, 1970). Burgess et al. (1974) and Sutherland et al. (1970) were the first researchers to specifically focus on the impact of rape on the victim. They proposed a two or three stage process of victim reaction, now commonly referred to as "rape trauma syndrome," a term coined by Burgess et al. (1974). Conceptualizing rape as a crisis, these researchers viewed rape as consisting of an initially disorganized phase and a later phase of integration and resolution. In the disorganized phase, victim behavior and lifestyle are considerably disrupted by typical reactions of strong fear, anxiety, depression, tension and fatigue. This acute phase may last several hours to several weeks. A period of adjustment, followed by integration and resolution, includes dealing with residual symptoms from the earlier phase, as well as lifestyle and personality changes. This phase may last as long as several years.
Because early studies were exploratory and failed to utilize control groups or systematic methods, there are problems in confidently assuming that the findings can be attributed solely to the rape. Other studies have also suffered from an over-inclusion of victims of all types of assault, loose definitions of the term "rape," and sample selection of largely indigent groups. Despite these methodological problems, these early studies attracted much needed attention from the clinical and scientific communities that has led to further research.

Recent research on victim reactions have utilized more rigorous systematic inquiry and means of assessment. For example, Calhoun, Atkeson, and Resick (1979) confirmed depression as a common reaction among victims, and Kilpatrick, Resick and Veronen's (1981) longitudinal study reported rape victims experiencing significantly more anxiety, fear, suspicion, and confusion for at least one year after the rape than did non-victims. Although sound methodology and studies have confirmed some findings from descriptive research, they have not tended to explore the complexity of the experience of the victim, specifically focusing on factors related to the extent of crisis experienced by the rape victim.

The National Center for Prevention and Control of Rape has suggested three main reasons why rape has a destructive effect on victims' relationships with significant others (Benedict, 1982). These reasons include (1) the shock of the rape makes both the woman and her partner withdraw instead of reaching out and helping each other, (2) the persistence of myths that women invite rape allow the man to blame the woman instead of offering her help and sympathy, and (3) men and women have different reactions to rape that often conflict and make it impossible for them to give each what they need. "Fury" is often the most common response to rape by husbands. Anger at the rapist and the victim only serve to frighten the victim and estrage her from her partner (Benedict, 1982).
Miller, Williams, and Berstein (1982) studied couple response to rape in a clinical case study of 43 couples. Using self-report and clinician assessments, they found couple response patterns included communication disturbances, sexual dysfunctions, and problems with commitment. Because the subjects were recruited through announcements offering free treatment in exchange for participation in the study, a strong bias existed for attracting couples with greater psychological problems than would have been expected from a normal population. Couples were also reported as being unable to fully discuss the rape so that it was difficult to assess whether their problems were related to the assault or to other factors.

**Intervention, Strategies and Techniques**

Strategies and techniques for counselors and other "helping" professionals dealing with rape have also been addressed in the literature. White and Rollins (1981) called attention to the likelihood that rape may precipitate marital and familial crises. Although these authors did not conduct research, they integrated current rape research within conceptual family crisis models. White and Rollins derived implications from their review that support Silverman's (1978) recommendations for adaptive family responses: (1) open communication about the rape; (2) facilitating understanding how rape affects the victim and what it represents to her; and (3) providing counseling to any member whose coping ability is impaired. Silverman (1978) notes that "abrupt changes in the balance of interpersonal relationships and functioning may occur in direct parallel to the intrapsychic disharmony experienced by the survivor." Burr (1973) proposed that integration and adaptability are continuous variables positively related to the ability of families to recover from a crisis. If the failure of the survivor and/or her significant others to cope with the crisis results in broken relationships, unemployment, and long lasting psychological damage, a serious mental health and social problem exists.
Short-term counseling does not usually address the victim in the context of her relationship. Silverman (1978) states that where rape brings to the surface long-standing issues, intervention should expand to long-term approaches. Rodkin et al. (1982) reported that the majority of their 16 clients in a men's support group did not shift from seeing themselves as primary victim, or offer support to the survivor until they had been in the group for over a year. Until they were able to resolve their own feelings of victimization, these men were not able to offer adequate support for the survivor; indeed, some were sources of additional stress. To the extent that these men are representative of other men facing this crisis, a survivor may suffer a substantial lack of support and slower recovery.

The lack of knowledge about the significant other of a rape victim also affects treatment practices. The survivor is usually treated out of context, with unrecognized victims being excluded. Because support is vital to the recovery of both victim and significant other, the recovery of the survivor may depend upon both being included in treatment.

The disrupted life of the survivor and her relationships as a result of rape makes it a critical area for practitioners to know how to intervene. If therapists are not aware of the problems men have in dealing with a survivor as well as the impact upon them, the clients are likely to feel misunderstood or not deserving of help. Practitioners are vulnerable to imposing their own biases about the experience of the client and to fail to recognize that the survivor is not the only person who may be in pain.

Whiston (1981) believes few people are comfortable with the victim. She found that although it seems logical that other women would be supportive and understanding of the victim, the opposite is often true. It is important for practitioners to examine the myths about rape and its victims so that their
responses to the victim do not reinforce feelings of guilt and self blame. If the therapist relates to the victim from preconceived notions that rape is an irreparable harm, or that it affects only the survivor and in specific ways, the therapists creates a painful gap which may reinforce hopelessness and despair. Burgess and Holstrom (1976) found that victim responses varied with the situation and the response of the attacker, hence a therapist's expectations of treatment issues and imposition of goals violates the victim's individuality and inaccurately guages her needs. Empathy then, is a major factor in successful treatment so that the victim feels accepted as she is and can describe her unique response to the rape.

**Theoretical Basis for Study**

McCubbin and Paterson's (1983) Double ABCX Model of Family Stress conceptualizes adaptation in terms of member and sytem behavioral efforts to achieve a balance at these two levels of functioning. The model examines the effect of stressor events upon family members' subsequent coping with the stressor by focusing on the individual and family member's perception of the event and their crisis meeting resources over time. By integrating this theory with rape research findings, White and Rollins (1981) identify three important variables in determining the impact of rape upon couples and their coping ability. The first variable is how the survivor defines rape, and if viewed as a crisis, their assessment of severity in terms of changes it produces. Since the initial phases of rape recovery include general disorganization of behavior and lifestyle and intense emotional reactions for the survivor, difficulties in maintaining roles and effectively performing tasks may be anticipated. The man's initial reaction may be incongruent with the survivor's reactions, thus fostering communication problems. The man may
experience a crisis reaction himself, or become overwhelmed with additional roles or tasks which he assumes during the survivor's recovery. The equilibrium of the relationship may be disrupted as the couple tries to cope with the crisis and the changes in their relationship.

The second variable in White and Rollins' (1981) model is the extent to which the individual and couple can externalize blame for the rape. As previously mentioned, victims often blame themselves or are blamed by others, including their partner, for the rape's occurrence. Sometimes the man blames himself for failure to prevent the rape. Internalization of blame jeopardizes recovery by disturbing the functioning of the couple to mutually accept and give support to each other.

The third variable in White and Rollins' (1981) model is the extent of change the couple must make to resolve the crisis. The vulnerability of the couple to the impact of the rape may be increased if pre-rape stressors were severe and insufficient resources were available or the couple was unable to use them. The reactions to the rape by the couple may be severe enough to become additional stressors which overload their capacity to cope and which drain or deplete current resources. For example, the survivor's loss of employment or emotional withdrawal from her partner may trigger collapse of either partner's ability to cope with the rape or other events which might not be otherwise be considered as stressful. If the couple divorces or separates, another major stressor may tax their weakened ability to deal with the loss or the problems which lead to it. Couples who can externalize blame, utilize resources, talk about the rape with each other, and accept temporary changes in their situation probably stand a much better chance of successful adaptation.
Statement of the Problem

Current research has largely failed to systematically explore those variables related to coping and adaptation related to the crisis of rape, and the impact of the rape on the victim in the context of her relationship with significant others, has only tangentially been addressed. Also, other studies have not explored the long-term impact of rape in terms of the survivor's perception of recovery and her adaptation to the rape over time.

It is the purpose of this research to explore from a family crisis perspective the subjective short- and long-term experiences of victimization for the survivor of rape, and her perception of the impact of rape upon her relationships with significant others.

The qualitative feminist method is considered the most suitable approach for investigating women's experience of victimization. It is believed that collection of sensitive information will be enhanced by the fact that the researcher herself was assaulted by the same rapist as subjects in this study.

Research Questions

The following questions have been developed to address the research problem:

1. What is the meaning of rape to the survivor?
2. What is the coping and adaptation process for the survivor in terms of symptoms experienced, ability to seek and use support, and changes in self concept?
3. How does the survivor view her responses to rape as affecting her relationships with others?
4. What are the long-term effects of rape described by the survivor?
(5) What coping skills are used by survivors to deal with the reaction to rape?

(6) How do survivors want significant others to treat them following the assault?

(7) Do survivors utilize community services for treatment of rape trauma syndrome, and if so, how do they evaluate treatment approaches?

(8) How does the survivor describe, assess, and utilize resources and what would improve them?

Definition of Terms

A number of terms will be used repetitively in the study and require specific clarification:

Adaptation is defined to include the person's ability to prevent an event of change from creating disruptiveness in their life, and is a multifaceted process wherein resources, perceptions, and behavioral responses interact in attempts to deal with stress (McCubbin & Patterson, 1983).

Rape is defined as non-consensual sex acts, including oral, anal and vaginal intercourse, perpetrated by threat or actual use of force; be it verbal or physical and includes the use of weaponry.

Severity of assault is defined as the level of severity of assault, including physical injury, threat of death, and psychological torture. In this study the level of assault is defined as high due to the use of weaponry and physical force to threaten death to the victim, through strangulation, suffocation, wounds or drowning. Psychological torture such as bondage, intentionally deceiving the victim as to what to expect and verbal degradation are included. In this population, many survivors were considered clinically dead and were revived by the assailant, a physician.
Stress is defined as a state which arises from an actual or perceived demand-capacity imbalance in ability to function (McCubbin & Patterson, 1983).

Stressor is defined as a life event or occurrence in, or impacting on, the individual or couple which produces a change in the person's life or in the quality of the couple's relationship. A non-normative stressor will be defined as one which does not occur with much frequency in life (McCubbin & Patterson, 1983).

Survivor is defined as the female who has been raped.

Victim is defined as the person who perceives that he or she has been harmed.
CHAPTER II

REVIEW OF THE LITERATURE

This chapter reviews the pertinent clinical and empirical literature on the impact of rape on female survivors. The studies reviewed are organized under the headings of 1) rape trauma syndrome, 2) the reaction of significant others to the survivor, and 3) treatment issues.

Rape Trauma Syndrome

Systematic research on rape in general is a phenomena of the last two decades. Historically, rape research has focused on the offender rather than the victim. The first research article on rape victimology, published in 1954 by Factor, a psychoanalyst, is a single case study of a victim's response to an attempted rape. Not until the 1970's did research begin to focus on identifying and describing specific responses to rape. The term "rape trauma syndrome" was then coined by Burgess and Holstrom (1974) to refer to the crisis response of rape victims. During the seventies and eighties, Veronen and Kilpatrick (1980) as well as other researchers noted the need for improved methodology while continuing to explore rape responses to identify those factors contributing to various symptoms and the recovery process among victims. During the last five years, a proliferation of rape research has occurred with a noticeable shift toward the study of attitudes toward victims. Such studies have frequently examined the observer characteristics as major influences in assignation of blame. Another recent focus in the research
literature on rape trauma has been treatment/intervention models used to deal with various reactions to rape.

**Rape Trauma Defined**

Sutherland and Scherl (1970) conducted the first research on rape trauma, interviewing 13 young rape victims within 48 hours following the assault. The authors developed a three-stage theory of victim response and recovery. Their crisis model defines an acute stage, when victims experience shock, fear, and anxiety; a second stage of outward or pseudo-adjustment, which includes feelings of helplessness, denial, withdrawal, loss of autonomy and aversion to sex; and a third stage of integration, when victims experience depression and a renewed interest in discussing the assault. Sutherland and Scherl found that the response of the family to the victim during the outward adjustment phase was important to the victim's ultimate recovery. During the denial phase, the victim may anticipate negative reactions towards her and pretend that she is unaffected by the assault. Despite the small sample size in this study, numerous researchers and practitioners have utilized the Sutherland and Scherl model in their own works.

Another crisis model of rape response frequently used by other researchers was developed by Burgess and Holstrom (1974). These researchers conducted numerous studies on rape beginning in the mid-seventies. In 1974, a large sample ($n=176$) of victims were studied. Burgess and Holstrom investigated the responses of victims who sought hospital treatment in a large midwestern city. They interviewed subjects at the point of treatment and followed them for a year. Based on their research, these authors developed a two-stage theory of victim response, which they termed "rape trauma syndrome". The acute stage, or disorganized phase, includes the immediate impact of shock and disbelief. The victim's life is disorganized by the assault. This stage lasts several days to several
weeks. Challenging a preconception that rape victims are hysterical following assault, Burgess and Holstrom found that victims exhibit one of two styles of expression of symptoms. In the expressive style, the victim demonstrated such feelings as anger, fear, and anxiety; victims cried and showed fluctuations of mood during this phase. In the controlled style, the feelings of the victims were masked and a calm, composed facade was presented. During the second, or reorganization stage, initial symptoms may overlap, such as somatic symptoms of sleep and eating disturbances, as well as tension and fatigue. Because the rape usually results in major disruption to a victim's life, changes in life style are common responses. Victims are able to function only minimally. Changing residences and seeking support from one's family and friends are common responses. Major symptoms during this phase included nightmares and phobias. Burgess and Holstrom found that victims who had had prior mental health contacts experienced "compounded reactions" which were more severe and enduring than other victims. These women needed more extensive help than crisis intervention.

Further analysis of victim coping behavior in the Burgess and Holstrom study revealed that victims tended to blame themselves for the assault. Self-blame was thought to be related to the victim's perception of the effectiveness of her attempts in averting the assault or lessening its severity. Burgess and Holstrom's 1976 study remains the sole research on the coping behavior of victims during an assault. Ninety-two victims were interviewed regarding the strategies used to survive the assault.

Burgess and Holstrom's findings indicated that the majority of victims used one or more of four strategies to prevent the assault: verbal, physical, psychological, and physiological responses. Only a minority of victims used no strategy, and this was because they were asleep, paralyzed by the suddenness of the attack or use
of a weapon, or under the influence of drugs or alcohol. A majority of victims used verbal strategies to negotiate the severity or duration of the assault. Ultimately, the victims in this study often decided to yield to the assailant in order to hasten the inevitable assault and get it over with.

Most researchers who have subsequently studied rape victims have attempted to confirm or specify new symptoms of the rape trauma syndrome and to ascertain the duration and intensity of various symptoms in order to improve intervention efforts. By formulating a standard of symptom formation and duration, counselors could then differentiate a typical reaction from an atypical or compounded reaction to rape.

In support of Burgess and Holstrom's findings and conclusions, Notman and Nadelson (1976) published their clinical observations and psychodynamic considerations relevant to the rape response. Their report was based on clinical impressions of victims who used their rape center. They viewed the rape stress reaction as similar to the four stages of stress reactions common to other crises such as community disasters. They concluded that the most salient factors in understanding the dynamics of women's responses to rape included: (1) affects; (2) unconscious fantasies; and (3) adoptive and defensive ego styles. Notman and Nadelson summarized the four primary and long-term responses to rape as: (1) mistrust of men; (2) sexual disturbances; (3) phobic reactions, and (4) anxiety and depression.

Focusing on one of the most frequent major symptoms in rape response, Veronen and Kilpatrick (1980) tested the hypothesis that fear responses of victims were classically conditioned, that is, that fear is present during or subsequent to the assault. Twenty victims and twelve non-victims were administered self-report surveys on fear. The results revealed a significantly greater variance of
rape-related fear scores for victims than for non-victims. Further analysis of the data was seen as supporting the hypothesis that victims are distressed by the rape-related associations and situations that resemble the violent rather than sexual aspects of the assault.

**Long-term Reactions**

In the late 1970's, researchers began to conduct longitudinal studies to explore and identify the long-term impact of rape trauma syndrome, using self-report surveys or psychological tests to measure more accurately the severity and duration of symptoms.

In their follow-up interviews of 130 rape victims one to two years after the rape, Notman and Nadelson (1982) reported that 65 women stated they were still fearful of being alone, and three-fourths (n=48) of the sample were still suspicious of others. Findings indicated that many women continued to feel restricted in their freedom of everyday life and experienced episodes of depression and sexual difficulties. Because none of the subjects had previously reported psychiatric difficulties, the problems reported by the subjects in this study were attributed to the impact of the rape. The authors recommended issue-oriented therapy for all victims of rape and the availability of long-term counseling to rape victims.

Kilpatrick, Veronen, and Resick (1979) used a psychological scale to measure nine symptom patterns in their longitudinal study of 46 victims and 35 non-victims. Their results indicated that three to six months passed before symptoms decreased and equilibrium was established. At the end of six months, victims scored higher than non-victims only on the anxiety scale. The authors concluded that phobic reactions, fear, and anxiety represented long-term symptoms that could be expected following a rape.
Ellis, Atkeson, and Calhoun (1981) also examined long-term reactions to rape in their study of 27 adult rape victims. Using written tests, they found victims were significantly more depressed than matched non-victim controls. They noted that victims of sudden, violent attacks by strangers were the most depressed and fearful compared to other subjects in their sample. Consistent with other findings, they subjects also evidenced problems in interpersonal relationships, phobic behavior, and more severe reactions to rape if premorbid histories contained significant mental health problems.

Specifically investigating the depressive symptoms in rape response, Atkeson, Calhoun, Resick, and Ellis (1982) tested 115 victims and a matched control group at five intervals during the one-year period following the assault. Depressive symptoms were significantly higher for victims than for non-victims until four months post-rape. At that time, depressive symptoms diminished, although the authors did not describe to what extent.

However, difficulties in pre-rape functioning were also found to be predictive of continued problems with depression—more, in fact, than variables associated with the rape. As others had implied, the experience of rape itself was not found to be compartmentalized in terms of the victim's reaction. For the individual who was raped, themes which replicate previous negative experiences became associated with the rape and contributed to the total meaning that the rape held for the victim.

Kilpatrick, Resick, and Veronen (1981) examined the long-term effects of rape in their longitudinal study of twenty adult victims matched with non-victim controls. Their findings indicated that victims were significantly more anxious, fearful, suspicious, and confused than were non-victims for at least one year following the assault. Balancing this conclusion, however, they reported that
significant improvement was also shown in symptom recovery between one and six months after the rape.

Examining factors which affected symptom formation in rape victims, Norris and Feldman-Summers (1981) studied the relationship of four factors (i.e. reporting the rape, victim vulnerability to claims of responsibility, presence of understanding others, and severity of assault) to victim impact. They utilized a questionnaire with 179 victims. Of the four factors investigated, only reporting the rape versus non-reporting the rape was not found to be significant in relationship to negative impact from the assault.

Three factors which were significant were the victim's vulnerability to the stigma of assault, the presence of supportive and understanding people, and the severity of the assault. These three factors were related to the symptoms of reclusiveness and psychosomatic reactions.

**Pre-Existing Conditions Effecting Rape Trauma**

As previously mentioned, pre-existing psychiatric problems have been noted by several researchers as a factor contributing to more severe and enduring symptomology following rape.

Frank, Turner, Stewart, Jacob, and West (1981) were prompted to explore this issue further after reviewing Peter's (1976) finding that one-third of his adult subjects had prior psychiatric contact. The extent of psychiatric contact in Peter's findings were inconsistent at that time with other studies. Frank et al. used interviews and psychological inventories with fifty victims and 22 non-victims to measure vulnerability to rape trauma. Nineteen subjects reported prior psychiatric contact.

As Burgess and Holstrom (1974) found, the women in this study who had previous psychiatric contact reacted more severely to rape and were less resilient
to stress than were non-victims. Additionally, prior suicidal ideation among subjects was found to be predictive of who would be more depressed and anxious following the rape. Myers, Templar and Brown (1984) also reported that rape victims were more likely to have a past history of hospitalization and suicidal thoughts.

**Sexual Functioning Following Rape**

Several researchers have focused on the investigation of sexual dysfunction following the rape. Burgess and Holstrom (1979) re-interviewed 81 adult victims from their 1974 study, four to six years post-rape. They reported that seventy-one percent of their sample complained of decreased sexual activity, and forty-one percent had difficulty either experiencing sexual feelings or being orgasmic during sex with a partner. Burgess and Holstrom's (1974) data also indicated a positive relationship between the number of sexual symptoms and length of recovery period.

Feldman-Summers, Gordon, and Meagher (1979) studied the impact of rape on sexual satisfaction utilizing a small sample of 15 victims who retrospectively rated satisfaction with 23 sex-related behaviors. They found that sexual satisfaction decreased substantially and was associated with longer recovery periods.

In 1980, Ellis, Calhoun, and Atkeson evaluated emotional and sexual functioning over a one-year period. The initial sample included 116 victims; a much smaller subgroup was interviewed five-years-post-rape. The authors explained the phenomena of post-rape sexual disturbance as a normal reaction to the abnormal use of sex as a weapon of violence. Their findings indicated that sexual dysfunction following rape was so common as to be considered normal. For most victims in their study, sexual functioning returned to pre-rape levels within four to six months. Ten to twenty percent reported difficulties that lingered over a longer period of time.
Becker, Skinner, Abel, and Treacy (1982) interviewed 83 rape and incest victims regarding their sexual histories. Tests to determine the incidence and type of sexual dysfunction were completed. The authors grouped subjects into four categories of functional versus dysfunctional rape and incest victims. There was no significant difference between dysfunctional rape and incest victims in the number of sexual disturbances experienced. Seventy-one percent (n=59) of those who were dysfunctional had problems as a direct consequence of the assault despite a year-long period of recovery post-assault, suggesting that chronic sexual dysfunction is common in rape and incest victims. The authors sadly noted the passage of time does not appear to eliminate fears of sexual dysfunction as had been hoped.

A study by Orlando and Koss (1983) utilized retrospective ratings of 99 women regarding the effect of rape on sexual satisfaction. Subjects were separated into four groups representing different levels of assault. The authors found that conceptualizing oneself as a victim was not a necessary factor in reporting lower sexual satisfaction following an assault. This study supported Feldman-Summers, Gordon, and Meagher's (1979) findings that victimized women report decreased sexual satisfaction.

Other Factors Related to Rape Trauma

Several researchers focused on other issues in rape research which seldom have been addressed, such as the victim's perception of available support following a rape. In Australia, Scott and Hewitt (1983) studied the short-term adjustment phase to rape within the context of their use of a sexual assault counseling service. Ninety-four female subjects completed three questionnaires surveying symptoms and support resources. Seventy-six percent reported anxiety, depression, fear, and guilt. During the early stage of recovery, fear and guilt were the most common reactions. The most novel aspect of this research was the information about the
subjects' perception of available support resources and its effect upon recovery. The authors noted that support was defined as "perceived support." A large number of subjects perceived significant others as unsupportive. Fifty percent of subjects' workmates, and thirty-two percent of boyfriends and fathers were viewed as unsupportive. Friends were perceived by subjects to be the most supportive. The authors stated that it was not known whether the lack of perceived support was a result of passivity or "blaming" behavior on the part of the significant other.

In another study, Myers, Templar, and Brown (1984) were interested in assessing the coping ability of women as a possible determinant of their having been selected as victims. Seventy-two victims and an equal number of matched controls were administered psychometric tests to assess psychosocial competency, mental health, alcohol and drug use, cognitive resources, and physical ability. The authors had assumed that some women are more vulnerable to rape than others. They reported that in predicting vulnerability to assault, the strongest predictor was low social competency and high external social locus of control. Victim characteristics associated with these predictors were women with a past history of drug and alcohol abuse, psychiatric hospitalization, and suicidal thoughts. They concluded that victims had less coping ability than controls, and tended to respond in a helpless and passive manner when confronted with stress. However, subjects were tested following the assault so that reactions noted are consistent with rape trauma syndrome and cannot be exclusively explained as pre-rape traits.

Ruch and Chandler (1983) in an effort to deal with methodological weakness in previous research on rape, utilized a multivariate model to test the relative effects of several independent variables on the level of rape trauma during the acute phase. They interviewed 326 victims over a two-year period. The authors' conclusions validated what other researchers have suggested based on
smaller samples. For instance, Ruch and Chandler indicated that assault trauma is not a unitary process but a complex phenomena reflecting an interplay of a variety of forces and factors. Three prior life stresses accounted for ninety percent of the variance in reducing victim's coping ability in the acute state: (1) mental health problems, (2) substance abuse, and (3) severe and recent life changes. However, recent moderate stresses were found to be a positive factor in coping ability.

These authors found that the victims' support system was a less important positive variable influencing their coping ability. It must be remembered, however, that subjects were investigated only during the acute stage when many are in a disorganized state and may believe they do not need help or that help is not being offered. The acute stage is also a very brief period of time lasting up to two to three weeks; therefore only a very limited amount of information about factors influencing the rape trauma were studied.

Ruch and Chandler in this same study also identified variables related to high risk for rape trauma. These variables included women with pre-existing life stresses, single women living alone, and married and ethnic women. These groups were seen as lacking sufficient support. Interestingly, Ruch and Chandler's high risk group represent the majority of women who are raped. Ruch and Chandler recommended that these high risk groups be provided special attention in service delivery.

Reactions of Significant Others

Societal

Much research on rape trauma reported the high frequency of negative responses toward rape victims by various members of society. In considering the
phenomena of rape, it is of utmost importance to acknowledge and examine the attitudes of society towards rape and towards rape victims. McCubbin and Patterson's (1983) Double ABCX theory of family adaptation to crisis stressed the importance of societal attitudes to coping ability and recovery. This conceptual model views adaptation as a byproduct of the interaction between an event and the meaning that the family gives to it and the resources available to the family to cope with the event. White and Rollins (1981) used this model to integrate research on rape impact. They stress that hardships associated with rape, such as rape stigma or the impaired functioning of the victim, can impede recovery. Support from significant others are crisis meeting resources which influence adaptation to rape. Thus significant others who blame a victim create additional stress and are also not as likely to provide needed support, doubling the impact of their reaction to the victim.

Metzger (1976) describes "rape as an act of power that is sanctioned by literature, myth, and culture. Rape is an aggressive act against women as woman. Rape implies total loss of self; woman is function, not person. The victim experiences an emptiness and isolation from self and society." (p. 406) Metzger views rape as the symbolic enactment of social and cultural attitudes which sanction rape as a form of social regulation and as a ritual of power. She suggests that three basic attitudes of power are involved: (1) to be weak is a crime deserving punishment; (2) the weak are accomplices in crime against them, and (3) the victim has committed the crime.

Stereotypes about victims abound. In a male-dominated society, rape is perceived as a sexual rather than a violent act. Rape myths include the ideas that victims are weak, immoral, and seductive; that women who are raped precipitate the attack; and that men who rape are the true victims who succumb to the
seduction of the female. Society, especially male members, thus readily attribute responsibility for the rape to the victim herself.

Wagstaff (1982) suggests that social psychologists should examine why such derogatory attitudes towards victims exist. He offers the "Just World" principle, often attributed to Lerner (1970, 1974). The central theme of this principle is that "there is an appropriate fit between what people do and what happens to them."

Heider (1958) saw the "Just World" principle as a cognitive tendency where the relationship between goodness and happiness, between wickedness and punishment is so strong that given one of these conditions the other is frequently assumed. Given then, the unfortunate occurrence of being raped, the victim is automatically assumed to have deserved what she experienced and to be responsible for the occurrence.

Alexander (1980) wrote that professionals as well as lay people are biased in their thinking and attribute blame consistent with the "Just World" principle. By believing that justice prevails, persons are thought to "get what they deserve or deserve what they get." Hence, a victim is always placed in a no-win situation by virtue of being victimized. Rape thus attaches a stigma to every victim according to this principle.

Katz (1979, 1981) conceptualized stigma as a psychological concept with two major aspects: the perception of a negative characteristics and the global devaluation of the possessor. Addressing these concepts in their research, Weidner and Griffitt (1983) studied individual differences affecting perceptions of rapist and rape victim. Seventy female and seventy-two male undergraduate students were administered four instruments to test the hypothesis that the sex of the observer and attitudes towards women and rape would predict target perception. Their findings indicated that negative attitudes towards women, belief in rape
myths, and perceived target behavior (responsibility for rape) were related to stigmatization of the victim and predicted more favorable perceptions of the rapist. They found that unwarranted stigmatization of rape victims existed in their sample, but was not as widespread as expected. This finding was clearly a discrepancy between research and overwhelming clinical and experiential evidence. The authors explained this discrepancy as understandable since attitudes and behavior are often unrelated. What a person says he or she believes is not always consistent with how one behaves towards a person. Another explanation is that college students were believed less likely to hold negative attitudes towards rape victims than those representative of a normal cross section of the population. Weidner and Griffith's research supports the sociological as well as feminist view that women in a patriarchal society are devalued; that is, women are viewed as the property of men, objects with no rights.

Further evidence to support the embedded prejudices and dehumanizing attitudes towards women and victims in our society is found in research by Thornton, Robbins, and Johnson (1981). Their 173 undergraduate student subjects (91 females, 82 males) completed a battery of questionnaires to measure causal attribution tendencies, the perception that rape victims play a causal role in their own victimization. Their results revealed that males are more likely to perceive rape as victim precipitated.

**Significant Others**

**Family**

Many rape researchers have found that a victim's social support system is a major factor in determining the quality and duration of her recovery. Webb (1980) gathered information from a random sample of closed case files, such that ten
cases from each month during a one-year period were represented. Webb concluded that women are socialized to believe in the same rape myths as the rest of society and that victims need sympathetic, non-blaming individuals in their support network if coping skills are to be enhanced. Her results showed that family members are most often relied upon for support, yet they are frequently the most uncomfortable with the rape and thus not as available to offer support as the victim might expect. Webb also found that victims who told significant others about the assault were more likely to engage in follow-up counseling, although most victims received only one follow-up contact.

Although it is clear that support from significant others is a major factor in a victim's recovery process, few researchers have considered the effect of rape and the consequent trauma as a stressor or crisis for those who are close to the victim. To the extent that significant others are affected by the rape, the less support they can provide to the victim.

White and Rollins (1981) have conceptualized rape as a family crisis. Taking the comparison of rape crisis to other catastrophes and crisis theory, they proposed a conceptual model integrating Hills' (1949) ABCX family crisis model with rape research findings. They hypothesized that the vulnerability of the family system to the stresses precipitated by rape is affected by the definition they make of the event, the extent to which they externalize blame for the rape, and the fact that rape is arbitrary and sudden. The family's ability to reject rape myths, mobilize past resources, and access new ones, while externalizing the blame for the rape on the rapist is related to the support they can provide for the victim. This shared crisis implies that the victim may also contribute to the family's stress and deplete the family's crisis meeting resources. The severe disruption in emotional equilibrium and life style that rape causes for the victim makes it likely that the family will be disrupted also.
acted differently, the rape would not have occurred. The next stage for the male is dealing with the victim and the effect of the rape upon their relationship. For some men, this is a concern never felt as the man remains fixed in his role as the true victim and may terminate the relationship.

Tasks which are relevant to these stages of reaction are discussing the rape, dealing with the women's phobias, and resuming sexual relations. Twelve of fifteen couples in Burgess and Holstrom's (1979) study did not ever openly discuss the rape. The authors suspected that most couples would have difficulty resuming sexual relations since the tendency is for the man to initiate sex immediately despite the woman's discomfort and fear in resuming sexual relations so soon after the rape. Since the man may be trying to prove his partner is still "his", the couple's needs are clearly in conflict. Burgess and Holstrom concluded that it is necessary for males to see the women as victim if they are to be truly supportive and maximize the chances for the relationship to continue.

Because loss of support or important relationships can create additional stress for survivors, adaptation may be compromised if male significant others are unable to respond appropriately to the reaction. Because the male partner is in most cases the primary support, his inclusion in treatment is necessary to prevent difficulties for both he and the victim as well as their relationship. Orzek's perspective evolved from similar beliefs expressed by Burgess and Holstrom's (1974) pioneering research.

Rodkin, Hunt and Cowan (1982) reported their clinical impressions of 17 adult males who participated for one year in a support group led by the authors. Their clients expressed a variety of feelings such as grief, fear, and anger as well as suppressing or denying these feelings for lengthy periods of time. Some men experienced short-lived somatic disturbances similar to what victims experience.
Silverman (1978) pointed out that "abrupt changes in the balance of interpersonal relations and family functions may occur in direct parallel to the intrapsychic disharmony experienced by the rape victim." (p. 166). He believes adaptive familial responses can be elicited through open communication about the shared crisis of rape, cognitive understanding of what the rape means to the victim, educating the family about what to expect in terms of symptoms and needs of the victim, and counseling for the family if they are not able to adapt effectively.

Husbands and Boyfriends

While rape is a crisis that affects significant others in addition to the victims, husbands and boyfriends in particular are likely to experience intense personal conflict or difficulty in being supportive (Orzek, 1983).

Important to understanding how the quality and nature of support affects victim recovery is understanding the attitudes, feelings, and responses of men who care about the victim. Burgess and Holstrom (1979) reported the reactions of 15 husbands and cohabitating boyfriends who accompanied some of the 146 victims to the hospital in the author's earlier studies. In analyzing interviews with these men, Burgess and Holstrom found that three issues are relevant to the first phase of a man's reaction to rape. The first issue for a man is dealing with his own reactions. His perception of who is hurt and who is the victim is established. Six of the men interviewed perceived themselves as the victim and felt betrayed, ashamed of or repulsed by the victim. This perception is a traditional response in keeping with a patriarchal society where women are property, which when devalued, injure the man. A second issue for the man dealing with rape is his desire to "get the rapist" and gratify his wish for revenge to salvage his sense of injury and loss, and to alleviate guilt. The third issue relates to the guilt feelings that "if only" he had
Half of these group members denied the impact of the rape, and saw themselves as victims, failing to ever offer support to their wife, daughter or girlfriend. Men who were able to identify with the victim, felt powerless, helpless and guilty for not having been protective enough to prevent the rape. They concluded that since the recovery process for the victim is often slow, feelings of resentment and impatience with the victim’s decreased level of functioning and dependency on the male may result. An important speculation derived from this clinical report is that male significant others and victims appear to go through similar feelings and behavior but at different times. Different phases of reaction are unsynchronized, exacerbating reactions of both male and female partners. The authors contend that limiting therapy solely to the victim results in serious difficulties and a lost opportunity for resolution of the crisis for both partners.

Beneke (1982) sought male reactions to rape from various groups of males. He interviewed lawyers, husbands, friends, police and doctors. He reported that boyfriends and husbands frequently felt powerless and enraged; protective and resentful of the victim; and victimized, yet unable to fully comprehend the victim’s sense of violation. Beneke contends that men are only beginning to acknowledge their anger at women and to reflect on its origins. Man’s low regard for women perpetuates rape, which Beneke viewed as man’s problem. He states that many men tolerate violence against women because of the benefit to them; by posing threats to women, men gain advantages over women both professionally and personally.

Notman and Nadelson (1976) reported findings on fathers, husbands and boyfriends of victims they had interviewed at their treatment center. Their subjects often felt indignation and sometimes identified with both the victim and the rapist. They viewed males as often feeling that their masculinity was violated
both by the attack on the woman who was felt to "belong to them" and by their own helplessness for failing to prevent the attack. Some men were found to be particularly threatened by recognizing feminine components in their own personalities (i.e. helplessness) and defended against this vulnerability by identifying with the rapist. Other men were seen as having difficulty coping with impulses for revenge which would re-establish their sense of control and ability to protect "their women". Notman and Nadelson (1976) also found reactions to the victims included overprotectiveness, arising from guilt feelings, or as a defensive means of handling anger at both the attacker and victim. These authors believe a complex series of feelings about the man's sexual impulses could be evoked, such as arousal of the man's own rape fantasies, concerns about the victim being "used merchandise" or the breakthrough of homosexual impulses. Anxiety about these sexual concerns may provoke withdrawal from the woman. Since denial operates to minimize the intensity of the crisis, the man may be unaware of his lack of support or negative behavior towards the victim.

Benedict (1982) summarized several research studies. The most sensitive area of conflict for a couple is the sexual relationship. Usually, the victim engages in sexual activity too quickly, out of fear that the partner will be offended or lose interest in the relationship. Flashbacks often occur, particularly if the partner replicates some activity that the rapist performed during the assault.

Veronen was quoted in this article as believing that marriages break up after the rape because the support system is exhausted, especially when the husband is supportive and the wife does not improve. Feuerstein (1982) commented in the article that partners are afraid or too confused to talk objectively about the rape. Generally both partners are strained by the assault—the man by his anger and protective feelings, and the woman by damaged self esteem. Often, these
reactions prompt the man to take control which makes the victim feel even worse since control is what she needs to regain for recovery to begin.

Miller, Williams, and Bernstein (1982) in a clinical case study investigated the long-term impact of rape on the marital relationship of the victim and her partner using clinician's ratings, observations, and 43 couple's self-reports. The authors found that couple response patterns include communication disturbances, problems with commitment, and sexual concerns and dysfunction. The couples in their sample were assessed as exhibiting a high degree of serious relationship disturbance. Consistent with previous research findings were the predominance of rage and anger experienced by the male and typical long-term rape trauma effects by the women.

While these findings reflect both predictive and empirical information on rape effects in previous research, the findings are marred by the inability to ascribe the high level of dysfunction in couples to the rape, rather than to possible pre-existing pathology.

Orzek (1983) integrated research findings with Fox and Schori's (1972) crisis model in her analysis of issues concerning the couple who must deal with the impact of rape. She advises that the victim not be treated in isolation from her relationship and the couple be told therapy for the victim alone is not sufficient to prevent difficulties in the relationship. Orzek believes the male must integrate the crisis into his life also. She believes the male's response to the victim is based on the relationship the couple maintained before the assault and the man's beliefs concerning rape.

**Professional Attitudes Toward Rape**

Because the attitudes and responses of significant others is so pertinent to the recovery of the victim, several researchers have sought to explore mental
health professionals' attitudes toward rape and rape victims. The potential damage to the victim being treated by a prejudiced or ignorant professional is clear. Resick and Jackson (1981) queried 38 professionals from one state through a questionnaire. The only significant finding was that mental health professionals tend to blame the occurrence of rape on social status; i.e. the rapist is viewed as a victim of poverty who should not be incarcerated for a crime seen as socially induced. Female professionals, however, tend to blame societal factors more so than men, which seemed to reflect a feminist belief that any woman can be attacked and that society encourages violence against women. If these findings are representative of mental health professionals in general, victims may feel further dehumanized by such attitudes, which excuse the rapist as a victim of society and absolve him of personal responsibility. The authors believe awareness that rape is a societal problem affecting every woman is excellent knowledge for the professional to possess, while holding also that responsible treatment must address individual issues as well as sociological and political ones. This perspective is shared by Scott and Hewitt (1983), and Notman and Nadelson (1979).

Treatment Issues, Approaches and Programs

Krulewit (1982) summarized the reactions to rape victims by society's helpers (i.e., police, judges, hospital personnel, and counselors). She remarked that consistent findings by prominent rape researchers such as Burgess and Holstrom (1974, 1976), and Sutherland and Scherl (1970) have shown that society's helpers generally revealed a pervasive tendency to "blame the victim" and generally to be insensitive to their needs. Much of this further victimization by social service and criminal justice system has been attributed to the assumption held by most professionals in the area that rapists are sexually motivated and that victims
themselves are selected according to their character, appearance, or behavior which elicits this sexual response from the assailant. It follows, then, that helpers who adhere to these assumptions are likely to think the victims do not experience much psychological trauma. Therapists have historically tended to perceive the victim's emotionality following the assault as a result of her motives and causal role in eliciting the assault. Counselors unfamiliar with rape research or firm in their beliefs that rape is victim-precipitated will be less sympathetic and less supportive to victims who are seen as having engaged in risks, such as hitchhiking, or walking alone at night. The values of a patriarchal society are clearly reflected in these attitudes since a man engaging in the same behavior would not be similarly judged.

**Individual Approaches**

As a result of the research on the rape trauma syndrome and general reaction to rape, some authors have developed specific therapeutic approaches for the rape victim. In 1977, Heppner and Heppner advised counselors to develop rapport with raped clients and to recognize the possible need for long-term counseling. They suggested utilization of cognitive restructuring to help clients deal with guilt, anger and catastrophizing thoughts. They recommended group counseling so that victims can meet others who are dealing with the impact of rape. Being able to see others in various stages of recovery helps the victim to gain a realistic perspective. The Heppners also recommended groups for friends and families, advocacy, education of the community and promotion of legal change.

Forman (1980) created a model of victim responses which included five phases: (1) initial, (2) denial, (3) decompensation, (4) anger, and (5) resolution. Forman criticized both Burgess and Holstrom, and Sutherland and Scherl's model as insufficient in their description of victim response, and too limited to provide a
useful foundation for practitioners to assist victims to full recovery. Forman made specific recommendations to practitioners in the treatment of rape, such as offering victims information and support during the initial phase, preventing unrealistic concern by use of cognitive restructuring, non-directive or reality focused techniques. He advocates warning victims of possible reactions during the denial phase and views denial as a not unhealthy attempt to restore equilibrium and conserve energy for dealing with daily activities. He explains that pressing victims for details during this phase is intrusive, and a better approach is to explain that sometimes people question themselves about symptoms they thought they had resolved.

During the symptom formation phase of Forman's (1980) model, active coping is taking place with various attempts to encapsulate the problem. If these ego adaptive mechanisms do not create progress, then decompensation and further stress will likely result. Overgeneralization, depression, omissions of information and guilt feelings are common and can be treated using cognitive restructuring or hypnosis and including families in treatment. Forman warns against the use of medication because it encourages somatization, masks the issues, and may even suggest to the victim that she is mentally ill.

During the anger phase, according to Forman, primitive range, narcissitic injury, feelings of despair, helplessness and shame are characteristic. The counselor needs to redirect feelings of devaluation away from self towards the rapist, and foster acceptance of the anger so that it can dissipate. It is important to help women distinguish between feeling angry and acting out their anger. Finally, Forman defines resolution of the trauma as the acceptance of rape and ability to discuss it without intense affect.
Dowelko (1981) presents a conceptual framework for counseling victims based on Sutherland and Scherl's three-stage model. He believes three factors influence victim response: (1) the uniqueness of the assault; (2) the developmental stage of the victim, and (3) the victim's characteristic coping mechanisms. Dowelk recognized that long-term counseling may be necessary due to rape-related developmental conflicts, such as identity and relationship conflicts.

Kennedy (1983) proposed a generic model of intervention for victims similar to problem solving models. He recommends: (1) assessing the problem; (2) planning and assessing the strength of resources; (3) cognitive structuring, and (4) resolution and planning which may include the use of a self-help group.

Taking a different perspective on the meaning of rape to the victim, Whiston (1981) likened the experience of rape to death and posited a loss model for counseling victims. While acknowledging that many have used a multidisciplinary approach to helping victims, Whiston believes additional perspectives are needed. Viewing rape as a loss--the loss of self, security, freedom, control and function--victims should be allowed a period of mourning and grief. The victim experiences a loss of identity and needs to create a new one where these losses are not so important. Whiston believes her approach is more respectful of the individual's meaning of the experience and perceived loss, allowing her to find personally meaningful options to restore her sense of self and new identity.

Orzek (1983) and White and Rollins (1981) both proposed models integrated with rape research findings that included the treatment of male significant others. Noting that previous models ignore significant others, they insist that not only do many males experience a crisis themselves, but that their participation in treatment is mandatory if the victim is to successfully recover. Even though many adult rape victims do not live with their families or origin, family members have also been unrecognized as severely affected by rape.
Feinauer (1982) emphasized that rape is the single most common crime against the family in America. While the victim, as an individual, experiences a prolonged period of pain and alienation, family members experience their own individual trauma. Despite treatment of the victim, family issues are often left untouched, unacknowledged, and unresolved, while fully impacting on the family's ability to function as a unit or within society. Feinauer recommends family therapy as the desirable treatment approach. In agreement with previous descriptions of male/significant others' reactions to rape and to the victim, Feinauer reinforces Burgess' (1974) comments that families also may deny the impact of rape, and communicate disapproval of the victim. The disengaged family who use denial as a pattern of interaction may encourage the victim to keep the rape a secret. The collusion to keep the secret becomes destructive to adaptive behaviors and further isolates the victim. Attempts by family members to distract the victim imply that the rape is inconsequential or simply too terrible to acknowledge. For the victim whose family reacts in these ways, she not only loses her most important and desired source of support, but also may convince herself that others less intimate with her could not accept her and provide support either. Feinauer recommends individual treatment for the victim during the first four to six weeks, then the initiation of family therapy. The purpose of family therapy is to counteract the victim's internalized guilt, shame, and vulnerability which immobilized her growth, to aid her parents as they attempt to resolve their feelings, and to function as a healthy support system. The main goals of treatment are: (1) facilitating emotional expression about the shared crisis; (2) exploring misconceptions and expectations so that issues can be clarified; (3) resolving family problems which arise out of the rape experience; and (4) focusing on the future to regain perspective and return of control over environment. Feinauer recommends a
co-therapy team of male and female therapists to facilitate discussion of the issues related to both sexes.

Just as victims experience isolation and alienation, families also feel estranged and divorced from their sense of community. Multiple family therapy provides support for the families and shared experience, lessening the burden of facing a crisis alone, and providing opportunities to learn unfamiliar coping alternatives.

The therapist's role in working with families is directive, facilitory, and modeling. Co-therapists need to work well as a team. Families may then not only regain a sense of control over their lives, but also function even more effectively and happily as a family.

**Program Approaches**

The early treatment programs were crisis intervention oriented, since rape victims who sought treatment were seen in hospital emergency units. This approach was viewed as normalizing the rape trauma syndrome and counteracting the myths that the victims either did not suffer because they unconsciously desired to be raped or that victims were, by definition of being selected as victims, sick or somehow defective in character. As Burgess and Holstrom (1974) suggested, rape trauma was not necessarily a time-limited, short-term process. As therapeutic approaches developed and programs in rape treatment centers were established, evaluation of their effectiveness followed.

**Evaluation of Programs and Services**

King and Webb (1981) evaluated 41 centers in a descriptive report on intervention services. After several years of working with victims at a hospital
emergency room, these authors revised their views of psychological interventions needed following victimization. They found that both crisis intervention and long-term counseling were needed. The responses from 41 rape crisis centers revealed that only half of them believed long-term services were necessary. These centers also reported that 50 percent of their clients who initially used services failed to follow up because the stigma of receiving services was more serious than the stigma of being raped. Without both rape and mental health myths being addressed, victims and their families are caught in a dual conflict which creates further embarrassment, depletion of coping resources, and punishes them for having needs.

Forman and Wadsworth (1981) sent questionnaires to 18 mental health centers to assess how services are delivered. Twenty-five percent of those sampled offered no services, and seventy-five percent offered differing levels of services, sometimes by untrained counselors. The centers stated their services were limited due to insufficient financial and community support.

Ruch and Chandler (1980) evaluated a sexual assault center in its first year of operation. Based on their evaluation, they recommended that services should be centralized so that crisis and long-term intervention and adjunctive services were easily accessible and integrated. They suggested that hospital settings were poor settings for services because of their authority structure.

Holmes (1981), in evaluating services to victims, proposed that professionals go beyond the crisis services extended to victims and engage in advocacy. He believes the social work perspective of helping the individual and working to change society is a superior approach consistent with social conditions while working for client and class advocacy.
Conditions similar to those in the United States were reported by Australian researchers Scott and Hewitt (1983). They, too, found that crisis and long-term services seemed effective for victims and families and that easily accessible, specialized services are needed. Like Holmes (1981), they shared the belief that advocacy and community action must be part of the total effort to address the needs of society and the individual victim and her family.

Summary

During the last twenty-five years, rape research has focused on the problems and needs of the victim. A rape trauma syndrome has been thoroughly described and validated. As various crisis and treatment models were developed, research interest turned to investigating the long-term impact and the role of significant others, not only as one who also experiences stress in response to rape, but as one who is an important source of support in victim recovery. Although the impact of rape has been well defined in the literature, samples have not controlled for the severity of assault or the level of coping resources available to the victim.

Some research has focused on determining factors influencing the stigmatization of rape victims while other studies have attempted to specify factors which could explain why some women are more vulnerable to assault than others. However, further research is needed to learn more about the responses of significant others to rape and what kind of support is most helpful to the victim. Treatment approaches recommended for short-term rape impact have not been studied in terms of their usefulness in long-term counseling of rape victims. Also needed is research on the long-term reactions to rape by victims and significant others. Coping resources which victims employ during their recovery have yet to be fully investigated.
CHAPTER III

METHODOLOGY

Introduction

The purpose of this study is to explore, utilizing a family crisis perspective, the subjective experiences of rape on the victim herself and her relationship with a significant other. The study is part of a larger research project funded by the Ohio Department of Mental Health, under the direction of this researcher and Dr. Patrick McKenry, Associate Professor, Department of Family Relations and Human Development, Ohio State University. This descriptive and exploratory study was designed to use qualitative and feminist research methods. In-depth interviews were chosen as the primary means of data collections.

This chapter includes a description of the methodological approach and research design, instrumentation, methods of subject selection, procedures, and data analyses used to address the research questions.

A Qualitative Feminist Approach

Historically, qualitative methods have been considered unconventional, criticized for being "soft", journalistic, or intuitive in its approach. Recently, however, the method has grown in popularity among researchers of human behavior by producing results that quantitative methods could not deliver (Guba & Lincoln, 1981).
Characteristic of the qualitative approach is the use of a natural setting as the direct source of data and use of the researcher as instrument. Qualitative research is descriptive and process-oriented versus outcome-oriented. Of essential concern is "meaning" or the participant's perspective as illuminating the dynamics of the process under study that is often invisible to outsiders. In contrast to quantitative analysis is the qualitative researcher's inductive analysis wherein abstractions are built as the particulars that have been gathered are grouped together rather than setting out to prove or disprove hypotheses (Bogdan & Biklen, 1983).

Qualitative methods are typically considered the most suitable approach for an investigation when there is much human complexity and avoid reducing data to their simplest form by accounting for the interactions of multiple realities (Bowles & Duelli-Klein, 1980). The case study method per se allows a focus on changes that occurred in individuals and in their relationships over time. In-depth interviews, while somewhat structured into topical areas, allow flexibility for the subjects to richly describe their experiences, feelings, and attitudes, and allow for exploration of many perspectives (Guba & Lincoln, 1982). This method is considered superior for exploring areas where there is little basis for knowing what questions to ask. The method is compatible with the purpose of discovering the subjective meaning given to rape by subjects and life changes over time. The case study method approximates everyday conversation and, when utilized from a feminist perspective, permits the most natural and interactive process in which to explore fully intensely personal experiences.

The Feminist Perspective in Qualitative Research

Given the resurgence of the women's movement in the 1960's, the importance of sexual divisions in society could no longer be ignored in research. In
addressing this issue, non-sexist methods require that gender is taken seriously, that is that women in research be taken into account (Roberts, 1981). Furthermore, the feminist perspective does not separate the intellectual pursuit of knowledge from the practical and political context of experience. In a patriarchal society, research on women cannot accurately be understood from a male viewpoint.

The use of traditional interviewing practices are seen as creating problems for feminist studies which strive to validate women's subjective experience as women and people. "Traditional methods prescribing detached, neutral, and objective attitudes by the research tend to exploit subjects and treat them as objects" (Oakley, 1981). This process has been considered to be a form of dehumanization. Due to the sensitive nature of this study, the qualitative feminist approach does not replicate the violation and exploitation victims in this study have experienced in being raped by questioning them in a detached, impersonal manner.

Feminist methodology allows the researcher to explore women's social history, perception of their own situation, their own subordination and resistance in a male-dominated society without subjecting their experience to distorting analyses (Mies, 1983). The goal of research is truth; yet truth is not absolute, but relative, as truth changes over time through experience and reflection. Hence, honesty between researcher and the researched is an obligation important to the feminist approach (Bowles & Duelli-Klein, 1983). This methodology recommends the use of intuition and emotions in ourselves and in those we investigate in order to perceive what is happening.

There are several advantages to this method. By replacing "value free" research with conscious partiality (the identification of researchers with the researched), a critical and dialectical distance is created between research and
This enables the correction of distortion of perceptions on both sides and widens the consciousness of both (Weiskott, 1983). Through open, concerned dialogue, the researcher is in a more favorable and honest position to discern what may be initially a socially acceptable response or intentional omissions of important experiences relevant to the questions under study. Weiskott believes feminist methodology allows for intersubjectivity—the dialectical relationship between subject and object of research. This permits the researcher to constantly compare her work with her own experiences as woman and researcher, and to share with the researched, who add her own opinions to the research in an evolving cross-validating process. This interactive process avoids the subject-object split between researcher and the researched, and hence avoids exploitation and measurement of female subjects against male standards, which by definition artificially construct an experience which is false.

**Subjects**

In a large midwestern city in 1982, a physician was arrested for the rapes of 65 women. This physician was later convicted in September, 1983. Subjects in this study were survivors of this serial rapist. Sixty-five survivors assaulted over an eight-year period were identified from a list found by the police. Forty-one of these victims were later located by the prosecutor's office. These women were witnesses for the prosecution and were separated into two legally-mandated trials, made necessary because of a change in insanity defense laws during the eight-year time span of the assault. Seventeen of these forty-one victims agreed to participate. A higher rate of participation was expected. Several explanations are offered to explain this level of participation:
(1) Many women wish to forget a rape experience, especially when resolution is delayed for so many years. A number of subjects stated they would have preferred being interviewed before the trial instead of afterwards, and suggested that non-participants may have declined so as to achieve final closure on the rape experience.

(2) The long delay between the initial announcement of the study and the interview may have resulted in some of the 32 subjects from the first trial changing their mind.

(3) Some women may have declined to participate because they did not realize that the researcher was also a victim in the same case. This was indicated by the fact that many of those who did participate did not remember reading this fact in the contact letter and stated they were more interested in participating because the researcher was also a victim.

(4) Some of the women may have been having emotional problems that prevented participation.

(5) The second trial took place nine months following the first, due to defense continuances. A pre-trial meeting in which the researcher participated, allowed personal contact to explain the study. Of this second group of eight victims, a 100 percent participation rate suggests that letters were too impersonal and confusing to encourage a high rate of participation in the first group of victims.

Subjects in this study were adult females, ranging in age from 22 to 49 years. All subjects were raped by the same assailant. The subjects' age, race, education, marital status and employment status are presented in Table 1.
Table 1

Demographic Characteristics of Subjects
(n = 17)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>At Time of Assault</th>
<th>At Time of Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-21 years</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>22-29 years</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>30-39 years</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>40 years and older</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Single</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>Divorced</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Separated</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Employment Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time</td>
<td>17</td>
<td>16</td>
</tr>
<tr>
<td>Part-time</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school graduate</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Technical degree</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>College degree</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Post-graduate degree</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

Six of the seventeen women reported incidences of victimization which occurred prior to the rape under study. These victimizations included incest, rape, and child abuse. This percentage of women who have experienced more than one victimization is lower than the average for the population reported in recent studies.
Procedures

The proposal for this research was submitted and approved by the Ohio State University Human Subjects Review Committee (Appendix A). The Chief Prosecutor sent a cover letter to all 41 survivors, which explained his cooperation with the researcher's request for participation in the study (Appendix B). Accompanying the prosecutor's letter was a letter from the researcher describing the nature and purpose of the study as well as interviewing process. The protection of confidentiality, subjects' rights, and possible risks and benefits from participation were explained in this letter (Appendix C). Subjects telephoned the researcher to indicate their willingness to participate in the study. Convenient interview times were then scheduled. Interviews for female subjects were conducted at either the subject's home or at the researcher's home, and lasted from two to four hours. No subjects withdrew from the study at any point once they telephoned. The interviews were tape-recorded, but all tape recordings were erased immediately following transcription of the data.

The consent form made explicit the subject's right to withdraw from the study at any time, and specifically indicated that all tape recordings would be erased when transcription was completed (Appendix D). No names were ever attached to any of the data. Also noted on the consent form as available to the subject was a list of practitioners experienced in the treatment of rape victims (Appendix E). This list was provided for subjects should the stress of the interview elicit a need for professional assistance. None of the subjects requested referral.

The participation rate for subjects was 41 percent (n=17), although a higher rate of participation was expected. Of thirty women scheduled to testify at the first trial, all thirty expressed willingness to participate and to be contacted when approached by the Victim Witness Coordinator. The prosecutor and researcher
agreed that no subject would be interviewed prior to the completion of the trial in which they were to testify. This agreement was made to avoid possible dismissal of the trial and to avoid possible subpoena of the data by the defense attorneys. Letters requesting participation, however, were permissible prior to the trial to allow sufficient time to schedule subjects. Because the researcher's proposal was not approved and funded until three months following the first trial, there was a substantial delay in contacting the first group of survivors. Only ten of the thirty women contacted agreed to participate.

**Instrumentation**

Demographic information was collected on the female subjects using a brief background information questionnaire (Appendix F). A pre-crisis stressor checklist was used to assess vulnerability to stress for the year preceding the rape (Appendix Q). Pre-crisis stressors are considered an important factor in the Double ABCX model (McCubbin & Patterson, 1983) of family stress and coping, used as a theoretical base for this study.

The majority of the data was collected utilizing guide questions (Appendix H). These guides were semi-structured to cover specific research questions, and yet allow flexibility in both interviewer and subject to pursue other topics relevant to the research.

**Researcher as Instrument**

Oakley (1983) has pointed out that of traditional interviewing practices have created problems in the lack of fit between theory and the actual conducting of research. Standard data collection procedures require the importance of the interviewer to objectively elicit information and refrain from any interaction with the subject in which the researcher expresses any personal experience. According
to Oakley, and Guba and Lincoln (1982), interviews without social interaction confine meaning of data to statistical comparability with other interviews and defeat the true purpose of research, which is to fully understand phenomena as experienced. The traditional procedure of pretending to be devoid of personal opinions and experience has meant to avoid bias (Bogden & Biklen, 1982). Oakley has suggested that bias be renamed as "interview differences, which are inherent in the fact that interviewers are human beings rather than machines which work identically from one moment to the next." Furthermore, Oakley believes it is unreasonable and exploitive to expect a subject to honestly share personal information with an interviewer who refuses to respond in any personal way, and who will impose an interpretation upon the data without verifying that interpretation with the source.

Reinharz (1979) addressed the need of "the research to suspend preconceptions about the research so as to not create a self-fulfilling prophecy." At the same time, the researcher investigates one's own experience, intentions and prejudices, in order to understand "what she brings to the study". Since bias cannot exist where it is acknowledged, she suggests that preconceptions be shared with the subjects. Based on this view of the role of the interviewer, it was believed that preconceptions by the researcher should be shared with subjects and offered as the researcher's subjective personal experience to be rejected or confirmed as relevant to the subject's experience.

Prior to interviewing the subjects, the researcher noted several preconceptions which were considered important because of the extensive literature review on the topic and because the researcher is herself a victim of rape. During the interview process, these notions were posed as questions to subjects as a way to share this author's thoughts and to gain insight from subjects. The following are preconceptions of this researcher:
(1) that rape is not a short-term crisis as it is frequently termed, but rather a pervasive and dynamic change event which may intrude on every facet of one's experience for many years.  
(2) that victims believe that those close to them also experience a crisis that may substantially change the nature and fact of their relationship.  
(3) that victims may view themselves and life differently than before the rape.  
(4) that victims are more conscious of dehumanizing experiences and may react in ways others do not accept or approve of.  
(5) a sense of alienation and isolation is common among rape victims who struggle with self-blame or the belief of society that rape is an uncommon experience precipitated by the victim rather than a socio-political problem, in addition to a personal one. By addressing this issue within the interview context, subjects are expected to respond in more detail to both the personal and political facets of victimization and stated that they felt less estranged and "different".

**Mode of Interviewing**

The subjects were interviewed by a female interviewer since research has suggested that subjects would be more comfortable with a same sex interviewer if the questioning is of a sensitive nature (Benney, 1956). Particular interviewing skills employed included active listening, empathy, warmth, and sensitivity to nuances of meaning particular to the topic of study as described by Guba and Lincoln (1982). The intersubjective approach was used to permit comparison of interviewer work with her own personal and scientific experiences and to share them with subjects. "Dialogue between researcher and subject aided in establishing congruence and consensus, and to detect socially acceptable responses" (Bowles & Duelli-Klein, 1980).
Female Researchers' Qualifications and Characteristics

The interviewer in this study was herself a survivor of assault by the same rapist who attacked the subjects. As a clinical psychologist, she has worked with both rapist and survivors prior to and following the assault on herself. As previously mentioned, the subjects were told of the interviewer's experience of victimization in the letter of introduction. As was anticipated, the special rapport between survivors enhanced the researcher's qualifications as well as the subjects' perception of her as someone trustworthy, and non-judgmental of subject's experiences. Personal knowledge of the difficulties subjects were asked to share fostered empathy, emotional responsiveness, and respect between subject and researcher.

Response of Subjects to Researcher

The researcher restated to subjects that they could withdraw from the study or refuse to answer any questions they wished, and that if they were becoming uncomfortable to tell the researcher and changes would be made to accommodate them. The response of the subjects to this interview had both positive and negative components. Some of them expressed that, while they did not particularly want to remember aspects of their experience, they were committed to helping to further understanding of the rape experience. Many of the subjects expressed concern for the researcher by acknowledging her own rape experience and that they assumed it would be unpleasant for the researcher to listen to someone else's experience. As indicated by the responses of many, subjects stated they suffered these emotional reactions for the sake of the research, feeling that the results of the study would educate the public about the feelings and needs of victims.

A majority of the women stated that their participation and opportunity to talk in-depth with another victim of the same rapist was therapeutic for them and helped them to feel less alienated and different. They believed that another victim
could understand what they believe others cannot. Evidence of the depth of their
trust and need for an empathetic companion was their sharing of "secrets" with the
researcher which they had told no one else or only family members.

At the end of the interviews, some subjects asked to continue the relation­
ship on some level, such as supporting each other after the trial, sharing newspaper
clippings, etc. All victims thanked the researcher for her interest and effort in
doing the research, and a third of them offered their help in doing their part to
effect changes in the justice and/or in service delivery systems.

Interactional Characteristics

Oakley (1983) has noted the frequent and unavoidable experience of subjects
asking questions of the interviewer. This researcher also found it both unethical
and unreasonable to take an objective, detached stance in relating to the subjects.
Every female subject interviewed asked some questions which were related to the
stated that "recognizing that a woman's personal problems may be similar to many
women's problems renders the person political" (p. 90). The problems of each
subject were not estranged from humanity and were expressions of the political
aspects of experience.

The questions subjects tended to ask were for information about the
researcher's experience as victim, for validation of their experience as relevant,
and to seek better understanding of their experience. The following are typical
questions asked of the researcher:

(1) What did you experience during the rape?
(2) What symptoms did you experience and how long did they last?
(3) What did you find helpful in dealing with the experience?
(4) What do you think about this "service" or lack of it?
What can I do to help?

Does anybody else feel the way I do?

Why is the defendant parole-eligible in nine years? Will he be released?

In answering these questions, unfailingly the subjects shared more information and frequently raised other issues for themselves which seemed important to them or reminded them of something which they had forgotten and wished to share.

During the interviews, the researcher sometimes responded to the subjects' reports by self-disclosing her personal experience in order to clarify whether she understood the meaning and experience the subject was trying to express. In several cases, this prevented a misunderstanding of either what had happened or how something was perceived and responded to by the subject. The subjects indicated they appreciated this attempt to be sure that what they reported was understood, and that they were better able to clarify for themselves the impact and meaning of what they experienced. The sharing and comparing of similar and different reactions and experiences between researcher and subject became a useful tool for validation of data and increased the overall depth of understanding.

During several of the interviews, both subject and researcher would cry. However, this did not result in the subject wishing to stop the interview, even when the researcher offered to do so if the conversation was becoming too painful. The subjects seemed to feel that the researcher really empathized with them and was not pitying them. Researcher and subject both agreed that certain aspects of the experience still brought tears regardless of whose pain it was.

Researcher's Reactions to Interviews

The researcher felt the pleasant effects of acceptance and rapport created with the subjects. Following an interview, however, the researcher frequently felt exhausted and spent several hours emerged in recollection and emotional responses
to the subject. Field notes were completed during this time. The researcher also utilized several personal friends to talk about her own emotional reactions to sharing so much of someone else's pain and her admiration of their strength and courage in dealing with their reactions to the rape.

The researcher also found that sharing with the subjects was confirming and validating of her own experience and reaffirmed the importance of her purpose and intent in carrying out this investigation. It became clear after collecting the data that substantial changes and additions to community services were warranted.

**Data Analysis**

Immediately following the interviews, tape-recorded sessions were transcribed and coded. All tape recordings were erased following transcription. The background data sheet and life events questionnaire were coded for descriptive analysis along with key items from the interview. While an interview guide was used so that the interviewer would not forget to touch upon pertinent areas, the method for analysis was experiential. Reinharz (1983) stated that the assumption underlying experiential analysis overlaps with those of symbolic interactionism and humanistic philosophy. This method of analysis is compatible with the methodological approach and design of this study, as the method assumes "human experience is mediated by interpretation and that meaning or 'truth' is subject to negotiation" (Bogden & Bilken, 1982).

According to these theories, people are "intentional beings who create and discover meaning, not simply actors carrying out meanings given in an objective reality." Experiential analysis is broad in its focus, admitting feelings, behavior, thoughts, and insights as data, and the researcher is open to being changed by the research. The role of the researcher is one of involvement, participation and
sharing of data, and recognizes that a subject's experience cannot be replicated. The analysis relies on inductive logic, the creation of meaningful gestalts and patterns, revelation of the researcher's own opinions (Guba & Lincoln, 1982), and values and complete saturation of the aspects under consideration in the study (Bogden & Biklen, 1982).

Limitations of the Study

The naturalistic or qualitative method used in this investigation attempts to present a "slice of life", documented through natural language and representing as closely as possible how people feel, what their concerns, beliefs, perceptions and understandings are. Its focus is aimed at understanding actualities, social realities and human perceptions that exist, untainted by the obtrusiveness of formal measurement (Guba & Lincoln, 1981). The following are limitations often associated with this method of investigation:

(1) The concept of generalizability is undergoing revision, even within the scientific paradigm (Guba & Lincoln, 1983). A generalization cannot be anything other than a context-free proposition. Context-free statements, however, cannot be made when the inquiry is concerned with human behavior since human behavior is never completely context-free. Thus, it is more useful to think of how the findings in this study have meaning and relevance to other particular audiences. Due to the small sample size and the severe level of assault among subjects, the findings may be representative and relevant to other female victims of a severe sexual assault who have similar in background characteristics.

(2) A bias existed in the voluntary nature of subject selection as those women who may have had difficulty in talking about the rape and its impact on them may have declined to participate. Forman (1980) and Burgess and Holstrom (1974) have
stated that the inability or unwillingness to talk about the rape is a feature of the denial, or pseudo-adjustment phase of rape trauma syndrome. Hence, it is possible, that the women who did participate were coping better with the impact of rape than those who did not. Several subjects told the researcher that other victims of the same rapist that they knew personally were having significant problems coping with the rape and suggested that this might be the reason they did not participate.

(3) The validity of the study is compromised to some extent by the passage of time between the assault and time of interview, and by the publicity of the case and trial process. These events affected the subject's perception of the impact of rape and were reported in the study so that they are detectable. The trial did vivify certain symptoms or reactions to the rape. However, women were able to identify most reactions which were evident prior to the trial and which reactions were in response to the stress of the trial. An important finding was the development of new reactions or relapses in recovery ascribed to the stress of the trial.

(4) Reliability in qualitative research may be checked by two tests (Guba & Lincoln, 1983). The first is whether the account seems plausible. The data reported is indeed consistent with human behavior under similar circumstances and is consistent with previous research on rape trauma syndrome and post-traumatic stress reactions. Additionally, the researcher's interpretation of data was shared with three rape specialists (Dr. Pat Semmelman, Dr. Mary Koss, and Dr. Meg Metts) who reported that findings from this study were consistent with their professional experience with rape victims. The second test is to assess the stability of the account to determine whether it is consistent with accounts from other sources who have been party to the event. The accounts reported by victims in this study were remarkably stable across subjects in theme and content.
The goal of analysis is the joint interpretation of meaning between subject and researcher. Limitations to this approach are that much time is needed to reflect upon and synthesize the data. There is no final interpretation which is valid for all times or for everyone and it does not give definitive answers to questions. More likely, it raises more questions and is satisfying to those who have participated or perhaps to others who are strikingly similar to those who have been studied.
CHAPTER IV

RESULTS: PRE-CRISIS VARIABLES AND SHORT-TERM REACTIONS

Introduction

This chapter examines pre-crisis variables affecting reactions to rape and presents the immediate post-crisis short-term reactions. This researcher defines short-term reactions as lasting from the moment of the assault to three months post-rape. It is recognized that human experience does not neatly follow definitions and boundaries described in theory or research findings. Hence, there is some overlap of short-term and long-term reactions described by subjects reported in this chapter.

The content of this chapter is presented as follows: (1) theory, (2) description of the stressor event—rape, (3) pre-crisis stressors and resources, (4) perception of the crisis—rape, and (5) short-term post-crisis variables, associated hardships, post-crisis resources, and post-crisis perception of the rape.

Although rape trauma syndrome has been described by researchers, the personal meaning of rape to the survivor as well as the long-term impact of rape have not been systematically investigated. Researchers have only begun to consider the various factors that may contribute to the severity of rape impact and to the recovery process. The purpose of this study was to examine in-depth, the subjective experience of victimization; its short and long-term impact on survivors;
and the factors which influenced coping and adaptation. Based on McCubbin and Patterson's (1983) theory of crisis, special attention was focused on pre- and post-crisis variables, such as vulnerability to stress, and the nature and type of resources survivors found beneficial.

Theory

Coping and adaptation during the short-term phase (up to three months post-rape) are discussed in this chapter; long-term reactions are presented in the next chapter.

McCubbin and Patterson's (1983) theoretical model, the Double ABCX Model of Adaptation to Crisis, conceptualizes coping and adaptation in terms of member and system behavioral efforts to achieve a balance at these two levels of functioning. Applying this model to an individual, the effects of stressor events on the individual's subsequent coping can be examined by specifically focusing on the individual's perception of the event and crisis meeting resources. This model considers both pre- and post-crisis factors, the severity of the stressor event itself and associated hardships, crisis meeting resources, and the perception of the total crisis situation—interacting to produce adaptation or maladaptation.

Rape is a non-normative stressor which is likely to produce change in nearly every incidence. The nature, duration, and quality of change may be viewed as a product of the interaction of the following factors taken together: the stressor event, pre- and post-crisis hardships and stress (A), pre-existing and new crisis meeting resources available for dealing with change (B), and the definition and meaning the individual makes of this total situation in terms of the ability to prevent the event from creating a crisis (C), (Figure 1). The qualitative findings will thus be presented according to these headings.
The description of the stressor event is presented first so that the reader will have an understanding of the context of subjects' experiences and have a reference point from which to relate subsequent data.

**Stressor Event**

McCubbin and Patterson (1983) define stressor event as a life event or occurrence in or impacting on an individual which produces change. This change may be in various areas of the individual's functioning, such as self concept, coping ability, goals, values, roles and patterns of interaction. Such change is greater in its magnitude than day-to-day changes (McCubbin & Patterson, 1983).

As one might expect, each woman interviewed evaluated the rape as a crisis. The type and frequency of sexual act forced upon these women only slightly varied. Ellis, Atkeson, and Calhoun (1981) note that the level of severity of assault
is a major variable affecting coping and adaptation. As previously mentioned, these rapes would be defined as severe and sadistic assaults according to Groth's (1982) typology of rape classification.

The majority of the women were forced to submit to vaginal intercourse, often repeatedly, as well as bondage, fellatio, and cunnilingus. Two women were forced to submit to unwanted touching of their genitals or other body parts, but were not forced to submit to oral, vaginal or anal intercourse. In several cases, the rapist did not elect to penetrate vaginally when the victim was menstruating. These victims were then forced to submit to other acts, usually fellatio or cunnilingus, as well as more physically painful forms of bondage or abuse. One woman's report was characteristic:

He made me kneel down, he was so angry that I was on my period, he made me a, a...perform oral sex on him, I told him, I can't do that and he took the knife and put it in my mouth, then he threatened to kill my kids. Afterwards, he beat my face and my stomach, the stitches from my surgery weren't even healed yet.

Approximately one-half (n=9) of the women who were forced to perform oral-genital sex found this form of violence more upsetting than vaginal intercourse as they did not anticipate this sexual activity as part of "rape", and also generally considered it an acceptable form of sexual activity only with fiancés or husbands.

In addition to the sexual violation, sixteen subjects were threatened with their life, or with the lives of their children (N=2). All seventeen women acknowledged that the rapist had the capacity to kill them.

All subjects experienced some level of physical abuse and psychological torture. All were assaulted during early morning hours--most when they were
asleep. Two women were taking showers and could not hear or see the rapist intrude. All subjects were tied up at some point during the assault. Most were blindfolded or had a pillowcase over their heads so that they could not see the attacker; they also were gagged so that they could not scream, breathe well or speak clearly. All victims had bruises and cuts; several were badly beaten about the face or softer areas of the body; many were cut with a knife. Women were injured even when it was clear that they were recovering from recent surgery or injury.

As the level of physical violence escalated, these women became more frightened as they felt they had less opportunity to control the situation, and that nothing they could do would spare them their lives if the rapist chose to kill them. Nearly all the victims were suffocated, strangled, hung upside down, or submerged under water until they were unconscious, and then were revived by the rapist. In several cases, however, the victims remained conscious, but so tightly bound and gagged or left with limited oxygen that they would have eventually died had they not been rescued by someone. The rapist repeatedly told all victims he would kill them if they tried to identify him or did not cooperate. Moreover, 15 of the women believed that they were going to be murdered and accepted their death as inevitable as they endured what they believed to be their last moments on earth. One woman vividly expressed this feeling of inevitable death:

I knew he was going to kill me, each time he returned it was worse. I thought about my life and decided it was okay, I would accept it. Soon it would be over and I would be dead. When he strangled me, I did fight back with everything I had, but I was so exhausted, so tightly bound, and couldn't breathe well anyways, that I was out in no time. When he revived me, I almost regretted it. I had accepted my
death and I thought, oh God, is this bastard going to do this again and finish me off the next time! Something has to stop it.

Another woman was fearful for her children’s safety:

I thought about my poor kids, Jesus, I’d just gotten a divorce, and now they’d have no mother either. I didn’t mind dying though, if it saved my kids.

And another woman who was hung upside-down in her basement reflected:

I was convinced he would kill me, and was completely resigned to it, nothing I could do about it anyway. I was prepared for it, I said, well, now I’m going to die here in this god-foresaken basement, and I thought of my father and how glad I was that he didn’t have to live through this because it would have been very painful for him, since my mother committed suicide.

Another factor influencing the severity of the assault and perceived intensity of trauma was the element of psychological torture. The rapist would instruct the victim that if she cooperated, he would not hurt her, or force her to perform a particularly offensive sex act. The rapist also told them he had personal information about them and played upon the idea that he would know if they lied to him. He insisted on stories about their sex lives and would play out roles of a lover in between more brutal assaults. The rapist consistently blamed the victim for the assault, degrading her life style and making comments that were sexist or otherwise offensive.

One woman reported offensive remarks by the rapist:

He said, tell me about your first sexual experience, I did and then he said, boy, you were a real prude. But I know you’re real good, I’ve been watching you.
Another woman told of being blamed by the rapist:

He told me I was careless, that I shouldn't have left my window open,
but I didn't think that I had left it open, and anyway, it was hot
outside.

In most cases, the rapist pretended to leave, only to return and escalate the
abuse. It was impossible, then, for victims to have any way to predict his behavior
or guess what strategy might work in reducing the abuse. In this way, many
victims saw themselves deprived of even being able to negotiate with the rapist.
Each woman interviewed attempted to use verbal strategies to negotiate with the
rapist to lessen or prevent further assault. Women who resisted physically or who
screamed were restrained and beaten as "punishment" for their lack of cooperation.
Paradoxically, however, some of the women who did not resist and were physically
and verbally "cooperative," were also beaten or cut with a knife. A woman who
"cooperated" stated: "I didn't scream, I rolled over like he told me to, and he
immediately cut the back of my neck with a knife. I didn't resist physically; I
couldn't, yet he still strangled me."
A woman who resisted said:

"I screamed and moved around, I tried to hit him, he told me 'you
better stop or I'll kill you,' and he beat my face, and beat me in the
stomach even though he asked me what kind of surgery I'd just had.
He saw the stitches."

Pre-Crisis Stressors

Pre-crisis stressors can be a contributing factor to the level of vulnerability
to a crisis and coping resources available to the individual at the time of the event.
Pre-crisis stressors as defined by McCubbin and Patterson (1983) include financial
hardships, developmental issues, situational problems, health problems, non-normative stressors, and prior victimizations. Pre-crisis stressors interact with other factors related to the stressor event to produce an outcome, which may eventually lead to adaptation or maladaptation.

Although the majority of women interviewed described mild to moderate stressors prior to the rape, most did not view themselves as generally stressed except in the area of finances. Most women described themselves as struggling to meet bills at the time of the assault and felt the lack of adequate financial resources prevented them from being able to utilize other resources to help them cope with the assault. Financial security was equated with self-sufficiency and personal power. When the assault necessitated moving, or purchasing services, victims felt inadequately prepared to provide these resources for themselves.

Of the 17 women interviewed, nine did report moderate levels of pre-rape stress on the modified Holmes-Raye Stress Checklist. The most frequently reported stressors were: (1) financial difficulties; (2) the break-up of a significant relationship or divorce; (3) death of the family member; (4) developmental issues such as emancipation from home, conflicts with parents, and career problems.

Additionally, of the six women who reported prior victimizations, five indicated these previous experiences were current issues which they had not resolved to their own satisfaction.

Most of the women perceived themselves to be under some stress, but were managing these stressors with some confidence prior to the rape. The pre-crisis stressors, however, once combined with the assault, were perceived quite differently. One woman said:

This was the worst time in my life this (the rape) could have happened. I was still mourning the death of my brother and was
depressed. I was barely meeting my bills and then this happened. I might have been able to handle it better if I hadn't already been depressed.

Nine women specifically connected the pre-rape stresses with the impact of the rape. They viewed their resources as severely taxed and perceived the rape as the "straw that would break their back". Another woman expressed her despair:

I wondered if I was doomed, I couldn't believe all these things happened so close to each other. I just didn't see any way I could feel confident about handling all this.

Prior experience with stressors can increase communication skills, development of personal resources, and increase confidence in one's self, yet even increased skills such as these and the knowledge that one has been able to cope well with previous stresses did not prepare victims in such a way as to lessen the impact of rape.

The two women who reported experiencing the least stress of any of the victims said they felt very positive about their lives prior to the rape. Although the rape itself was severe in its threat to life, these women were only concerned with survival and said that as soon as they were rescued, they felt they would have little trouble recovering. One of these women reported:

I was under financial stress, my father had recently died and I was in love for the first time in my life at age 39. All in all, though, it was an exciting time. During the rape I resigned myself to it (death). I thought of Dad and was glad he had been spared this. The sexual violence didn't bother me, I thought other women, prostitutes go through this, I can too. My life has been a soap opera, so many strange things have happened to me, my relatives' suicide, the war,
the secret affair, but this is all part of life. I had survived worse things in life than rape. I loved life and all that was important was that I survive.

The Perception of the Crisis—Rape

The individual's definition and perception of the objective stressor event is a necessary and sufficient condition to produce a crisis, McCubbin & Patterson (1983). The extent of the crisis and resulting coping and adaptation is very much related to the definition the individual makes of the stressor (Hill, 1949; McCubbin & Patterson, 1983). Rape typically is viewed either as an act of sex or an act of violence, or both. The victim's definition of rape may be based upon societal definitions, those of significant others, or other personal experiences. The victim's definition of rape may also be contrary to society's definition and thereby create a lack of consensus or conflict between the victim and members of society.

Subjects were asked how they defined rape prior to being assaulted. Fourteen women defined rape as predominantly an act of violence, such as "rape is a violent act of forcing sexual contact." Only three women defined rape (prior to the assault) as a sexual act. "Rape is a woman being attacked sexually," she added, "that's what I thought before the assault!" Most subjects defined rape clearly in terms of power or violence as indicated by these responses:

I always thought it was the worst thing that could happen to me. The worst kind of violation.

It's a man's crime, an act of violence, women don't rape.

I never thought of it as terribly sexual, maybe when I was younger but as I got older and began to hear stories about two year old children or
80 year old women, I knew it couldn't be a sexual act, so I revised my thinking even before it happened to me.

It's a mad man's crime, that kind of violence is crazy, rapists are crazy.

All subjects commented that in spite of their definition of rape as violence rather than sex, they viewed the use of sex as a weapon to be the worst kind of violence possible. The abuse of a woman's body, the forcing of a person to do things which normally are expressive of tenderness, caring and pleasurable feelings, for the gratification of violent purposes, was viewed as the most traumatic experience that most subjects could conceive compared to any other they could think of. One woman's response was typical: "Being raped is worse than death, you have to live with it. Well, I always thought being raped would be the worst thing possible, and it is."

Subjects' definitions of rape brought to their minds knowledge of how others viewed rape. Prior to their assault eight women noted that males they knew generally viewed rape as a sexual act, one precipitated by the woman. Representative of these women was:

I can never forget my father saying, 'If a woman is raped, it's her fault, no doubt about it'.

I used to have a difficult time around my friends even some of my girlfriends, who would make jokes about rape that the woman must have wanted it. I'd never say anything though.

When rape is viewed as a sexual act, Burgess and Holstrom (1974) found that women tend to blame and are blamed as precipitating the assault. These researchers comment that self-blame may constitute a major obstacle in recovery, resulting in more severe symptoms and difficulty in accepting help.
Rape is a potential danger for all women and is a subject frequently considered. Women in American society are given the role of setting sexual limits, with the implication that rape is a sexual activity which women can control. Many women are socialized to control male behavior and may even thinking about how they would react or resist if attacked. All of the subjects in this study had thought about rape as a potential problem and as an event they might possibly be expected to resist. Few, however, stated that they believed it could ever happen to them and therefore did not seriously consider their ability to cope with an assault. This perhaps, is the ultimate deception that such violence only happens to others. Consistent with this thought, one woman said:

I thought about rape, but never worried about it, I would never let that happen to me—boy was I wrong! Although I lived in New York, I was careful when I would come home late, but I wasn't afraid, because I never thought it could happen to me.

Hansen and Hill (1964) believe that the more sudden or unanticipated a stressor event is, the greater the disruptiveness that will result. Inherent in the definition of a non-normative stressor, such as rape, is the suddenness of its occurrence and the lack of preparedness to cope with its occurrence. Hence, lack of preparedness influences the severity of the impact of rape. Rape and murder are so frightening to most people that denial is frequently a way of coping with the threat of its occurrence. Even in acknowledging rape as a possibility, there is ultimately no absolute defense or preparation. Cognitive preparation and behavioral strategies for dealing with assault can, however, raise awareness of danger, and self confidence. In discussing these issues with victims, most of these women were acutely aware of how their denial of the possibility of rape increased their sense of shock and disbelief when they were raped. Also, initial feelings of self-
blame or "why me" were related to their earlier belief that rape happens to somebody else.

Only one woman considered the possibility of being raped enough of a reality to try to prepare herself. She took body building classes and wrote many school papers on rape. Yet even with this cognitive and behavioral preparation, this woman did not see herself as better prepared to cope with the assault. She said, "I wrote all my school papers on rape; and I compete now in body building, yet as strong as I am, I wasn't prepared."

Pre-crisis Resources

Burr (1973) defines crisis meeting resources as the ability to prevent an event of change from creating some crisis or disruption in the system. Pre-crisis resources are defined as financial, personal (such as mental health status and coping skills), prior success in dealing with crisis, education, community resources, and support from personal relationships. The extent of pre-existing resources, or lack thereof, influence the extent to which an event becomes a crisis (McCubbin & Patterson, 1983).

As previously mentioned, financial resources were perceived by the women as being inadequate, either because they could not afford emergency expenditures or had large bills to pay. All the women, however, were employed, and had transportation and residences of their own. Since most women were in their twenties, their careers were not so advanced as to yield more substantial salaries.

Psychological stability appeared to be a strong resource for these women. None of them had ever been hospitalized for mental problems. Three had been in outpatient treatment, however, a fact that can be considered an asset as these women were obviously able to seek and benefit from professional help and had
achieved some mastery of previous problem areas or awareness of their strengths and weaknesses. Although every woman could think of a major stressor which she considered successfully resolved, previously successful coping was only a minor factor in the woman's assessment of how well she thought she coped with the rape. Nine of the women perceived themselves as strained by pre-crisis hardships. Their perception of vulnerability to the rape and fears that they were seriously damaged by the assault were based on their belief that they had not resolved earlier emotional conflicts at the time of the assault and that their personal resources were thus inadequate. Confidence in one's previously successful coping ability does not necessarily sustain one's faith that a new stressor will not be traumatic or disruptive. Despite perceived confidence in general coping ability, a relatively high level of education, and adequate mental health, these women did not, on the whole, feel confident in their ability to cope or secure in the availability of resources. These feelings are likely to be characteristic of people who experience severe non-normative stressors such as rape, natural catastrophes, and unpredictable severe hardships (Bard & Sangrey, 1979).

**Significant Others and Community Services**

Relationships with family, friends, and co-workers are generally a major source of support for most people. Knowing that one can depend on another in time of stress can bolster confidence that any crisis need not be overwhelming. Supportive relationships appear especially important to the recovery of the victim of rape (Burgess & Holstrom, 1984).

All of the women stated they had some supportive relationships. Even women who were not close to their families or were depressed over the loss of love relationships sought out friends who they considered willing to help. In terms of family support, the history of the individual's relationship influences how strongly a
person views the family as supportive. Families with strong bonds of affection, adaptability, effective communication and flexibility, and ability to meet family member needs are major factors in their capability to support each other (Angell, 1936; Cavan & Fanch, 1938; Olson & Sprendle, 1979).

Six women did not view their family as a source of support prior to the assault. Parent-child, sibling conflicts, or family disorganization/dissolution were mentioned as sources of negative feelings and expectations among victims. One woman mentioned her mother's response:

After my brother died, I was depressed a lot. My mom couldn't stand that, she didn't know what to say, I guess because she hates weakness. I've never seen her cry, she keeps up a front and I couldn't do that. She couldn't even put her arm around me.

Hill (1964) notes that when events are perceived as reflecting poorly on a family member, family and other significant others are not as likely to be supportive.

Interviewer: What was it you needed?

Subject: I don't know what it was I wanted. I went back to drugs. I was really mixed up at home with mom. What I needed and didn't get was a good friend. My friends did not want to be there for me. Every time I would bring up the subject to my friend, she didn't want to deal with me. She would talk about something that happened to her. It would have been helpful if someone had just handed me a bunch of money. I did go to a counselor, but I felt someone couldn't recuperate for me, they couldn't tell me anything I didn't know already. I needed more than talk.
The other eleven women viewed family or friends as sources of support, even when these sources had failed them or been limited in their helpfulness before. Desiring parental support, one woman said:

I called my parents and my dad came right over. They contacted work, and took care of moving me. They were there for me whenever I needed them.

Another woman described increased intimacy:

My family is always there. This brought us closer.

I couldn't tell my mom, she's unstable, but my step-mom and dad were tremendous.

Victim Perception of the Crisis (Rape Trauma Syndrome)

The crisis, itself, is the individual's reaction to the stressor—the change or demand believed to have caused an imbalance. The level of perceived crisis is mediated by pre-crisis stressor, defining the stressor, and resources.

The experience of rape was perceived as a crisis by all subjects interviewed with clear manifestation of symptoms of rape trauma syndrome. Representative of the subjective experience of rape for the women involved in this study are two poems, offered by one of the women:
THE LORD'S PRAYER (SACRILEDGE)

Our father, who art in heaven—
(am I awake, I can't be awake
because if I'm awake, -- there's
someone, O God, in this room!
Hallowed be they name—
(this can't be happening --
not to me
he's choking me, -- and hitting me --
Someone must hear my screams.)
Thy Kingdom come, Thy Will be done--
(no one can hear me)
On Earth as it is in Heaven--
(I'm going to die)
Give us this day, our daily bread
(I don't want to die--
not with a knife...don't
let me die.
But, forgive us our trespasses--
(all right, rape me)
As we forgive those who trespass
against us--
(oh no, please don't take off
my clothes)

The use of the Lord's prayer as a motif for this poem reflects the
importance of religion in this woman's life and suggests the struggle she is having
maintaining her faith—questioning on one hand how God can allow this violation
and drawing strength on the other hand, so that she can forgive and accept such a
violation by another human being.

The second poem, by the same woman, addresses the acute immediate phase
of recovery and the confusion and turmoil experienced in deciding how she will
handle immediate needs.
AFTERMATH

He put on his plaid slacks
and windbreaker and left—
and how, all I have to do is;
call the police, no, rape crisis first
and get out of this place—
but, where and how, and
hell, I have to move—

and tell the cop, "No, it was not
normal intercourse".
"And yes, I was dressed in a tee shirt
and terry cloth shorts."

And no, he was not drunk, black,
retarded, or Appalachian.

And that's it officer.

And go to the Doctor, -- if I can find one
who will see me—

And start taking pills
and wonder how I should be feeling.
And O God, my parents can't be told,
and no, (Robert*) I'm okay.
and where can I go?
And yes, my windows and doors were locked
and yes, I know I'm lucky to be alive....
not an abortion, too!

And how can I work when
I can't even walk

And please, right now—
Don't think about
your wife, sister, daughter, friend
Think about me
Not a statistic in
Newsweek's feature story—
Don't talk about the
Politics of Rape—
"Hold me".

*name changed to protect confidentiality.

This poem so aptly and pointedly expresses the confusion and difficulty in
making decisions, and the need for human tenderness, sensitivity, and concern to
address the intense feelings of depersonalization and dehumanization—major features of the rape trauma syndrome.

Rape trauma syndrome as described and defined by Burgess and Holstrom (1974) and Sutherland and Scherl (1970) specify the common reactions victims experience following an assault. Similar descriptions of symptoms are defined by the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychological Association, third edition, 1980, classified as post-traumatic stress disorder. This classification includes a few symptoms not mentioned by rape researchers and is, therefore, useful in considering the short-term symptoms reported by subjects in this study. Additionally, this disorder (an unfortunate term since the APA doesn't consider post-traumatic stress syndromes to be a mental disorder in the sense that it is a pathological response) corroborates rape research findings in the universality of human response to severe stressors. From the DSM III, "Characteristic symptoms of post-traumatic stress disorder involve re-experiencing the traumatic event; numbing of responsiveness to or reduced involvement with the external world, and various autonomic, dysphoric or cognitive symptoms....The disorder is apparently more severe and longer lasting when the stressor is of human design. Re-intrusion of the event may be in the form of recurrent, painful recollections of the event or recurrent dreams and nightmares during which the event is experienced."

All the subjects experienced flashbacks or dreams in which they relived the rape experience. Disassociative experiences may occur where the individual behaves as though experiencing the event at that moment. Several subjects reported mild dissociative experiences, which they worried were indications that they were losing their sanity. Complaints of "psychic numbing" or emotional anesthesia began soon after the event, as well as feeling of estrangement,
Depersonalization and loss of the ability to feel emotions associated with intimacy, tenderness and sexuality. These symptoms were experienced by all of the subjects.

Of most significance were the perceptions that victims felt they were different; they often felt depersonalized, even sensitive to mild forms of dehumanization, such as being ignored at a checkout counter. Intimacy issues, including fears about being close, or about rejection, were of particular concern. While sexual dysfunction and temporary loss of sexual interest or pleasure were reported by most victims during the first several months, these problems were later resolved by all but two women and were not reported as being major concerns. These results are somewhat surprising given the research literature regarding sexual dysfunction and the use of sex by the rapist to humiliate the victims. The literature suggests that 50 percent of this sample would have complained of sexual dissatisfaction even several years after the rape.

Typical of sexual difficulties, this woman explained:

For a while every time (we had sex) I relived the rape, sure. There were times when if he restricts me in any way....he knows by the tone of voice to stop it....I've worked really hard (to enjoy sex)....my mind plays tricks and I just tell it to straighten up....it's too enjoyable to make nasty.

After experiencing the rape, many develop excessive autonomic arousal, such as startle responses and difficulty in falling asleep. All victims experienced these responses, with many reporting sleeping difficulties for as long as ten years. Most women reported memory and concentration difficulties as being troublesome soon after the assault, although some women mentioned they had never regained their ability to concentrate as well as they could prior to the assault. None of the subjects expressed guilt feelings about survival.
The APA Diagnostic Manual (1980) also notes that symptoms are intensified when the individual is exposed to situations or activities which resemble the original trauma. Associated features with post-traumatic stress syndrome include depression, anxiety, increased irritability, and sporadic explosions of aggressive behavior even upon minimal or no provocation. Headaches, impulsivity, and dizziness are also associated. These features were present for less than half \((n=8)\) of the subjects, especially anxiety and depression; these symptoms were severe enough for those victims to last for years and required treatment or medication for some. Increased irritability was also reported by most \((n=12)\) subjects and was described as a very unpleasant symptom. Intense anxiety was characteristic for many of them during the first year following the assault.

During the short-term phase, nine women also mentioned difficulties with anger and aggression. The rape trauma syndrome as described by Burgess and Holstrom (1974) and other authors frequently encompasses anger as a feeling important to recovery. The victim needs to be able to experience anger over the violation and to deal with that anger in constructive, self-assertive ways. Given the social reactions to rape and to victims, all victims reported some situations where they felt they were not treated well—either being blamed in some way for the assault, or repulsed by the attitudes they were exposed to. The women stated that frequently they felt impotent to do anything with their anger, or else too exhausted and overwhelmed to use their anger in constructive ways. Examples of the feelings reported: "I was consumed by anger, that's all I felt for a long time." "I had this rage, that I didn't know where it came from." Over one-half the victims stated that they had difficulty accepting the intensity or even the presence of angry feelings as these were not a usual part of their emotional responses. During the acute phase and into the long-term phase, many women were trying to
minimize the violence and deny their anger by finding reasons to forgive or excuse the rapist, i.e. "he must be crazy." Many struggled with feelings of guilt for being so angry or for being out of control and acting in an aggressive, belligerent manner. For some, these feelings were viewed as ego-dysyntonic (the DSM III definition: a symptom or personality trait which is recognized by the individual as unacceptable and undesirable and is experienced as alien). It was as though the rape now created another "impairment"—the experience of intense rage or anger which subjects previously had not experienced and did not feel was a part of their personality. Four of the women experienced their anger as ego syntonic and like the other women, definitely understood that their anger was a legitimate response to the rape or to insensitive reactions of others. For these women, however, their anger was acceptable although it occasionally created difficulties in interpersonal relationships. As one woman reported:

I used every chance I had at the office to tell men how I felt about what happened, I'd point out their chauvinist ways and nail them whenever I could. It got so I don't know how they put up with me, I was obnoxious. On the other hand, they started to understand what I was talking about and didn't see me as quite so bitchy. They also stopped behaving in sexist ways around me.

A woman uncomfortable with her angry feelings said:

I felt tremendous guilt about the angry and aggressive feelings I had. I was angry and irritable all the time. That wasn't me— I felt like a different person I did not choose to become. I worried about losing friends, about losing other's respect. I worried about hauling off and hitting people. My therapist kept saying I needed to accept and tolerate this anger for a while, that it was healthy but I was scared
because it was the only feeling I felt. It consumed me and I had no idea how I was supposed to manage it or how "it" would simmer down so I could be normal again.

Finally, the DSM III states that "Impairment may be mild, or affect every aspect of life", resulting in occupational or recreational impairment. Substance abuse disorders may develop.

Three subjects admitted to substance abuse problems following the rape.

One woman said:

My only social life was going out after work with friends and drinking. For a couple months, I was drunk very night, I guess I was depressed, I didn't realize what was happening either. Thank God my parents sat me down one night and said, Look, you can let him (the rapist) ruin your life or you can win. We're worried about you. They said, there's a number on the kitchen counter we'd like you to call. Well, that did it, I stopped right there. I needed my parents to be watching me.

Another woman said:

I had done some recreational drugs before, then my brother died from an accident and I was real depressed. I was still mourning him when the rape occurred. For a while, I was stoned all the time. I just wanted to have a good time. I was numb. The drinking helped me sleep. I became irresponsible though I didn't go to work anymore, I didn't feel like being responsible for anything. I wanted to party.
Post-Crisis Variables

Associated Hardships

Interacting with pre-crisis stresses, and resources and definition of crisis, are post-crisis hardships. These hardships may be other life events or changes that individuals and families had to adjust to over time and which happened independently of the stressor of rape. These normative occurrences may be illnesses, the birth of a child or marriage. Coping efforts used to adjust to the rape may produce additional stressors. Moreover, the experience of rape does not end when the act is finished. Additional hardships related to the stressor event may be reporting the crime to the police, moving to a place which feels safe, and the impact of the event itself.

Some hardships of the stressor may persist because by their nature they are unresolvable or because the individual is unable to resolve it, such as when their coping ability is overtaxed or insufficient resources are available. These persistent hardships become chronic strains, an aspect of pile-up. Finally, another source of strain also related to coping, is the ambiguity inherent in every stressor since change produces uncertainty about the future (McCubbin & Patterson, 1983).

Acute Phase. The acute phase of rape trauma syndrome typically involves many of these associated hardships. The acute phase of impact is defined as lasting variously from 48 hours to several weeks (Burgess & Holstrom, 1974; Sutherland & Scherl, 1970). The symptoms include shock, fear, anxiety, fatigue, disbelief, and disorganization of life style.

All subjects reported feelings of shock, disbelief, fatigue, and varying levels of terror and anxiety and depression. The utter surprise of the assault coupled with the violent intrusion into their bodies and the perceived safety of their homes, seemed to intensify the shock and disbelief they experienced. There was no time
to prepare or even consider the possibility that an intruder was present, since victims were caught sleeping, or in two cases, taking a shower. Two women's reactions were:

I was totally numb, I couldn't believe this happened, it was unreal, I didn't feel real either, I was an automaton. For days, I was in shock. I still though he was around. I could still smell his foul odor on my body, even though I'd bathed twice a day.

Most subjects exhibited the more controlled style of expression as described by Burgess and Holstrom (1974). They tended to act calm and unemotional when talking to police, hospital personnel, or significant others. Because all of the women reported that one of the most bothersome reactions to the rape was feeling out of control, they coped with the overwhelming feelings by over-control. However, victims did report crying or emotional release once they were with people they felt close to, or several days after the assault when they were more fatigued. One woman's response was:

I was a zombie, but I did what I had to do. Later that night, after I had gone to the police and into work, I played softball. Then, I was home with my folks, and suddenly my mom said, you've been sitting on the bathroom floor for two hours now...I didn't even remember mom rocking me for two hours, but suddenly I just started crying and couldn't stop. Before that, I couldn't cry at all. Dad wanted to call the doctor and get me tranquilizers.

Most of the victims took time off work following the assault so that they could get moved, and because they were emotionally overwhelmed. Others went to work as a way to cope with their feelings. Typical responses were:
I went to work even though I didn't feel I could do much because I thought if I didn't keep busy I'd be worse.

I took some time off—my boss was afraid I'd crack up and not be able to work, so he wanted me to come back in. They were supportive, yet it wasn't enough really. I had no idea how I'd function but I went back to work.

I went back to work after two weeks and my boss who knew what happened just kept hassling me, she was terrible and tried to fire me. My dad went to her boss, and finally she lost her job for what she did to me.

I was glad to be at work, it kept my mind off the rape more, but there were mixed messages from people at work. After a while, it was like they expected me to be over it.

Hospitalization is an additional hardship for some victims. Yet despite severe difficulties with emotional stability or behavioral performance, no victims required hospitalization for reactions to rape. However, a small number of the victims (n=5) suffered extreme perceptual distortions of reality, which might be termed by some clinicians as psychotic features. These perceptual distortions included such manifestations as believing they could hear the rapist's voice call their name, seeing a figure in their room, or hearing footsteps in their apartments when no one else was there. These auditory and visual distortions border on hallucinations in that subjects believed that they heard or saw the rapist, yet they were able to question the validity of their experience. These experiences can be viewed on a continuum of intense anxiety and autonomic responses where the overload strains judgment capacity. One woman's feelings were expressed as:
I would lay in bed at night, unable to sleep and hear a noise which I thought was footsteps, or I heard a voice call out my name and I would think, He's here again...then I would force myself to get up and go check it out, always terrified that I would find the rapist in my house and then feel stupid when I found no one there. I could never seem to just reassure myself it was a creaky floorboard.

The most frequent reactions during the acute phase were disorganization of behavior and extreme terror, loss of control, and inability to sleep. Only two victims experienced comparatively mild reactions. Their situations were atypical in terms of support available; i.e., for one, the suspected rapist was caught five days following one woman's assault, which relieved the anxiety and fear responses and removed much of the potential for becoming angry over lack of supportive friends or services. This woman also coped with feelings of loss of control by "taking care of others" and was determined to maintain control over her decision making. Even a "mild" reaction such as hers was stressful. Another woman's response was:

My friends wanted to take me to New York with them. They were crying and I kept saying I was alright, I had to make them feel good. I couldn't stand they're being upset. I sent them back. That night I was trembling so bad...like I was possessed...my boyfriend just held me all night, because I couldn't stop. I felt terrible. I wouldn't accept their help and they were sad and upset about that but I had always made my own decisions." (Note: two years later, this woman is unable to move into an apartment by herself. She travels in her job and sleeps at hotels.)
All of the subjects made decisions about work, their residence, and who they needed or wanted to talk with and which services they needed to contact. Only two subjects chose to continue their residence where the rape occurred. All the other women were not able to stay in their homes because of fears of the rapist returning, or memories that were frightening and too difficult to forget.

All of the women who moved considered it a major hardship, both financially and personally. They felt uprooted and displaced, deprived of their freedom and safety, and of the familiarity and sense of community in their neighborhood. Some also felt a sense of loss of their investment in social relationships with neighbors or roommates, as well as for decorating and making a home they took pride in. Typical of these responses were:

I had just finished painting, wall papering and buying flowers for the garden. I loved my place, and that S.O.B. took that from me too, but I just couldn't stand to go back there.

Since I moved, it changed the way things were because there was a social scene where I lived and it was devastating to me to leave it. I wasn't around people much where I moved. I felt isolated and out of touch.

I had moved just two weeks before the rape, after my divorce. I had just started a job and wasn't even unpacked yet. I had no money for anything, not even furniture, much less another move.

Three women moved back with their parents shortly after the assault because of financial strains or not being up to finding a place of their own so quickly. For two of them, this move was stressful because of conflicts with parent(s), and the sense of humiliation they felt in not being independent. The third woman stayed with her parents over a year, and needed strong encouragement
from parents to move out on her own again. During the year at home, she still did not feel safe. This woman responded:

They couldn't leave me alone, I ran the electric bills up, the lights had to be on all the time, and they had to install more locks. We had never locked the home before when we were there, now they had to do that.

Other life changes included changing phone numbers, locks, and routes to work. Women found themselves thinking all the time about their safety and how they went about daily activities. Some kept shades drawn all the time; others locked windows during the summer even when they had no air conditioning. Most were reluctant to let any one new know where they lived. During this acute phase, most of the women did not travel anywhere alone. Either friends or family accompanied them to work, to the store or to social activities.

Another associated hardship of the rape was having to make the decision about reporting the crime to the police. It is this decision-making process which is stressful, although having made the decision does not ensure less stress. All 17 subjects reported the rape, which was a criterion for their selection. For some, there was only one choice—to report. For others, fears emerged about whether they would be believed, how they would be treated, and whether it really would help to report the rape after all.

Representative of support from police, one woman said:

The police were very kind and supportive. They encouraged me to get counseling, and said to call them if I remembered anything or thought they could help. I wondered though whether they'd do anything to catch the rapist.
An assessment of support from a therapist:

I asked my therapist what to do- he'd said he'd know if I reported it and come back to kill me. I believed him - I was afraid to report it. I thought I was paranoid, but I wasn't, there was a real threat. My therapist said, either way he can kill you if he wants to. She was right, it seemed so simple a decision when she said that. I felt stupid.

A woman upset with the police said:

It took forty-five minutes for the police to get there--my Dad was furious with them, they didn't even bother to collect evidence, my dad had to do that. I reported it later after the detective came and talked to us. I felt good about that guy so I reported but I had little faith they'd catch him.

Immediately following the assault, many decisions needed to be made. Eleven subjects sought medical attention for their injuries; six believed their injuries so slight as to not warrant attention. All women made calls to friends, employees, neighbors, or family to notify them of what happened. A large majority of women made arrangements to stay with others rather than be alone. They needed the sense of safety and someone to be with during the first phase of recovery. The women's major concerns appeared to be continuing to function by going to work, keeping appointments, and taking advantage of procedures which might be helpful to them or required to prosecute the case, and finding a safe place to stay and someone supportive to talk to.

The data represented here indicate a large amount of change was associated with the rape, which constituted additional hardships for many women. The women's ultimate ability to recover, i.e. cope and adapt, was very much contingent on post-crisis resources and perceptions of the event.
Post-Crisis Resources

Post-crisis resources are those newly acquired following the stressor event and interact with pre-crisis resources that existed prior to the rape, including personal psychological resources such as friendships and family, personal skills, and community-based resources such as medical and psychological services, court services, and churches. When viewed over time and in response to a crisis situation, these resources strengthen or are developed in response to new or additional demands emerging out of the crisis situation or as a result of pile-up (McCubbin & Patterson, 1983). Individual's long-term reactions and coping skills are addressed in-depth in the following chapter. Immediate external resources available shortly after the rape are addressed here.

Support from Significant Others. All of the women, despite the confusion and emotional turmoil resulting from the rape, carefully considered the reactions of the people they would ordinarily expect to support them. A third (n=6) of the women had serious concerns; expecting rejections or criticisms or lack of support from family members and boyfriends, or being concerned that knowledge of the rape would upset them too much.

Concerned about her mother's health, one woman said:

I worried about my mother's heart condition and whether she could take it if she knew. She had enough to worry about.

Another woman expressed her fear of parent's reactions:

I waited three months to tell my parents -- I thought they would be upset with me and I did not feel I could defend myself. I didn't want to argue. When I did tell them though, they took it pretty well.
Confident of support, this woman said:

I knew just who would be supportive and who wouldn't. My girlfriend was tremendous, I never had to doubt that she would be there for me. My co-workers were pretty insensitive, but that didn't surprise me.

A potent resource enabling these women to cope was their awareness that family members or friends would listen, comfort, and accept them. The perception that friends and family would support them provided some semblance of stability amidst feelings of internal and external disorganization in their lives.

Nearly all women said they wanted to be protected or rescued, and that they needed to be taken care of. A conflicting need, however, was to remain in control and to be independent. During the first few months of recovery, some victims admitted that they didn't really know what they wanted others to do or how to treat them. When others would try to be supportive, some victims perceived help as demeaning and were irritated to the extent that they rejected such help or criticized that person for not being sensitive enough to know what was needed. As time passed, victims later changed their perception of other's support and recognized that they, the victims, would not have felt satisfied regardless of what others did because of their emotional state. Effective communication was difficult from some women during the early months post-rape, as exemplified by this woman's quotation of her husband's remark:

"I would listen when she talked, and I comforted her. One day this worked fine and she responded, the next day she would be angry with me. I didn't know what to do and she wouldn't say what she wanted." His wife said, "I never had to tell him what I needed, it seemed like he just read me, he knew. There were times
when I didn't want to be held and he didn't, he was really in tune with me. But there were some days when it didn't matter what he did, I was angry. I expected him to know what I needed even though I didn't now. I expect that from a husband. I know I made it rough on him, but I was going through hell."

Another woman said, "I thought I wanted to talk about it, and when my friends would listen, I'd get mad....later I realized I didn't know what I wanted people to do so how could they please me!"

Despite the changing and unstable perception of others and self, all the women believed the presence and interest of others was the most significant source of support which helped them to cope with the rape. The presence of others lessened the fears victims felt for their safety, lessened the sense of alienation and depersonalization.

**Community Services.** The majority of women were advised by police or medical personnel to seek counseling immediately and eleven women did so. As Burgess and Holstrom (1974) have noted, many women deny the impact of the rape and decline services immediately following the assault. In this study, only six women sought counseling soon after the assault.

The six women who did seek help immediately also chose to contact the Rape crisis center. Depending on the year they made contact, some of the women complained that services were not readily available because of staff shortages. One woman was told she was lucky to be alive, sounded fine, and did not need help. The women who called the center were hoping to be in a support group, where they could meet other victims to share their experience and their coping skills. None of the women were included in such a group. Four women sought help from a mental health professional and one from a pastoral counselor. Three of these women discontinued counseling after five sessions or less. Two women remained in treatment for several years following the assault.
There were difficulties in accepting help through some of these resources such as this woman's perception:

When I called the Rape crisis center and they told me I was doing fine and didn't need help, I felt really upset. I was not doing fine and I felt so let down I didn't think about contacting anyone else. I really didn't know where to go after that.

A different perspective:

The counselors at the crisis center were helpful but later on I quit because I needed them to talk to me, not tell me how bad men are. I didn't have bad feelings about men, in fact I was worried about my relationships with men and I wasn't interested in discussing politics.

This experience points out the need to address the victim's perceived needs, and to provide relevant help. Although rape is a social problem where understanding the political aspects can be beneficial, the victim must be ready to deal with that aspect rather than have it imposed upon her. Several other women felt further alienated by the feminist approach to helping a victim. Later, they were interested in dealing with social and political aspects, and found that involvement in activist organizations or activities were quite helpful in restoring a sense of power and control over their lives, and in helping to make the world a little safer and more just for others.

Another difficulty with counseling services which influenced victims terminating treatment perhaps too soon, were safety issues, competency issues, and the cost of services.

One woman described these problems:

I had to drive at night across town to her office and it was dark when I left. Even though she walked me to my car, I was terrified. She
helped me tremendously though. Then it got to be too expensive and I stopped going.

Another woman said:

The counselor kept talking about my relationship with my boyfriend. I guess that was okay but I thought we should be talking about how I was handling the rape.

The counselor was very helpful, I got better every week but it was in a bad section of town and I hated going there at night. Then, I kept getting bills and I had been told that victims witness assistance would pay for treatment and I couldn't afford to pay $50 an hour. I was really mad about that, I got collection agency notices for a year and the center did nothing to help. I felt like I got lied to.

All women stated that the counselors did not explain rape trauma syndrome sufficiently to them so that they could understand and anticipate possible problems which might ensue. Counselors also did not suggest the possible need for long-term treatment beyond crisis intervention.

Post-Crisis Perception of the Event

The post-crisis perception of the event is the family or individual's perception of the total "crisis situation," which includes the added stressors and strains, old and new resources, and estimates of what needs to be done to adapt to the crisis and restore equilibrium. The post-crisis perspective is oriented towards a redefining of the crisis situation. When this effort is constructive, the individual attempts to clarify issues, hardships, and tasks to render them more manageable, decrease the intensity of the emotional burdens associated with the crisis situation, and promotes social and emotional development (McCubbin & Patterson, 1983).
Efforts to redefine a situation as a challenge or opportunity for growth or to endow the crisis with meaning, such as believing it was the Lord's will, appear to play a useful role in facilitating coping and eventual adaptation (McCubbin & Patterson, 1983).

Kessler (1984) notes that one clue to survival after severe trauma is the ability to use tragedy to discover unsuspected abilities within one's self. Individuals may rely upon religion or a philosophy of life which bolsters their perception that they can survive tragedy. Representative of the ten women who reported reliance on religion or philosophy of life: "God gives us the strength to handle whatever He sends our way."

Individuals may redefine the situation as more severe and damaging over time, particularly if hardships overtax their resources, or they become tired and demoralized in their efforts to cope. Coping efforts, in themselves, may create additional hardships which may then influence the total perception of the crisis situation as previously discussed. Coping efforts also do not necessarily constitute growth, but may represent regression to earlier levels of functioning in order to conserve energy, or avoid dealing with issues until resources are more available.

Maddi (1984) believes the survivor personality has three components: a commitment to one's life, a feeling of control over circumstances and willingness to accept what cannot be controlled, and the ability to see change as more a challenge than threat. Survivors have a deeper sense of their own mortality than most other people. By accepting their vulnerability, they mobilize resources. Representative of a challenge perspective, one woman said:

I coached myself as best I could. I said, look, you're not going to let this creep ruin your life, you're too strong for that, until I listened to my own coaching, I let it destroy me for a while.
Representative of a pessimistic perspective, one woman said:

This was the last straw, I was already down, not much support...I
wanted to pretend it never happened.

Kessler (1984) reports that most experts believe that, within limits, a person
can decide to be a survivor. Some have speculated that women may be better
survivors than men because of social influences. Women are raised to cultivate
paradoxical traits that contribute to survival: gentleness and strength, self-
confidence and self-criticism, dependence and independence, toughness and sensi-
tivity. She states that the more counter-balanced a person is, the more options he
or she has to respond to a situation. A woman who exemplified this counter-
balance:

Because of the rape, I discovered I could let myself depend on other
people and not feel I wasn't being independent. I believe I am a
strong person.

Kessler (1984) noted that survivors are better able to make sense of what
happens to them. "They have the flexibility and ego strength to integrate even a
terrible experience into the rest of their lives so it seems to have meaning. Others
simply believe in the value of their own life and of life itself."

Characteristic of the "survivor personality", eight women evaluated their
response to rape as effective and courageous. This woman stated:

I survived...as soon as he left, I knew I had survived and that was all
that was important. I didn't feel persecuted, like why did this happen
to me, it was just part of life and the only important thing was to go
on living.
CHAPTER V

RESULTS: LONG-TERM COPING AND ADAPTATION

Introduction

Chapter IV presented the findings of this study in terms of short-term reactions to the stressor of rape. Specifically, the data were examined in terms of pre and post-crisis factors related to the extent of short-term stress experienced as a result of rape and subsequent coping and adaptation ability. This chapter examines the findings, specifically in terms of long-term coping and adaptation.

The content of this chapter is presented as follows: (1) researcher’s redefinition of long-term reaction, (2) definition of coping, (3) definition of adaptation, (4) long-term hardships, (5) resources in coping with victimization, and (5) factors in transformation of self and world view.

Re-definition of the Long-term Phase of Rape Trauma Syndrome

Most researchers define the long-term phase of rape trauma syndrome as lasting one to two years. As the results of this study show, long-term reactions may, in fact, last indefinitely.

Research by Veronen, Kilpatrick and Resick (1979), Ellis, Atkeson, and Calhoun (1981), Notman and Nadelson (1982), Atkeson, Calhoun, Resick, and Ellis (1982), and Kilpatrick, Resick, and Veronen (1981) used written tests to measure long-term reaction one to two years post-rape. They reported that symptoms
decreased, or that some equilibrium had been established six to twelve months post-rape. In the present study, no similar pattern emerges. Although many women reported a decrease or resolution of some symptoms, they also reported new symptoms appearing as long as three years post-rape. These new symptoms were additional stressors affecting coping ability. Various interacting factors could explain this phenomenon. Characteristic of women in this sample was the drive to maintain control. A third of the women (n=6) utilized denial regarding the severity of symptoms or did not label a behavior a problem for them initially. For others, support resources were not as available as they were for others, or other associated hardships appeared later on in time.

In general, however, there were symptoms reported as troublesome for all women up to ten years post-rape regardless of resources, or hardships. Major problem areas for all of the women which did not decrease the first two years included problems with self-esteem or personality reorganization, anxiety and depressive symptoms, and stressful changes in interpersonal relationships.

The following long-term symptoms were reported by at least a third of the women: fear, anxiety, alienation, somatic reactions, nightmares, health problems, phobias, depression, social isolation, suicidal feelings, anger and rage, homicidal feelings, concentration and memory problems, regression, and increased dependency.

**Coping Defined**

Coping, as defined by McCubbin and Patterson (1983), appears to be a multifaceted process wherein pre- and post-crisis events or resources, perceptions, and behavioral responses interact as the individual tries to achieve a balance or equilibrium following a crisis (AxBxC). Coping is thought of as the bridging
concept, linking resources and perception with behavioral responses to the stressor event, its associated hardships, and the pile-up of other stressors and strains. Coping has behavioral and cognitive components that interact with each other in the face of demands.

Coping with victimization requires the ability to acknowledge and successfully deal with a broad spectrum of events, issues, and reactions related to the rape. Coping and adaptation are the central concepts in the Double ABCX model used to describe the outcome of an individual's efforts to achieve a new level of balance in the individual's functioning which was upset by the crisis (rape) (McCubbin & Patterson, 1983).

Coping strategies may be either positive or negative. Coping additionally is defined for the purpose of this study as defense mechanisms which are employed to deal with the crisis and long-term effects, as well as specific, time-limited activities which serve a particular purpose in attempting to ease stress or emotional discomfort, or to utilize resources which may augment the individual's internal coping skills.

Laughlin (1979) states that ego defenses are present in normal, psychologic function as well as in the unhealthy and pathologic. Ego defenses, therefore, do not constitute apriori evidence of a psychopathologic condition. He states the presence of defense mechanisms is pathological or normal in varying degrees according to: (1) how they are employed; (2) how psychologically efficacious they prove to be as a defense; and (3) whether the net contribution they make to the total individual psychologic economy is constructive or destructive. Hence, individuals may utilize certain defenses in response to a stress and abandon them if they are not useful, or continue to use them even if ineffective.
Other forms of coping may include development of new defense mechanisms or strategies, such as cognitive changes, for example, changing one's attitude about people or planning a different life style.

In coping with a stressor, the individual must recognize and deal with changes in her social environment and consider how changes in herself effect changes in others. In part, successful adaptation includes the individual's satisfaction or acceptance of new behaviors and self-image in terms of how these changes produce a new reality.

**Adaptation Defined**

Adaptation, the (xX) factor, has generally been adopted as the major outcome variable describing disruptions in response to a stressor. The purpose of post-crisis adjustment, or goal of regenerative power (Hansen, 1965), is to reduce or eliminate disruptiveness. Hansen and Johnson (1979) noted however, that it is questionable that reduction of crisis alone is an adequate index of post-crisis adjustment, since disruption may stimulate desirable changes in an individual's life. Adaptation, then, may be the result of an individual's ability to prevent an event from disrupting one's life, or the creation of desirable changes which enhance one's life. Coping is the process by which the impact of the event, perception, and resources interact to produce adaptation.

The definition of adaptation involves not only adequate levels of functioning, but also the individual's perception of self as successfully managing the impact of the stressor event. The individual does not live in a vacuum, but is part of a social network so that changes in the individual and in others who make up her social world affect each other, as well as the nature and quality of their interaction and relationship. An aspect of coping then includes recognition of this
interaction and that changes in part of the system, effect changes in the total system. The positive end of the continuum of adaptation is bonadaptation, characterized by a balance at two levels of functioning: member to family and member to community. If demands from member or family exceed the capabilities of either, an imbalance occurs which may disturb functioning at either or both levels.

A balance results in maintenance or strengthening of individual and family integrity, continued promotion of both member and family development, and maintenance of individual and family independence and sense of control over environmental influences. Maladaptation on the negative end of the continuum is characterized by continued imbalance at either level, member to family, or member or family to community, or the achievement of a balance at both levels, but at a price in terms of deterioration in individual integrity, curtailment or deterioration in personal development or as loss or decline in the individual's or family's independence and autonomy (McCubbin & Patterson, 1983).

Because adaptation involves the management of often competing dimensions of life such as independence versus need for support, it is likely to involve compromise. Individuals who tend to adhere to rigid expectations for self and others will have difficulty compromising. The disorganization of personal functioning, characteristic of rape trauma syndrome, produces internal chaos, which may pave the way for openness and flexibility in management of the crisis or, in others, elicit a strong retreat to rigid and limited options in an effort to restore equilibrium. Denial or minimization of the impact of rape is a frequent response among victims. Characterizing the need to return to the "old self" rather than tolerate the ambiguity of attempting compromises or new options. Eleven women in this study viewed this victimization as a threat to their identity which elicited strong resistance to changes in an effort to restore the previous identity.
Application of Coping and Adaptation to Findings

Evaluation of women's adaptation to the rape crisis involved several major elements which affected the coping process. This process involved the interaction of post-crisis variables, such as the pile-up of stressors and the utilization and assessment of the benefits of resources. Subjects' overall perception of these interacting variables are presented in this chapter. Adaptation is the outcome variable of the coping process and is described in the last section of this chapter.

McCubbin and Patterson (1983) reported that post-crisis stressors can contribute to the difficulty and effectiveness of coping attempts in a crisis situation. In coping with victimization, women were faced with a pile-up of stressors resulting from (1) the hardships of the initial stressor event, (2) which increased and persisted over time, (3) the consequences of efforts to cope with the rape, (4) additional life changes, and (5) ambiguity related to the availability and usefulness of resources, expectations about reactions by others to them, and the outcome of the trial. These various factors constituted the pile-up of stressors which for some victims' account for their coping abilities, and for others, served as challenges which promoted new growth and improved satisfaction with self.

Long-term Hardships Associated with Rape

The major stressor event in this study, according to McCubbin and Patterson's (1983) model would be the rape and its impact upon the individual. The impact of rape includes those emotional, cognitive, and behavioral responses resulting from the crisis event and subsequent attempts to deal with both the rape and reactions to the rape. Long-term reactions, by virtue of their persistence over time, may become additional hardships for victims as symptoms which reflect their attempts to cope with the rape. These symptoms may represent coping and
defense mechanisms which serve a healing purpose when they are effective, or may create additional stressors for the victims when they are ineffective. The very effort to deal with the consequences of the rape as well as subsequent changes in themselves (which were often viewed as ego-dysyntonic) created an imbalance in functioning for all victims. Hence, coping efforts depending on their success, may be additional stressors, or internal resources.

Most rape researchers define long-term reactions to rape as beginning several weeks after the assault and continuing for one to two years post-rape. Relatively few researchers have challenged the idea that long-term reactions end by one to two years. Burgess and Holstrom (1974), Dowelko (1981), and Heppner and Heppner (1977) have suggested that recovery may last indefinitely.

The length of time which has passed since the assault among victims was from one year and three-quarters to ten years. Some long-term reactions were previously noted in the discussion of short-term reactions in Chapter IV, reflecting the fact the "boundaries" researchers have defined for short and long-term phases are not that distinct.

For twelve of the women, at least three to four years had passed since the assault, yet all subjects were still experiencing symptoms at the time of the interview. Many women did comment that some symptoms they initially experienced had been forgotten. By asking questions about commonly experienced symptoms, many of the women were able to recall whether these reactions had occurred.

There is one contaminating factor in the analysis of long-term reactions in this study. Because it was necessary to wait until both trials were completed before interviewing, all subjects stated that the trial had resurrected old symptoms which they had thought were mastered, or that new symptoms had emerged.
Hence, some symptoms which were reported were either more severe or had reappeared because of the stress of the trial and having to recall the actual assault in order to testify. This quote is a dramatic example of a victim's relapse as the woman had used extensive denial to cope with the impact of rape the first two years following the assault and now was unable to utilize that defense any longer:

After I had gotten notice of the trial, I went through just a real hair-raising episode. I was at the time going to an HMO and had crisis services and I wasn't there as an emergency to see their counselor and then I continued to see him for several sessions. He said I was having flashbacks, triggered by having to go to court and rehashing the whole thing in my mind and at those meetings, I actually felt like I went crazy, and I asked him to lock me up. He said, I'll lock you up if you think you need to be, but you don't need to be, so it was very strange to me until I was through it. I felt like I worked through some things I hadn't worked through before. I was intellectualizing a lot.

Another problem with the validity of studies such as this one is the possible distortion of facts because of subject's reconstruction of past events or poor memory. All the women, however, remembered what they perceived as important and gave detailed descriptions which were consistent with other data they had shared. Subjects were also open about admitting what they did not remember well. **Stigma as Hardship**

Another major hardship associated with the stressor event was the stigma of rape. In addition to coping with the impact of rape, victims had to face the reality of society's perception of the victim. The stigma of being raped implies a defect in the victim's character, or judgment and places responsibility upon the victim for
precipitating the rape (Brown-Miller; 1975; Burgess & Holstrom, 1974). People are inclined to think that individuals get what they deserve and deserve what they get, a "Just World" hypothesis described by Lerner (1966). Regardless, then, of whether the victim holds these beliefs herself, her social world includes the awareness of such beliefs.

Part of the stigma for some of these women in being victims was viewing themselves, or being viewed, as careless or weak, since women previously viewed themselves as competent, strong, independent individuals. When asked about the kind of responses a victim received from others who knew she was assaulted, one woman said:

Oh, different ones, a lot of them were amazed...it's the biggest rape case ever, and you're involved and they look at you and think, God, she must have done something because that's the kind of impression people have of a woman who gets raped. Here I am, the top woman at this business, I'm a role model for other women and it's like I want them to know normal people get raped. I don't come with my skirts slit up to here and I'm not weak and incompetent.

In addition to the stigma of the rape, all women thought about seeking professional help in dealing with the impact of the rape or related problems. For most of these women, there was also a stigma attached to needing mental health services. As McCubbin and Patterson (1983) point out, coping attempts, or the resources sought to help a victim cope, may in themselves create stress. One woman's reaction was:

I really didn't want to go to a mental health center. It's like not only was I raped, but now people will think I'm crazy, I worried maybe I was crazy.
In this study, the stigma of rape was relatively less severe since the rapes were in a sense "legitimized" by several factors. Because the suspected rapist forced entry into victim's homes at night while they were sleeping, "blaming the victim" was not as easy. Also, over time, the community became more aware of a large number of victims raped by a single assailant. Once the suspected rapist was apprehended, the rapes were "legitimized" as perpetuated by a stranger who had successfully eluded police for fifteen years. News media coverage reported the suspected rapist's motivations and methods, creating community recognition and sympathy for the victims.

A third issue was seeking an explanation for having been selected as a victim of rape. All women used this cognitive strategy of coping with the impact of the rape to successfully resolve issues of self-blame which increased during the short-term phase as part of their adaptation to rape during the long-term phase, and to accept that crime can happen to anyone regardless of circumstance. Finding an answer to "why me" did not mean that victims blamed themselves for the rape, but rather was an effort to make sense out of a senseless act. As Burgess and Holstrom (1974) explained, victims need to regain a sense of being in control of their lives and often search for what alternative behaviors they could have made that would have prevented their rape. Satisfying one's self with a causal chain of events helps to restore some predictability to life. Regaining a sense of control over one's life is an important factor in coping, with the impact of rape and a primary activity of the long-term phase.

In struggling with the intense feelings of powerlessness, vulnerability to attack, and loss of control over their life, victims were willing to establish some sense of control by assuming the risk for vulnerability; e.g., by believing for a time, that an open window was the reason they were victimized.
Other women associated the rape with other negative experiences in their life, and sought deeper explanations for being selected as victim. Exploring deeper explanations, one woman said:

I wondered if by being open and friendly and risk-taking I somehow appeared vulnerable to rape, an easy target or something, good God, does a person have to be on guard all the time so some nut doesn't assault them?

Another woman responded:

Why me? I tried to answer that one for years, I didn't deserve this, I didn't do anything careless, even if I did, this just doesn't make sense to me.

As time passed and the suspected rapist was identified, and his motivation and methods revealed, women were more able to make sense out of the crime. All women in this study shifted then from "assuming the risk" and taking personal responsibility to sociological, political, and psychological explanations for the assault. Because rape is so intimate a violation, the victim readily seeks to personalize the cause of rape. A turning point in recovery, then, is the shift from the personal to the societal meaning of rape. This shift is a cognitive change which represents another aspect of the coping process. As Burgess and Holstrom (1974), and White and Rollins (1981) have pointed out, externalization of blame for the rape must occur if adaptation is to be positive.

Metzger's (1976) analysis of the societal motivation of rape describes the point of view that these victims eventually shared as a result of thinking about the rape as a reflection of broader issues. Representative of externalizing blame, one woman reported:
I finally stopped thinking about what circumstances led him to assault me and started noticing things wrong with society. I mean I wasn't the only woman raped, and the reasons he chose women were of his own crazy mind. I realized that women are the only ones, women and old people who suffer the worst things at the hands of men. I began to notice discrepancies at work in the use of power and the sexist attitudes of most of the men there. I'm aware now how easily a woman can be victimized, but I see that as a problem of society.

Another difficulty for victims in coping with the impact of the assault was the absence of knowable human qualities of the attacker. Fifteen women were not able to identify the suspected rapist, as they did not see him. This inability of the victim to be able to relate to or view the rapist as a person made the experience more dehumanizing. There is less a quality of unreality to an act if two people can know each other on equal terms at some level. Most women shared this woman's perspective:

For six years, he was a phantom. I had nightmares about the assault that were more like he was a demon, rather than human. I had not seen him, so he was faceless, he was so controlled that he seemed like a machine, no vulnerability, no way to know or think of him as a person. If I could have, it would have made it less frightening afterwards.

Another woman's reaction was:

Eight years before I knew who he was—what a relief. He was no longer an unknowable entity. Now I have a name, a face. He's not gotten away with it.
A few women felt they got to know the rapist and some of his human frailties.

I told him God would forgive him for what he was doing. He said, "God would forgive me for this?", like he really didn't expect that. In a way, I felt sorry for him, like he really couldn't control what he was doing. He called my landlady afterwards and told her to check on me. He said he wanted to get caught.

The psychic energy needed to cope with the trauma of rape over time depleted women's energy for other tasks or projects which they had hoped to pursue. Efforts by victims to protect themselves frequently limited their social activities.

Additional life changes that required attention also created a pile-up of stressors. Developmental issues, such as separation from parents or spouses, raised children or academic careers are not easily negotiated when the victim's resources also had to be directed towards dealing with the assault. An overload of changes depletes coping resources and creates increased stress. Characteristic of the increased pile-up, one woman said:

I went to bed crying every night, living with fear that overwhelmed me, to the point of being crazy. I had a gun by my bed, cocked and ready to go off at anyone who came in the door, and my son would got up in the middle of the night and come into my room. And I'm supposed to be his mother, and reassure him, and I'm falling apart.... I've got this rage and you know, it affects families. I'm a role model and he's seen this rage pop up and now he has problems at school and I know that it is a direct result of me and the rape. It's like another way that the thing never leaves you, hurts you again, because you are feeling responsible for the way your son has learned to behave because of what you are going through, even though you don't want to do it.
Availability of Support

The ambiguity of social interactions also created additional stresses for victims. All women reported not being able to predict how others might respond to them following the rape. The anticipation of possible negative responses created a dilemma regarding whether to discuss the rape with others, or to expect support from them.

The totality of the impact of rape on the victim cannot be overstated. Major facets of daily living as well as the future have been permanently altered. As Webb (1970), and Burgess and Holstrom (1974) noted, support from others is the single, most important resource in the victim's recovery. The victims in this study, at times, perceived support as lacking or inadequate from some significant others.

As mentioned in Chapter IV regarding short-term reactions, victims in the early stages of recovery (the first six months) are already vulnerable to rejection or criticism, and usually ambivalent about seeking support. Ineffective communication persisted throughout the long-term reaction phase. Most victims did not ask for clarification about other's reactions to them. Most of the women passively waited for others to talk about the rape, taking that as an indication that others were interested before they asked for any specific help. Others falsely assumed lack of support because of certain responses from significant others. Representative of the reasons for not bringing up the subject of rape, one woman said:

I did not want to say anything at work because I didn't know how people would feel, when they said they were sorry or asked how I was, I thought then, they might be supportive.

Another woman reported:

I wasn't going to bring it up unless someone else did. It was too hard for me to talk about it unless I knew someone was willing to listen.
Many of the women recognized later in their recovery that they had misinterpreted other's behavior as negative when in fact others were waiting for an indication from the victim as to what she wanted from them. These women realized that others had just as much difficulty knowing how to help and feeling uncertain as to how they should behave as did the victim.

Another aspect relating to the perception and expectation of support was the fact that most women were not sure what they wanted from others, and therefore rejected overtures of help, sent ambiguous messages about what they expected, or were not able to evaluate other's reactions to them as helpful or unhelpful because they did not know what they needed or wanted. Given these characteristic behaviors of victims during earlier stages of recovery, it is understandable how significant others felt helpless and confused about how to offer support and may have withdrawn their concern out of frustration or perceived rejection by the victim. Difficulties in assessing and securing support were characteristic of problems experienced well beyond the first few months following the rape.

When asked to look back on what people did to help, most victims reported that while they did not always know what they wanted, others who listened and offered their presence and willingness to do things for the victim were seen as helpful. Nearly all the women were concerned that significant others would not want to hear about the assault or felt that asking for help from others would be expecting too much and might damage important relationships, hence creating another loss.

One group of significant others were generally perceived by women to be critical, or unsupportive of them during recovery, and this group also has been reported by Burgess and Holstrom (1974) to be the least supportive of significant others. In this study, nine of the 17 subjects indicated that co-workers and bosses
were unsupportive. Bosses were concerned that the victim might not perform as well on the job or would quit. In a few cases, the women were harrassed on the job and were fired or sought transfers. Co-workers were seen as frequently unsupportive, asking inappropriate questions about the assault or making sexist remarks about rape victims, such as asking if the victims enjoyed the rape or knew the rapist since he broke into her home.

The other eight women reported either no problems with co-worker responses to them or that co-workers were, in fact, supportive of them, taking them to lunch or sympathizing with them.

**Resources in Coping with Victimization**

Resources are part of an individual's capabilities for meeting the demands and needs created by the crisis. Interacting with stressor demands and the individual's perception of the total situation, resources are utilized then in the coping process, leading to eventual adaptation to the crisis at some level (McCubbin & Patterson, 1983).

Webb (1980), and Burgess and Holstrom (1974, 1979), as well as numerous other researchers, noted that psychological or emotional support is the major factor in determining the duration and quality of recovery. They imply, then, that external resources, such as support from significant others or community services, are more influential than the singular efforts of the individual to cope. Scott and Hewitt (1983), however, suggest that support must be perceived as such if it is to exist in the experience of the individual.

The resources used during the long-term impact phase by victims in this sample can be categorized as external and internally located resources. External resources include support from significant others and community services. Internal resources are the individual's personal coping abilities, their defenses, personality traits, intelligence, communication skills, etc.
Primary external sources of support in rank order of importance to victim:

- Male significant other (n=14)
- Friends (n=9)
- Family (n=7)
- Mental Health Practitioners (n=6)
- Co-workers, employers (n=4).

Perception of Support from Male Significant Others

The loss of autonomy and independence, fear of being alone, need for protection and love motivated nearly all the women to seek support from a male during the long-term phase (Crenshaw, 1978). Miller, William, and Bernstein (1982), Veronen (1982), and Feuerstein (1982) report a high frequency of broken relationships following an assault because of various problems such as the man viewing himself as victim, and the victim's needs overtaxing the relationship as mentioned earlier on short-term reactions. Fewer relationships ended in this sample than one might predict from previous research. Six women perceived the breakup of an important relationship to be related to the stress of the rape. However, this perception of the victim may not be valid as other factors also interacted over time, such as previous relationship problems or unreasonable expectations by the victim, such as demand for constant companionship. Despite the breakup of a relationship for some women at the time of the assault, nearly all (n=15) women sought other relationships with men.

Four women married a man they either knew at the time of the assault or met within six months after the assault. One woman, married at the time of the rape, remained married. Two other women maintained a close monogamous relationship with a man without being married for at least eight years. Four women remained in relationships they perceived as negative because of their need for protection, security, and the fear of not finding someone else. Two of these four women remained in these relationships for six to eight years.
I was so upset because my boyfriend couldn't be with me and it was "that's all I needed", and I made up my mind very shortly after that I was going to end it. There were lots of problems but it still took me a long time to finally do it.

Four women sought relationships but did not succeed in finding one which satisfied them. Two women had not dated following the assault, and were not interested in doing so at the time of the interview. Both these women reported that previous heterosexual relationships had been generally unsatisfying prior to the assault, and that they did not think they could handle dating because of their distrust of men in general, and expectations that they would be hurt emotionally.

In general, eleven of the seventeen women were able to discover, maintain, or improve supportive relationships with a man by the end of the first year after the assault. These women reported that the relationships provided them with an increased sense of security. They perceived the men as caring about them and willing to listen and support them throughout the duration of their relationship. These women often stated that they believed these relationships were necessary components which enhanced their ability to cope. The support and acceptance perceived by victims restored confidence that they were still desirable, worthy of concern, and able to enjoy intimacy with another.

These relationships were not without conflict or strain, but were perceived by victims as essential to their ability to cope.

Six women reported negative experiences with boyfriends, such as blaming them for the assault, withdrawing from them emotionally and sexually, or being unwilling to provide emotional support by listening and responding to rape-related feelings and concerns.
One woman recently left her husband because he could not stay with her enough, and three other women admitted remaining in the relationship because they were not able to deal with rape-related issues such as meeting other men, phobias, or the need to be accepted by a man in a different way.

In summary, fifteen of the subjects had experienced at least one relationship with a male significant other that was perceived as supportive by the women. These experiences served to restore trust in men, validate their continued desirability to men, provide opportunities to resume normal sexual relations and intimate relationships. One woman summarized these feelings as:

I needed to know that my life meant something to him. I needed to know I was still lovable, to be held, protected, and taken care of for a while. His acceptance of the rape, his concern and helpfulness got me through this.

In terms of dealing with the need to regain one's autonomy and independence, twelve of the women maintained close relationships with a man following the assault. In part, their determination to remain in good or even troublesome relationships served to help them avoid being alone, to feel safe and protected, and to reaffirm their existence as lovable people. In doing so, some of these women avoided or slowed down the process of regaining autonomy since they cohabitated or married the man rather than date him and maintain a single life style. Increased dependency and social isolation was worth the benefits gained from these relationships in the perception of these women. Considering that nearly all women experienced phobic symptoms and increased dependency, cohabitating or marrying a man may represent an attempt at coping which sacrifices or compromises a more complete resolution of autonomy issues and management of disturbing affect. As one survivor stated:
We have many problems in our relationship, if I'd count, there are more reasons to break up than to stay, but I look to him for protection. I'm afraid, any new man I met, well, you could misjudge a character. I have a great fear of being involved with anyone. That's what keeps me in the relationship, isn't that terrible, but I feel comfortable with him, not afraid.

Parents offered emotional support, the safety of their homes, financial assistance, advice, and reassurance of their caring to the victim. Mothers, in particular, were seen as supportive in allowing their daughters to regress to earlier levels of dependency. Mothers were more able to identify with their daughter's experience and could empathize. They were perceived as sensitive to their daughter's feelings and fears. Victims reported that their mothers were generally strong sources of support although the rape created some disturbing and painful experiences for them. Five women viewed their fathers as protective, e.g. offering to change locks, move them to new residences, and offering advice on dealing with employers.

The other ten women reported various types of problems in obtaining support from parents or siblings throughout the long process of adaptation. Typically, these problems related to mothers who were perceived as insensitive or critical of their daughters or who lived too far away or were simply too unstable to be able to provide support. Some parents were perceived as communicating to their daughters that they did not want to hear about the assault by changing the subject or making comments that they should forget it. One woman said:

My father, I have no contact with. My mother, it was sort of a thing where she found it hard to believe that this happened to her. I didn't get much support from her, but then I never have. She moved out of
town about a month later (this woman had moved in with her mother) and my brother and sister went with her and the rest of the family still doesn't know.

Another woman said:

My mom was real upset at first, she was helpful at first, making sure I ate, but when she saw how much I was partying she'd just sit and stare and she didn't like that. She's the kind of person who doesn't like weakness and thinks that you should get over it just like that. She wasn't very tolerant at all. She helped financially, but as far as talking to me, she wasn't helpful at all. We got into arguments, I finally told her, you expect people to be like you and react to things the ways you do and that's not going to be, so let me be myself. I told her I appreciated her letting me stay with her, but could she just let me recuperate the way I can for myself, instead of her way. Now we don't see each other much.

Another woman said:

My brother's reactions were pretty interesting, not what I expected at all. I imagined them getting really mad, but it's like they controlled their anger and like everybody else, they didn't talk about it unless I brought it up. It was like they didn't care, I know now they did, but then I felt like they don't even care. My father was pretty upset, he cried. I talked to him and we hung out for a while, and I'm sure I got him real upset, it's hard for him because he's a christian-type person, and this was real hard for him to deal with.
One woman's relationship with her mother is closer now:

Interviewer: What was her reaction?

Subject: She was just sick. I mean she went through as much as I went through as far as not being able to sleep. She lost a lot of weight. And I can understand that because if that had happened to my daughter, it's just as if my daughter....My mother is very supportive. We have big phone bills because we call each other all the time, we're even closer now than we were before. It was very painful because we both needed Dad, and he's gone (father deceased).

Support from family, then, allowed seven of these women to feel comfortable and safe depending on them and returning more to the role of a child.

**Perceived Support from Friends**

Support from friends was a primary resource for nine women. Whiston (1981) believes few people are comfortable with rape victims. She found that although it seems logical that other women would be supportive and understanding of the victim, the opposite is often true. Fortunately, many of the women whose families were not available or willing to offer support, did perceive some friends as supportive.

Friends were described as willing to listen, to be willing to stay with the victim, to offer advice or feedback, and to share the pain of the assault. Typical of the importance of friends to a victim:

I think if I had been alone without friends or without feeling their concern, I think it would have been different for me. It made a vast difference to me that you know, that everybody without having to ask them, they just rushed, they took a flight, or drove right over to see me and everybody treated me with great consideration.
Another woman shared how a friend helped her verbalize her experience:

My friend's got a degree in anthropology and she's studied women. She hasn't ever been raped or anything, but it's funny, because she helped me verbalize a lot of my feelings and I think you know, I've helped her a lot by being raped. I mean she actually sees a close friend of hers go through it, I can't imagine where I would be if she hadn't been there. I would have hated men, I just didn't like their aggressive behavior, pointing at me, throwing something on the wall, I got really angry with men. I started to see things wrong with society. All the things wrong with society that are directed against women and helpless people are done by men. I think talking about that to male friends helped them see some things. They would be just furious with me when I'd say things to piss them off, but they started understanding what I was talking about.

Other women stated: "My friends were totally supportive, it didn't matter to them what the cause was. If it hadn't been for them, I'd been totally lost." "Three people came and stayed with me. I think they knew I was out of commission, and that I needed them."

One woman felt hurt by her roommate-friend's reaction:

My roommate resented the attention I got. The rapist had meant to rape her, she said. "If I had been there, I would have done this, it should have been me, I could have handled it." She told me to be strong. That really bothered me because it was saying I wasn't strong to begin with. My roommate kept the doors open, came in late at night, isolated herself with her boyfriends and really ostracized me. We don't talk at all now. Luckily, when I came back to town, I met a
woman who lived two doors down. She knew what had happened because the complex told everybody to be careful. She said whatever, whenever you need something, you just let me know. I didn't even know her, but we got to be best friends. She was tremendous, I couldn't have gotten through it without her. She stayed with me at night, she took me places, she listened. She's been there over the years now.

Other women reported that friends were supportive only the first few weeks following the rape and seemed more remote after that. As Whiston (1981) states, many people are uncomfortable with the rape, feel helpless or distressed. They distance themselves from the victim to relive those feelings. The lack of support from friends was quite painful for some victims, as this woman stated:

It's like it makes all the difference in the world that somebody is there...and you know it's just, I guess acknowledgement that I will get through this no matter if you are here or not, but it certainly would have been a lot less painful if they would have been here for me, and I could have talked to them. I mean it cut me to shreds and that's what I was trying to recover from anyway, not so much the rape, but the jolt to my emotional well being from the rape, and they just contributed to that even more.

Support from family, boyfriends or husbands, and friends represented affirmation of the victim's worth and countered fears of loss of those who were important to the victim. For those women, then, whose families or friends were not perceived as supportive or concerned, they had to cope with an additional loss and feelings of anger or depression. Although every woman reported at least one person who was seen as supportive, many felt that support was insufficient at times.
during their recovery. In particular, the more time which elapsed following the rape, the more women perceived some friends or family members as withdrawing support. Women commented that it seemed as though people expected them to recover much more quickly than was possible, or did not understand their feelings, and gave rise to feelings of guilt, isolation, or depression. One woman reflected:

It's like, okay, we've listened and helped you move, so get over it already...people just don't understand that you can't put this thing in a little box and put it away. It affects you every day of your life. I mean, I'm a lot better now, but there are times when I get depressed, like when the anniversary date comes up or when the trial came up and no one seemed to think that was real or worth dealing with or something.

Another woman best described what most women felt:

I wish I had a scar or something so people would know how I've been hurt. Everybody would say, "you're so strong, you've done so wonderfully." Well, the person on the outside was very proud she'd made it, I mean you want to be that way, you want to conquer the thing, but there are times when it's got you surrounded--the inside person is a fake...saying you've put on a good show, but they don't know you go to sleep crying every night. After a while, nobody asked about it, I could see it on their faces, like, "well you weren't beaten up, you're alive, so there's the bright side." Well, there's no bright side to me. You know, if you're killed that's a hell of a way to learn that you're lucky, not being dead.
Community Services

Most researchers on rape trauma syndrome have defined recovery as a relatively short-term process and hence, recommend treatment immediately following the rape, yet acknowledge that many victims do not seek treatment because of denial, the stigma of rape, or being a mental health care consumer. Burgess and Holstrom (1974), Heppner and Heppner (1977), and Forman (1980) have questioned the accuracy of the assumption that recovery is a short-term process, unless the victim has prior mental health needs. They have suggested that rape trauma may take years for a victim to resolve, necessitating long-term or repeated periods of treatment.

In this study, therapeutic support includes mental health practitioners, pastoral counselors, and the services offered by a local women's group. Sixteen of the seventeen women interviewed sought support from one or more of these groups. Six women perceived treatment they received from community services to be major support resources in terms of coping with the assault. Many women stated they did not know who to contact, or how to select a practitioner.

The women's rape center offered a crisis phone line, and depending on the year a victim contacted them, some services were not available, such as a crisis worker who would come to the victim's house and accompany them to the hospital. Despite the singular focus of this group on helping rape victims, only four women reported satisfaction with the services. One woman's response to these services was:

The woman they sent to my house was very helpful. She calmed me down and she definitely could relate to what I was experiencing. She went to the hospital with me and was very knowledgeable about what was supposed to happen. She was openly hostile or defensive though, and I worried about a scene with the police because I hadn't decided
on reporting it yet. I liked her and was glad she was there. They had
a support group, but with all the other changes in my life, I didn't
have the time to go, and I was seeing a counselor anyway.

Of extreme importance to a victim's ability to seek and utilize community
support was the quality and responsiveness of the first contact to the victim's
needs. Most of the women who contacted a community agency contacted the
Women's Rape Center first, although only two women continued contact for one or
two years following the rape.

Ten women eventually sought professional help from pastoral counselors or
mental health centers. None of these practitioners stated they were experienced
in dealing with rape victims and none of the counselors included significant others
in treatment. Only two of these ten women remained in treatment for more than
five sessions. These women were involved in treatment for years. The other eight
women either received short-term counseling or sought short-term (less than five
sessions) treatment several times over the course of years.

Generally, women described their treatment experiences as at least some­
what helpful. In most cases the women wished they had continued in treatment and
did not do so for several reasons. Major obstacles to continuing treatment were
the cost of service, and the location and time of the appointment.

The counselor was very helpful, but at $60 an hour I couldn't afford to
go as often as I needed. On top of that, the center was in a
neighborhood that was not safe, and the appointments were at night.
I was just too scared. It was too difficult to deal with the fears just
to go get help.
A woman's positive experience:

The counselor really helped me to see just how much pressure I put on myself to be perfect and to get through this like nothing happened.

She really helped, we had a good rapport.

None of the counselors included significant others in the treatment process. Given the difficulties women reported with family members, friends or boyfriends, inclusion of these important people was viewed by victims as helpful in reducing stresses in the relationships or decreasing the risk that these relationships would deteriorate or end.

Group counseling or support groups have also been recommended as useful interventions for the rape victim (Heppner & Heppner, 1977; Orzek, 1983). Only one woman was referred for group counseling, and terminated after one session because she was not prepared to listen to other women's problems. Twelve women believed group support would have been a strong resource for them.

Lack of adequate financial resources have been viewed as a hardship for victims and continued to be so when they sought treatment at various times over the years. Despite interest in services, victims stated they choose not to continue because of the cost. Only one woman had been informed that the Victim's Compensation Fund would reimburse her for services and she reported that it took a year for her claim to be processed. During that time, she was sent notices from a collection agency about her overdue bill at the mental health center and therefore she terminated treatment after one year.

Benefits of treatment were compromised by counselors not being knowledgeable about rape trauma syndrome. Victims reported that they wanted to know what to expect or how to cope with symptoms and counselors seemed to have little knowledge about rape. Some women commented that counselors avoided discussing
the rape and focused more on dating relationships or job issues, or told victims that everything would simply get better with time. These types of interventions tended to increase feelings that victims would have to cope in their own way with less support than they had expected.

Positive aspects of counseling were victims' belief that counseling did help them cope with the rape by providing someone who would listen, provided specific suggestions on how to cope with certain symptoms and helped women to be less critical of themselves. Counselors fostered victims' acceptance of their reactions as normal and encouraged victims to request support from significant others, or to change their unrealistic expectations for recovery.

**Internal Resources**

During the long-term phase of adaptation, both internal and external resources are utilized by victims to continue coping with the assault. The utilization of external resources depend upon and are enhanced by an individual's personal resources. These personal resources include the ability of the individual to protect ego integrity by strengthening or developing defenses, flexibility in changing or developing new behaviors, previous successes in dealing with major developmental or environmental stressors, and ability to seek and use external support.

Because rape is the ultimate violation of the self, short of homicide, with invasion of the inner and most private space of the individual as well as the loss of autonomy and control, damage to one's self-esteem is unavoidable. The preservation or loss of self-esteem is a major element of rape trauma syndrome (Notman & Nadelson, 1976; Hilberman, 1980). Restoration of self-esteem can be characterized by the victim's perception that she is coping adequately with the impact of the rape and other problems which present themselves to her, and that she accepts herself in spite of perceived weaknesses or problems.
One woman noted a change in her self-concept and self-esteem:

I don't know yet that my whole self-concept has changed, but part of it has. How? Strength, seeing myself less as a victim...less as a waif waiting for a man to take care of me...having no control...and society's plans for me...I've gotten over that bothering me.

Internal coping resources involved the management of emotional, cognitive and behavioral experiences which had been disruptive or new for victims. In managing the internal disruption and need to cope with changes in self and environment, fourteen women described the process of restoring self-esteem as one which required substantial effort.

Experiencing the Self as Alien

One of the difficulties in transforming one's self from a damaged to whole person involved taking responsibility for feelings, thoughts and behaviors which are not experienced as under one's control. None of these women wanted to be hurt or believed that they deserved to be so violated. They did not believe that they had done anything that warranted what they experienced, either in being raped or in the sometimes poor treatment they received by others. In addition to suddenly becoming victims, they felt victimized by their own responses--depression, fright, anger, internal reactions which were not experienced as under their control. The loss of control over their lives was something which they did not wish to be responsible for. They had been hurt enough by the rape itself, now they did not wish to do battle with themselves.

The Diagnostic and Statistical Manual, third edition, defines ego-dysyntonic as a symptom or personality trait that is recognized by the individual as unacceptable and undesirable and is experienced as alien. Victims then felt that their phobias, depression, fear symptoms were not acceptable reactions to the
rape, not behaviors they chose to exhibit and not results of their own misconduct or mistakes, but rather results of a horrible experience which was forced upon them.

Interviewer: You said you felt a rage that no one can understand—that it took two years before that feeling was apparent to you?

Subject: Yes, but I think people who have had experiences, that are just now being understood, the Vietnam Veteran thing, people don't know how to deal with that, hiding them under the rug....no one really accepts what we go through, it's all supposed to be neatly over with in a couple of months.

In a conversation with Dr. Pat Semmelman (November 14, 1984), a therapist who has worked extensively with rape victims, this researcher's notions about ego-dysyntonic traits were consistent with Dr. Semmelman's clients' experiences. In discussing this perspective, Dr. Semmelman shared her comparison to the Vietnam Veteran post-traumatic syndrome. The comparison is striking. A man who is obligated to fight a war he does not believe in, to kill a stranger against whom he harbors no malice, to witness the killing of helpless women or children and his buddies, also may feel he is out of control. He may resent that he suffers from experiences over which he had no control and did not wish to participate in. Years later, perhaps despite treatment and support by his family and friends, he is experiencing feelings and thoughts which are ego-alien, his rage, his fears, etc. He often may feel others do not understand his reactions and beliefs, feel frustrated that he is not the person he was before the war and that he did not choose to be the way he is now.

To be captured, in a sense, in one's own personality that does not seem made of choice, is perhaps a living death. The rage at having been so permanently
altered and damaged is not easily directed at the source, i.e., the rapist or the war, in any personally satisfying way. The anger cannot undo what has been done, nor take away the subtle blame that is cast upon those who are not silent about their pain.

A turning point, then, becomes the woman's willingness to give up her belief and expectation that the world is fair, and to take on the making of a new identity, once she has mourned the death of the old one. As one woman explained:

Once I realized I had every right to be out of control, that I didn't have to fight it, or hide it and that no one could really change it, I accepted it and I was okay. I started thinking about what I could do that I would like about myself. I looked at life differently and I was a different person.

In describing her transformation, another woman said:

I stopped seeing myself as a victim, yes, this had been done to me and I was damaged, I had a hard time, but I started to see how much strength I really had too.

One woman viewed the change as a catharsis:

I had gotten to a point of frenzy, and it was dark one night. The next morning at this hotel, I got up and the sun was shining, and I went outside and said, "Oh God, it doesn't look like Star Wars out here, it look like a regular place, not nearly as bad as it did last night," and it was all over with. That served a real purpose for me, a real catharsis. I purged myself that day, I felt great, like I could lift the world, and I said, "I did it!" It turned out that it was absolutely necessary for me to take that trip by myself. I felt strong again.
Another woman spoke about her anger:

I was so mad, I didn't deserve this and my whole life was out of control. I used to complain to my therapist, not only have I been raped, but now I've got all these damn problems with myself that I don't want, didn't create, and don't see how I can change. Who do I get angry at, what good will it do? I liked who I was before and I don't like me now. Yet, over time, I keep functioning and I would associate every bad thing that happened with "here the world goes again, screwing me over," but there were people who cared and there were little things that kept me going and finally, I realized, there were some good things to be realized from all this, I had always thought that from bad experiences there's something to be learned, so I figured this happened to me for some reason, harm or whatever, I better figure out what I should be learning.

Had this not happened, I wouldn't have become so strong, assertive. Now I know I survived nearly being murdered, there are a lot of things I can handle and I have more confidence.

Factors in the Transformation of Self and World View

An important factor in the process of transformation of self and world view is time. Time itself held many meanings for women in this study. Initially, women felt that time stood still, that life had become demarcated by the rape, and that they were caught in a paralysis of pain. Later, time became hope.

Searching for an end to her suffering, a woman said:

I asked my therapist, "how long will it take to recover?" It was as if I could at least look forward to a time when I would be different, an
end to this. She told me usually people are over it in a year, well, she was wrong, it's never over with, you don't get "over it," you live with it.

I did feel better as time went by, but I hated having to realize that no matter what I did, just waiting for time to go by actually helped.

The passing of time allowed intervening experiences to gain importance and to mediate the thoughts and feelings associated with their rape, as well as allow for the effects of supportive resources to ease the suffering. As time passed, women changed internally as well. Their perspective of life changed, their personalities and life style changed as cumulative effects of coping strategies progressed.

With time, the rape became less of a central issue in women's minds, as the desire to change their lives became foremost. Most women reported that they noticed a change in their philosophy of life. Representative of this change was:

I found a new respect for life I don't think I would have felt had I not been raped. I remember tears coming to my eyes that first Christmas, just being so glad I was alive, a reaffirmation of life.

I guess I'd say it's changed to taking responsibility for your life, that nothing is truly an accident, bad things happen to everyone at some time in their life, yet it is the way you deal with them that makes all the difference in the world, and that comes up to me all the time now. I'll never be the same, but after seeing all those women go through this thing, I want to say it was an opportunity for me, that changed my whole being, I'm the only person that's going to get me through this.

As evidence of self-transformation emerged, the development of new behaviors was in a sense like growing up again. Feeling dependent, insecure, and
unsure of themselves, women sorted out their goals, their plans for a new image and identity. They re-evaluated relationships and the meaning of life. Some of these changes were practical ones, based on changes in their view of the world as an unpredictable, unsafe place. These women also recognized and accepted that bad things can happen to anyone and that they would accept responsibility for protecting themselves as best they could against unpredictable harm.

As part of the transformation, specific behavioral changes took place. All seventeen women made permanent changes in their lives to provide more safety, even after the short-term recovery period. They bought locks for doors and windows, guard dogs, guns or took self-defense classes. They moved to different residences which they thought provided more safety. They ordered unlisted phone numbers. Despite disliking having to do these things, they felt safer and that relieved some of the fears. They also were willing to accept that these changes were necessary because of the rape and that they no longer thought that violence happens to someone else.

Eight women described themselves as more assertive and valued this change as quite positive. Representative of these changed feelings were: "I have nothing to apologize for, if someone thinks ill of me, I don't need that person. I stick up for myself," and "I had always been easygoing, doing things for people and never getting angry even when it was warranted."

Another woman said:

After seeing how other people could be so calloused and so unconcerned about important things, I started taking the risk of speaking out. I was scared at first and sometimes I'm probably too aggressive, but I've had so many good experiences asserting myself that I'm glad I changed.
Nine women described themselves as activists:

After I went public in the courtroom, I'd get calls from other women who were raped. I've answered every letter and every call. I had a way to do something about what happens in society.

I worked with Women Against Rape and learned a lot about things I'd not thought about before. I enjoyed being involved.

This woman reported:

Because I feel so strongly about violence in our society and about how others deal or don't deal with it, I make a point to try to get legislation changed, to call up an agency and complain when something seems wrong, or to let them know what might help others.

Eight women found that physical changes were helpful in increasing their self-esteem. Several women took self-defense lessons, while others took up sports which stressed physical fitness, endurance and strength. These efforts resulted in renewed self-confidence and pride in their appearance. Because physical and sexual assault can create a distortion in body image, a woman may view herself as unattractive after an assault. Women who exercised and participated in sports reported feeling less vulnerable and less dissatisfied with their appearance than the women who did not.

I got held up at a bank six months after the rape. That did it; I went to take karate lessons and I loved it. I was stronger physically and I felt that the next time someone tried to victimize me, I would be able to do something to defend myself.

Another woman reported:

I gained a lot of weight after the rape. I hated how I looked. Now, I've lost 45 pounds and it's easy. I just tell myself "he's not going to win again."
Philosophy of Life

Nearly all the women stated their philosophy of life changed as a result of the assault. Most of them had believed life was fair, and that they were in control of their life, until the rape. As one woman summarized:

I'm more pessimistic, more cynical. Just carve out whatever good you can because you're going to get screwed, so find as much happiness as you can. I'm not naive anymore, but I wish I had that innocence I'm never going to have again.

The loss of innocence this woman mentions sums up best how women described the change in their view of themselves and the world. Life held risks and danger that they could not always be aware of or in control of: "I don't blindly trust anything or anyone anymore. Now I expect that bad things can happen to anyone, that is life."

Other changes that women mentioned as helpful were putting more faith in religion, or becoming more involved in nature.

One woman said:

I needed to find beauty and peace somewhere other than just in living itself. I had to find different interests so I would do things to put me in touch with nature.

Another woman described her faith:

I pray for strength, maybe God gives you weakness so that you learn to be humble. I wonder if it happened for a reason, so that I can be compassionate to someone else who has been victimized. I keep a prayer on the bathroom mirror to remind me every day that God works in mysterious ways.

Several other women found writing to be helpful in expressing their feelings and the changes they were experiencing: "I decided to write, it helped put my feelings
Another stated: "I've been writing a book, so that other people can understand what is life and maybe learn something valuable."

**Summary**

Coping with victimization involved a multifaceted process where pre and post-crisis resources, perception and behavioral responses interacted as individuals attempted to achieve a balance or equilibrium following the rape. Coping is conceptualized as the linking of these factors over time to achieve a level of adaptation (McCubbin & Patterson, 1983).

In this study, victims were faced with numerous post-crisis hardships, which brought additional stress as well as benefits. As has been mentioned, external resources in the form of support from significant others was viewed as the most important factor in recovery. Yet, the data also illuminates the importance of internal coping skills that enable the victim to benefit from resources.

**Adaptation**

Hill's "X" factor has generally been adopted as the major outcome variable describing disruption in response to a stressor. Burr (1973) conceived of "crisis as a continuous variable denoting variation in the amount of disruptiveness, incapacitatedness, or disorganization of the individual." Given this definition, it might be concluded that the purpose of post-crisis adjustment is primarily to reduce or eliminate the disruptiveness and restore homostasis. However, disruptions potentially may help an individual to maintain relationships or stimulate desirable changes. It is questionable that reduction of crisis alone is an adequate index of post-crisis adjustment (McCubbin & Patterson, 1983).

Adaptation is a descriptive criterion of post-crisis outcomes, rather than a clearly defined and operationalized set of measures. The concept of adaptation...
describes a continuum of outcomes that reflect efforts to achieve a balance of functioning, and, like coping, may be positive or negative.

Bonadaptation is characterized by the maintenance or strengthening of personal integrity, independence, and a sense of control over environmental influences. Maladaptation, at the negative end of the continuum, is characterized by continued imbalance in functioning or the achievement of a balance but at a price in terms of deterioration in the personal development of the individual, a loss of independence, or deterioration in interpersonal relationships.

In investigating the outcome of coping with victimization, it is clear that the victims' adjustment also cannot be operationally defined and measured. Their adaptation is characterized by movement across the continuum of bonadaptation and maladaptation, depending on the numerous factors presented, such as availability of resources, amount of disruptiveness and perception of the total crisis. Consistent with Hansen's (1965) research, individuals are often observed to transform disruptions and crisis into opportunities and growth.

Researchers and practitioners have tended to define recovery as the absence or decrease over time of rape-related symptoms, which certainly does not describe the victim's quality of life. Forman (1980) defined resolution as the acceptance of the rape and the ability to discuss it without intense affect. Decreases in symptomatology or the ability to discuss the rape without intense affect are only elements in the total meaning of recovery for the victim and may be misleading as a single measure of adaptation. In fact, denial, depression or passive acceptance of the assault may be mistaken for resolution instead of pseudo-adjustment. While objective measures of recovery may have meaning for the rape victim, ultimately she must be satisfied with herself, regardless of how others evaluate her.
The women in this study, as well as the researcher, found Forman's definition and the concept of decreased symptomatology as recovery to be substantially lacking in meaning for them. In discussing what recovery is, women stated that in the earlier stages of dealing with the rape, recovery meant not having any symptoms, "being able to totally wipe out the effect of the rape," or returning to "their old self again." As time passed, however, the change in what constituted recovery for them was integral to bonadaptation.

To further expose the subtle implications of the term, Webster's dictionary (1976) defines "to recover" as (1) to get back, (2) to compensate for something lost, (3) to save one's self a loss of control or poise, (4) to reclaim. As women discussed the meaning of the process of recovery, it became clear that one does not "recover from rape" the way one recovers from the flu or recovers a lost wallet. Yet being able to compensate for the loss, being able to reclaim one's identity, or self-control, are still no less important because they do not fully equate with resolution.

In this study, symptoms did indeed decrease over time, and self-esteem improved. However, when women were asked, "Do you consider yourself recovered?", fifteen answered no. The two women who responded affirmatively qualified their answers by stating that they still experienced symptoms or were troubled by changes in their personality which they did not like. Representative of the majority of women, the following two women reflect their views on recovery:

I don't think you really ever recover from this, ever. I think there will always be a part of me that will be damaged or different. It's damaging to your spirit.

The other stated:

I will never be the same again. I am different and there is nothing I can do to erase what happened, I must accept that I am a different
person. I can never be what I was, I wish I could be, but that person
died in a way; I am a new person now.

Hilberman (1976) notes that "rape is the ultimate violation of self." Rather
than equate the impact of rape with symptoms, Metzger (1976) views rape as a loss
of identity, like death. Rape means that, in essence, the person does not exist in
the previously known identity. In focusing, then, on adaptation to victimization,
one must recognize that the total meaning of the rape for the victim centers on
the formation of a new identity, which incorporates the changing perceptions of
the event, one's resources and hardships, and ability to be satisfied with one's
efforts in dealing with life, past and present.

From Injury to Rebirth

In coping with victimization, the woman faces an enormous task of facing
that she has been damaged physically, emotionally, psychologically, and spiritually
by the rape, by the hardships that may follow, by the difficulties she may
encounter in receiving support, and by the discrepancy which may exist between
her perception of herself and her ego ideal. Denial and minimization are common
attempts to avoid confronting the damage done, yet these defenses do not protect
the victim from her awareness that she has suffered a death blow to life as she
knew it before the rape. Restoration, then, depends upon a woman accepting that
she is changed and that she must change herself, rather than passively waiting for
herself to heal.

Although increased dependency feelings were evidence that these women
were damaged by the rape, they used the support from family to gain their strength
and make decisions about how to restructure their lives. Family support generally
decreased the strong feelings of isolation, alienation, and fear women felt
following the rape.
Some women reported that their relationships with their parents or friends grew closer or improved after the rape. Parents were seen as communicating their respect and admiration for their daughters, which helped to restore self-esteem and confidence. Women also valued and discovered new qualities about their parents. The families were able to bring old and new resources to the crisis, and consequently family closeness, communication and cohesion improved.

The process of developing a new identity involved accepting what had happened to them as real and allowing a period of mourning. As one woman said:

Bad things happen to everyone, I felt entitled to cry and cry I did, a lot. I needed to mourn, to mourn my father's death all over again, and to mourn what happened to me....but I'm a toughy.

As women were able to accept their suffering and think about what this event meant to them, new perspectives on life and what they wished themselves to be emerged. Representative of this perspective:

I'm damaged, yes, there are things I can't do now that I used to, and I hate that, but I am also better....I'm stronger, more realistic, less naive. I have changed for the better, I have learned more about life.

Another woman said:

As time passed I realized I could never be the same person again, she's gone. I'm someone else, different.

For these women, adaptation then was the development of a new self-concept and identity, emerging from total experiences over time following the rape.
CHAPTER VI

SUMMARY, DISCUSSION, RECOMMENDATIONS, AND IMPLICATIONS

Introduction

Using McCubbin and Patterson's 1983 Double ABCX Model of Adaptation to stress, research questions focused on multiple variables over time which interact to produce adaptation. Special attention was paid to the meaning of the victimization to subjects. Ruch and Chandler (1983) have stated that the nature of emotions following a rape are best explained from a symbolic interactionist perspective as the meaning of the victimization is necessarily a function of the social experiences and relationships of the actor, in this study, the sexually assaulted women.

The basic findings were as follows:

1. What is the meaning of rape to the survivor?

All seventeen subjects eventually viewed rape as a violent rather than a sexual act. The significance of this perspective was apparent in the relative lack of self-blame among survivors for the occurrence of the rape. All women experienced the rape as a threat to their life or that of their children's, and viewed the rape as a major crisis in their lifetime. Rape was perceived as a pervasive and dynamic change agent that altered important aspects of life and identity. This confirms Whiston's (1981) belief that rape is similar to death and constitutes a loss of self.
(2) What are the long-term effects of rape described by the survivor?

This study investigated long-term effects ranging from one and three quarters years to ten years duration. Survivors did not believe that rape was a crisis that was short lived. Indeed, at the time of the interview only two women stated they would describe themselves as "recovered". Fifteen women believed that they would experience some effects from the rape indefinitely. The long-term effects noted by most women included continuing fears, anxiety and phobic reactions, a reduced sense of autonomy and independence, cautiousness and mistrust of others. In general, a change in their view of the world from relatively safe to relatively dangerous, and concern that they would not be able to change certain behaviors or aspects of their self-concept which they did not like. Long-term effects also included relapses or development of new symptoms when the rapist was arrested.

(3) What is the coping and adaptation process for survivors in terms of symptoms experienced, ability to seek and use resources, and changes in self-concept?

Several factors were found to be significant in coping and adaptation. The majority of women had to overcome experiencing symptoms as ego-dysyntonic, that is a personality trait or symptom that is unacceptable to the individual and is experienced as alien. Once accepting the rape as a reality, women struggled to accept responsibility for their own reactions as acceptable responses to the rape. Until they did so, they felt re-victimized by their feelings and behavior, over which they felt no more control than they did during the rape. Time was acknowledged as a major resource in coping. The passage of time seemed to allow women to rest and retreat to a more dependent level of functioning, gain perspective, and gather new resources. Time permitted the ambiguous process of developing a new identity to become stabilized.
All victims reported that they had some degree of difficulty in communicating effectively with others who could offer support. These communication problems included lack of initiative in asking for support, failure to perceive support as available when it actually was, failure to give feedback to others about their needs and feelings, concerns about the relationship, or their appreciation of support so that others could assess whether they were being helpful. Women indicated these difficulties were obstacles to receiving or utilizing support and to their adjustment, and that it took several months to several years before they realized their absorption in their own symptoms interfered with more accurate perception and interpretation of social support. All women, however, were able to find support from at least one significant other which helped them to utilize other resources in coping with the rape.

None of the women believed recovery was the best term for the adaptation process. Rather, they believed that one does not recover from rape; one is changed and changes permanently. The adaptation process, then, is not a return to the previously known identity, but the creation of a new identity which incorporates the acceptance of the rape as a significant experience in one's life, with the effects that the rape has brought to bear and the person one chooses to become. The new identity is a paradox: a damaged person mourning the loss of self who sees herself emerging a better person having survived the experience of rape. Women reported continued symptoms which they tolerated, while developing increased self-respect for new-found strengths and capabilities and consequent rewards. Often, women attributed valued new behaviors, attitudes, and personality changes to the effects of the rape and believed that these changes would not have taken place had they not had to battle such a formidable crisis in their lives.
What coping skills are used by survivors to deal with the reactions to rape?

The desire to survive and feel good about one’s self motivated these women to use various coping skills in dealing with the assault. In coping with symptoms, attempts were not always totally beneficial, although they served a purpose or fulfilled a need, such as a need for protection or for reduced expectations for functioning. Nine women maintained or developed a monogamous relationship, cohabitating or marrying within a year following the assault. Most of these women were aware that their need for a committed relationship with a man allowed them to be more dependent and offered them a sense of protection, security, love, and acceptance which may have compromised their resolution of these issues at a higher level.

Despite the apparent contradiction between victims' need to remain independent and their dependence upon a monogamous relationship, this researcher believes it is possible for these needs to co-exist. Although independence may have been compromised for a time in favor of increased dependence on another, the security of a caring relationship can also provide the necessary support for renewed independence.

Women sought support from others, benefitting from the concern and caring of others who were needed to listen, comfort, and take over some tasks for the victim until she could resume more responsibility. Life changes such as moving, restricting certain activities, and implementing self-defense information were used by survivors to cope with the rape. Some women utilized religion or specific philosophies of life to help them accept the rape and motivate them to deal with the hardships it presented. Nearly all (n=15) of the women utilized community resources, such as counseling, through the local women's center, pastoral counselors or mental health practitioners, and found this source of support a beneficial
addition to their other resources, despite complaints regarding the quality or cost of care.

(5) How did survivors view their responses to rape as effecting others?

Women were sensitive to the reactions of others and to the stigma of being a rape victim. All were upset or angered by negative responses from significant others or strangers, and viewed this as a hardship they had to deal with. Generally, women noted that others were also upset by their victimization and were concerned about the possible changes or loss of these relationships as a result of the stress brought to bear on the relationship either by their own needs and reactions, or by the inability of others to deal with their reactions to the rape and to the victim. The women who lost relationships with boyfriends or girlfriends believed that the rape played at least some part in the dissolution of the relationship. Women were particularly insightful about their own behavior creating problems in relationships by the time six months to a year had passed since the rape. Self-absorption, fear of rejection or blame, and intensity of reactions significantly impaired their communication and relationship skills for a brief, or in some cases, an extended period of time.

One-half (n=8) of the women also noted that the crisis of the rape had brought them closer to people important in their lives or introduced them to people they would not have otherwise become close to.

(6) How do survivors want significant others to treat them?

All women mentioned the need to be treated with respect and acceptance following the rape. While many acknowledged their difficulty in communicating what they needed, they wanted others to initiate talking about the rape so that they would know others were not uncomfortable discussing it or were rejecting them because they were raped.
Of primary importance to victims was simply being listened to and comforted, either by verbal or physical responses. Women noted that others frequently would try to comfort by saying they would be alright or that they were strong. Women pointed out that this type of response assumed a feeling that they did not possess, and suggested that others did not want to know how it felt to be victimized or what was needed from them.

Survivors appeared to be accepting the fact that some people cannot deal with such an event or with the need for support, but wished that instead of withdrawing from the victim or being hurtful, that these individuals would clearly state that they did not wish to deal with the issue or the victim.

Most importantly, survivors needed to be validated as still lovable and valued individuals. They did not wish the rape to be a cause for another loss—the loss of acceptance, friendship and caring.

(7) How did the survivor assess and utilize resources, and what would improve them?

All women reported that some services were available and useful to them. Nearly all women made use of counseling services and found them helpful, within certain reservations. The most frequent complaints were that counseling services were too expensive for them to afford. The location and times of appointments were reasons given for terminating treatment too soon. Professionals were seen as not offering enough relevant information about the recovery process, or other resources, or did not have services which were available at the time they were needed.

Most of the women reported that police and hospital services were surprisingly well prepared to meet their emotional needs, and were sensitive to their feelings immediately following the rape.
All but two women in the study were perceived by the interviewer, and
admitted themselves, that they would have benefitted from further treatment.
They had difficulty knowing how to choose the appropriate practitioner or were
demoralized by hardships such as having to go to an appointment when it was dark,
or in a section of town which they perceived as a high-risk crime area. Another
factor which inhibited their utilization of resources was the need to deny or
minimize their problems in order to bolster their self-esteem that they were not
"damaged" or unable to handle the problems by themselves.

All of the women believed that practitioners should be better informed
about the effects of victimization. They recommended that the lack of availability
of self-help support groups be addressed. A theme shared by all women was the
need to meet another woman who had had a similar experience and who successful­
ly coped with it.

The lack of resources were deemed most crucial at the time of the rape and
when the rapist was arrested. The court staff was necessarily limited in their
scope of providing support and the trial was viewed as a second injury for which
there was no compensation except the guilty verdict. For some women, however,
their "day in court" was a point in time which marked closure of many issues and
which allowed them to confront their attacker as no longer an object, and no longer
powerless. Being unable to direct anger at the rapist or the community for so long,
the trial was an appropriate outlet for their anger and restored a sense that some
justice had been served.

All women stated that receiving financial compensation through the Victim
Compensation Funds would have greatly eased financial hardships and constituted
some relief from the psychological pain of victimization. Only one woman,
however, received compensation for treatment. The other women were either not
aware that they could apply for compensation, or in the midst of their crisis did not seek more information as to what compensation would cover and how to apply for it.

**Discussion**

There are several contributions to the research literature stemming from the findings of this study. First, this is the first research where it has been possible to investigate effects among victims of the same rapist, thereby controlling a major variable affecting the impact and recovering from rape, the level of severity of assault. Secondly, long-term effects of rape trauma syndrome lasting over two years have not been explored previously. This study then confirms that women may experience effects from rape that may last indefinitely. A third contribution of this study is the intensive analysis of the subjective perception of the survivor's experiences. Rape research has thoroughly documented rape trauma through inventories, observations and psychological tests. The perception and self-appraisal of the experience of victimization and adaptation has not been investigated over time. These results have contributed to our understanding that objective definitions of recovery may be misleading and ignore crucial aspects of a victim's quality of life following assault. Indeed, the implication that rape crisis is time-limited and of relatively short duration, such as one year, is not supported by these data. The findings from this study support and clarify those from other studies or theories.

**Theoretical Contributions**

By integrating rape research findings with McCubbin and Patterson's (1983) Double ABCX theory, White and Rollins (1981) identified important variables in determining the impact of rape upon couples and their coping ability. This theory
provided a useful framework from which to understand and explain subject's individual reactions to the rape crisis and encompassed all of the variables presented by subjects as effecting their recovery. The theory proposes that the individual's subjective perception of the total situation is an important factor in understanding the level of adaptation achieved through coping efforts. Ruch and Chandler (1983) support this assumption in their statement that sexual assault trauma is best explained through a symbolic interactionist perspective, where the meaning of victimization is necessarily a function of the social experiences and relationships of the actor, the sexually assaulted woman. A major finding in this study is the victim's insistence that objective measures of adaptation, such as continued employment or relief from depression or anxiety, does not capture the meaning of recovery for them. Rather, a major aspect of adaptation is the victim's self-appraisal that a new and acceptable identity has emerged which incorporates all her experiences, whether positive or negative. The utility of this theoretical framework for analysis of normative and non-normative stressors appears to be substantial.

Rape Trauma Syndrome

This study confirms most of the previous literature on rape trauma syndrome described by major researchers of this phenomenon, i.e. Burgess and Holstrom (1974, 1976, 1979), Sutherland and Scherl (1970), and Kilpatrick, Resick and Veronen (1981). Findings indicate that victims of severe assault experience the same symptoms during acute and long-term phases of recovery as victims studied in other research.

Several researchers have suggested specific symptoms that could be expected to be long-term. Confirmed by this study are Notman and Nadelson's (1982) findings that long-term effects from rape include fearfulness, restriction in
freedom and episodes of depression. Also supported by this study are Kilpatrick, Vernonen and Rosick's (1979) conclusions that phobic reactions, fear and anxiety could be expected as long-term reactions. Ellis, Atkeson and Calhoun (1981) noted that their subjects who were victims of sudden violent attacks by strangers were the most depressed and fearful compared to other subjects in their sample. All of the women in this study were victims of a sudden and violent attack by the same stranger and characteristically reported strong fear and anxiety reactions, which resulted frequently in restricted social activity, increased dependence upon a significant other which compromised their independence, phobic reactions and reduced self-esteem, including suicidal ideation.

Anger and feelings of loss of control have been identified as symptoms by most researchers on rape. However, Forman (1980) and Burgess and Holstrom (1974, 1976) focused on how important successful resolution of these feelings were to recovery. This study indicates that for victims of a severe stranger assault, anger and loss of control are major symptoms which trouble women and which impede successful adaptation if not successfully dealt with.

Sexual dysfunctions have also been noted as major symptoms affecting rape victims. In contrast to what other researchers have found (Feldman-Summers, 1981; Feldman-Summers, Gordon and Meagher, 1979; and Notman and Nadelson, 1982), sexual dissatisfaction and dysfunction were not reported as frequent or major concerns by victims in this study. Eight women reported mild sexual dysfunction during the early stages of recovery and only two women complained of sexual dysfunction as a long-term reaction. This incidence is significantly lower than one would expect given other research findings. This finding is somewhat unexpected and surprising in that the nature of the assault was so severe in its violent use of sex as a weapon of torture and humiliation. One possible
explanation of this phenomenon is the subject's perception that their survival was more important than the injury to their sexuality.

Most researchers have defined long-term reactions to rape in terms of one to two years, and noted a decrease of symptoms after six to twelve months following the rape. (See Kilpatrick, Veronen, Resick (1979), Atkeson, Calhoun, Resick and Ellis (1982), Kilpatrick, Resick and Veronen (1981), and Sutherland and Scherl (1970).) Burgess and Holstrom (1974), however, noted that long-term reactions may last indefinitely, later supported by Silverman (1978), White and Rollins (1981) and others. This study confirms that for victims of severe stranger assault, long-term reactions persist in varying degrees indefinitely.

Much of the literature on rape suggests that recovery can be defined as a return to pre-rape levels of functioning, or a decrease in symptomatology over time. Forman (1980) defined recovery as the ability of the victim to discuss the rape without strong affect. In contrast with the majority of opinion regarding recovery, Whiston (1981) believes that rape is more appropriately conceptualized and experienced as a loss which cannot be regained. She views the process of recovery as the formation of a new identity that evaluates and incorporates the past experiences using the losses and changes for growth. Significantly, the women in this study took exception to the definition of recovery as the decrease in symptoms and believed that they were different people, as a result of the rape and were forming new identities.

**Coping**

Ruch and Chandler (1983) reported three major pre-rape factors that reduce coping ability during the acute stage of recovery, substance abuse, mental health problems, and severe life stressors. Women in this study who reported such pre-rape factors did not differ significantly in their reactions or coping ability during the acute stage.
All researchers, and specifically Burgess and Holstrom (1974) and King and Webb (1981), have stated that social support from significant others is the single most important factor in recovery. This notion is supported by the study as women who perceived themselves as securing adequate support reported more self-confidence and higher self-esteem. Interestingly, however, those women who perceived themselves as receiving inadequate support compared by objective standards with the other subjects, were coping as well as the other women. By their own subjective standards, however, these women were more depressed, reported less self-confidence and trust in others, and more relationship problems.

Scott and Hewitt (1983) noted that support cannot be utilized and does not exist in the experience of the victims if it is not perceived as available. Subjects reported that during phases of their recovery they frequently misinterpreted or did not perceive support as available when, in fact, it was. Subjects indicated that these perceptual errors seemed to be the result of emotional fears of rejection or criticism by others, and poor communication on the part of both the victims and their significant others.

Complicating the availability of support, are the findings noted by White and Rollins (1981), Burgess and Holstrom (1974, 1976, 1979) and Orzek (1983) that significant others may also be victims of crisis and may not be able to respond to the victims positively. Subjects in this study reported that they perceived others as experiencing various difficulties themselves in response to the rape, either in terms of personal or interpersonal reactions. In the victim's perception of how support from significant others affects her adaptation, others are critically important to the victim and can thwart or foster recovery depending upon their own reactions and ability to support.
Services from the community are viewed by most researchers as major supportive resources. Researchers have typically recommended short-term counseling for victims of assault. This recommendation is supported by this research, however, the findings indicate that for victims of severe assault, longer participation in counseling is needed. Burgess and Holstrom (1974), Silverman (1978) and Whiston (1981) have recommended that long-term counseling may be more appropriate for victims of assault.

Orzek (1983), Feinauer (1982), and White and Rollins (1981) have recommended that significant others be included in the treatment process in order to deal with their reactions to the rape, offer information and support, and foster adequate communication between significant others and the victims to facilitate recovery. The women in this study did not benefit from this kind of approach when they sought treatment and believed that such an approach would have been beneficial.

Group approaches have also been recommended as appropriate interventions by Kennedy (1983) and Heppner and Heppner (1977). Peer support groups were not utilized by women in this study although they reported a strong desire to participate in such a group and believed that a support group would have many advantages over traditional individual counseling.

Support from community resources has also been evaluated as too often inadequate in its service to victims (Burgess & Holstrom, 1974; Krulewit, 1982; Sutherland & Scherl, 1970). The stigma of rape, poor understanding of rape trauma syndrome, personal discomfort with the victim, and negative societal and political attitudes contribute to inappropriate or inadequate responses to survivors from courts, police, hospital staff, practitioners and the community. Findings from this study suggest that police and hospital staff were generally highly qualified and
sensitive in their dealings with victims. The women's rape crisis center and mental health practitioners were not rated as highly by women because of long waits for treatment or services, minimization of the client's needs, insensitivity to client's needs for safety, and information about recovery and resources.

**Recommendations for Further Research**

(1) It would be misleading to conclude that research on the impact of rape on survivors is complete without consideration of rape's effect on significant others, whose support is crucial to recovery. Further research should examine how significant others react to rape and how they perceive and respond to victims. The current study addresses this need as part of a larger investigation on the impact of rape on survivors, their significant others, and the recovery process.

More information regarding how significant others perceive the victim's response to rape and the difficulties they may have in providing support would add to our knowledge of how support contributes to adaptation or maladaptation, and how community services could assist in helping significant others deal with rape victims.

The rape of a loved one may create a crisis for significant others, who typically are not viewed as potentially needing support or treatment. Research has only begun to consider the effects of victimization on significant others and as crime remains a major problem for our society, we need to better understand the needs of "secondary" victims.

(2) Further research should compare the reactions to rape among women who have experienced different levels of severity of assault to determine how the level of severity of assault affects various aspects of impact and recovery. More studies are needed on specific types of rape; such as comparisons of reactions by victims and significant others in cases of date, marital rape, or gang rape.
(3) More studies are needed with larger samples to confirm both the quantitative and qualitative aspects of adaptation to rape.

(4) Now that research has thoroughly investigated short-term effects and coping with rape, longitudinal studies are needed to investigate the long-term impact of rape more systematically.

(5) Little research has been conducted investigating the use or reluctance to use mental health services for support in recovery. Studies which examine the engagement and treatment process of victims by practitioners would add to our understanding of difficulties in service delivery and treatment quality, and effective approaches.

(6) Because many women experience participation in the criminal justice system as a second "victimization," studies involving court policies, procedures and methods of the court in dealing with victims would clarify how this process might be improved or what can be done to ease the stress of participating in prosecution.

Implications

Numerous implications for the community, service agencies, such as the police, courts and hospitals, and the mental health community can be derived from the findings of this study. Many of these follow from victims' reports of services they believed were lacking, of poor quality, or inaccessible. The following recommendations have been mentioned by at least one victim in the sample.

Community

Holmes (1981) believes that advocacy and community action must be part of the total effort to address the needs of society and the individual victim and her family. Many subjects in this study indicated that others continue to attach a stigma to victims of rape. Given that the stigma of rape and the use of mental
health services create additional hardships for victims and their significant others which may thwart recovery, educating the community is an important step in reducing the impact of rape.

Subjects in this study pointed out that neither they nor significant others were prepared or aware of the possible effects of victimization. They recommended increased community awareness of the hardships associated with victimization and that more information be publicly available regarding resources for victims.

Through media attention, accurate information and positive approaches can lead to changes in the community's perception of victims and rape, and the expulsion of many myths that still surround rape and in one way or another blame the victim. Recently, television and radio stations have invited victims and professionals to speak on the effects of rape. News reports or special features could elaborate on services which are available and how community members can respond positively to someone they know who has been raped.

Newspapers, television and radio stations can also begin to create change in public beliefs about victimization by confronting the denial of most people that victimization is non-selective. As citizens begin to confront their own vulnerability to crime, they may change their beliefs and responses to others who have been victimized. Service agencies through their interaction with each other and the community can also further education about rape and its effects by publishing pamphlets, and giving public seminars on the topic. In this way, they provide needed leadership in reducing stigmatization and increase willingness to address and support victims of crime.
Law Enforcement Services

In the last decade, many police departments have provided specialized training in dealing with victims for street officers and detectives. This training is necessary as the police officer may be the first person a victim meets after an assault, or be the first community representative to confirm positive or negative expectations of how professionals will treat her. It is important, then, that police are trained in recognizing the symptoms of rape trauma syndrome, and are sensitive to the needs of the victim, even though these needs may create a delay in the officers obtaining information needed for the investigation. Police officers may be viewed as reflective of how others will treat the victim or as important sources of support during the investigation and trial process. Sensitivity is necessary in gathering evidence so that the victim does not feel she is being treated like an object or as a criminal. Police should inform victims of resources and victim compensation funds so that victims may begin to utilize these resources without undue delay or mistakenly believe services are not available.

The data from this research indicate that the positive treatment victims received from trained police personnel reduced fears that they might be blamed for the rape or dehumanized by the process of reporting. Generally, victims found police to be understanding of their reactions so that they felt calmer and more willing to follow police recommendations for help or protection.

Hospitals

Hospital personnel are also often the first professionals that a victim may meet following an assault. Equally important as speedy, quality medical care is the psychological treatment of the victim. Crisis intervention almost always begins with police and hospital personnel, necessitating quality training about rape trauma syndrome and crisis intervention techniques. Hospital staff can also inform victims
about possible symptoms which they may experience, refer them to other services, and help them make contact with these agencies. Those women in this study who were able to use a hospital's rape crisis center reported great satisfaction with their services.

While there are differing opinions about whether hospitals are the best choice for victims' short-term needs, a centralized hospital that is recognized by the community and where all rape victims are referred, and which is identified by the police would have distinct advantages. The community and victim can feel secure that such a hospital, specialized in meeting their respective needs, will have adequate staff to quickly handle emergencies, rather than expose victims to a "generic" emergency room where their needs may be seen as minimal or where they are possibly subjected to embarrassing lack of privacy. Cooperation among involved agencies, including police, enhances the quality and smooth operation of all departments.

Women's Rape Crisis Centers

Because women's rape crisis centers may be "grass roots" organizations, they are often inadequately funded or staffed with volunteers who possess differing amounts of training and information. Services may be insufficient at times or unavailable. As a group easily identified as specializing in helping rape victims, ideally these services should provide 24-hour crisis lines, crisis support teams that can accompany a woman to the police department or hospital. Staff should provide victims not only with crisis intervention and support, but with information about other resources. Support groups may help the victim to feel that she is not alone or different, and that she, like other victims, can cope with the crisis in time and with support. Victims in this study looked to the women's center initially expecting the most specialized help from them. Rape is a social problem and crime where societal attitudes and political aspects stigmatize the victim.
However, many victims are not ready to deal with the socio-political aspects of rape until the personal aspects of the rape are addressed. As Metzger (1976) has pointed out, recovery must include recognition that rape is a personal crime perpetuated by a socio-political problem.

As mentioned by a number of women in this study, the personal aspects of victimization are their first concern when seeking help. They believed that directing their attention to the politics of rape too early following their assault seemed to reflect a lack of interest in their personal problems and feelings, and often led them to seek help elsewhere.

Therefore, women's centers staff should be especially self-conscious to prevent over-zealous attempts in fostering the feminist perspective when talking with survivors. Although it is important to raise a person's awareness of rape as a political and feminist issue, a woman's personal needs must be attended to first. In placing the personal before the political, the survivor is better able to view her relationship to other survivors and to gain trust in the helping organization as a group which respects individual women's beliefs. Because some women are concerned about losing their ability to relate to men or losing an important relationship as a result of the rape, discussion of sexist and other negative aspects of male roles in society should be guided by the survivor's readiness to consider these issues. Emphasizing the political before the personal may increase feelings of depersonalization and exploitation by suggesting that a woman's interest in heterosexual relationships is not approved of and further alienates a survivor from an important source of support.

Another issue for personnel at rape crisis centers is the need to be sensitive to the victim's appraisal of her needs. Women who reported being told they were doing well in coping with the rape tended to perceive this message as an indication
they were not deserving of help or that their problems were minimal in the eyes of the worker. Although rape trauma syndrome is not a pathological reaction, many women can benefit from treatment and should not be discouraged if they ask for a referral or information.

**Courts**

Many victims view the justice process as the second victimization (Bard & Sangrey, 1979). Coupled with the police, courts are in an important position to prevent this phenomenon. Knowledge of rape impact along with patience and cooperation are necessary if victims are to endure the often long and difficult process of prosecution. It is unlikely that testifying is perceived as a totally beneficial act with no hardships for the victims. Victim witness staff are important resources for information about the trial, the status and location of the defendant, from whom the victim may fear further attack or threat, and details about what will be expected from the victim.

The trial itself, may be dreaded as victims must relive the rape, and may suffer from relapses. Pressure from family or friends to prosecute or not prosecute may create serious conflicts which affect the victim's memory of events or her composure on the stand. Courts should consider providing as much information about the trial process to the victim and significant others so that inaccurate information is not a source of further trauma and so they can prepare themselves for realistic expectations. Victims are often upset when they discover that as victims they lack some of the same civil rights that the defendant possesses. The courts are in a difficult position as they have no power to rectify these inequities and may seem as powerless as the victim feels.

In response to releasing the rapist on bail before trial, one woman required medication and said:
I was obsessed with it, it's like let's make sure he (the rapist) gets his rights...let's feel sorry for him and to hell with the victim who's got to worry about whether he'll come back and finish us off.

Another woman complained:

He's got all the rights, he can put his money in his wife's name so we can't get compensation, he can delay the trial for two years, he can plead insanity even though he's not crazy--but we are told there is nothing anybody can do, we have to put up with it. It's like he's the victim, but he has all the power.

Legislation

In many states an imbalance exists between defendant and victim's rights (President's Task Force on Victims of Crime, 1982). Examples of this are the defendant's right to a speedy trial, unless waived, while the victim is at the mercy of the defendant's choice, sometimes waiting a year or more for the trial to be heard. Evidence may be lost, memories faded, and witnesses unavailable or unwilling, resulting in dismissals or acquittals of defendants. In many states, maximum sentences for rapists may be less than for property offenders, implying that society values property more than people, and that rape victims are somehow undeserving of full justice. All women in this study were disturbed by these issues relating to victims participating in the criminal justice process.

Plea bargaining may be seen as an arbitrary form of justice, where victims may feel they are not seen as legitimate victims but as co-responsible for the rape, or as statistics that the court wishes to dispose of as quickly as possible. The President's Task Force has stated that the victims of crime have been oppressed by the criminal justice system that was designed to protect them.
Another recommendation of the Task Force which could significantly reduce the perception that the courts commit a second "rape" is to allow victim impact statements at the disposition of the trial. This enables victims not only to be heard as equal parties in the court procedure, but to indicate the extent of injury caused by the crime so that the consequences fit the crime.

Finally, many states now have or are forming victim compensation funds. Given the disorganization and overwhelming effects of victimization in the early stages following a crime, many victims are likely to need not only the information that such compensation exists, but help in applying for assistance, and advocacy if their claim is not handled in a timely fashion. The financial hardships of recovering from victimization can be greatly eased by compensation. All subjects in this study indicated compensation would have eased their hardships had they known how to obtain it. The psychological consequences of all of these factors can be a belief that society and the criminal justice system does work for citizens, and that the victim is validated as not only having been harmed, but as deserving restitution.

**Mental Health Professionals**

Practitioners should recognize that victims may need long-term treatment, without defining such needs as pathological. As Kennedy (1983) suggests, practitioners should assess problems, needs, and resources while also recognizing developmental or situational issues which may complicate the picture. Of special importance, practitioners should be knowledgeable about rape trauma syndrome so that they can recognize symptoms, educate the client about what to expect, and instill confidence with their clients that they can provide competent treatment.

Practitioners should include significant others in the treatment process. As Orzek (1983) and White and Rollin (1981) have noted, significant others may
experience a crisis themselves and need support, and they are major sources of support for the victim. Their inclusion in the treatment process facilitates recovery, may prevent additional stress upon both, and speed treatment and recovery. The subjects in this study all recommended this approach to treatment of future victims.

Practitioners also need to be advocates for the victim. They should be aware of various resources, such as support groups and information related to victims issues such as victim compensation funds, and assist the victim in making contact if she cannot do so herself. As an advocate, the practitioner is also concerned about how the community deals with victims (Heppner & Heppner, 1977). There are times when a practitioner's advocacy efforts model important attitudes and behaviors for the victim as well as convince the victim that the practitioner is concerned about rape as a social problem and the victim as a person.

Treatment Issues and Approaches

Intrinsic to any effective treatment relationship is the attitude and concern of the therapist. In dealing with rape victims, it is especially important to establish rapport with the victim and to be empathetic. Because many women feel dehumanized or depersonalized, and are fearful and distrustful of strangers, genuine expressions of acceptance, warmth, and concern are appropriate. Victims may be denying fears that they will "go crazy" or that they need help; therefore, it is important that the practitioner inform the victim of the various symptoms of rape trauma syndrome and the various ways that other victims have dealt with the impact of rape. Victims reported that this information was a serious omission for their contacts with professionals. It is important that the victim be told what resources are likely to help her the most, and that her response to the rape is dependent on a number of variables, some of which are not totally under her control.
Numerous researchers have recommended short-term crisis intervention and specific techniques for treating symptoms following rape. Practitioners do the victim a disservice by limiting their conception of recovery as a short-term process. Victims who later experience a need for help may view themselves as mentally ill because of such attitudes, and resist entering into treatment.

Specific approaches, such as cognitive restructuring, behavioral techniques, and desensitization may indeed be helpful for specific symptoms with certain individuals. Practitioners should explain their techniques to the victim and for what purpose they are being offered. This author agrees with Whiston (1981) and Koss (personal conversations, October, 1984) that techniques aimed at specific symptom reduction or removal should not be substitutes for holistic treatment, even though they may be effective in alleviating symptoms. The rape victim often has experienced a major disruption in her life, a violation of her body and loss of identity. Adequate time should be given the victim to mourn the losses she has sustained. The victim's perception of the event and of herself and others cannot be addressed through symptom reduction as the data in this study has revealed. Practitioners, therefore, may need to employ ego supportive approaches to facilitate the development or utilization of effective defense mechanisms and the creation of an acceptable and realistic new identity, which incorporates acceptance of the rape with all the changes which have occurred, internally and externally.

Relationships are crucial to the victim's adjustment and, therefore, should be addressed in treatment. Victims' primary fear, other than their mental stability, was the preservation of important relationships. Depending upon the individual, family, friends or coworkers should be included in treatment either individually or conjointly to reduce possible stress or termination of relationships.
Recommendations for Practitioners

Initially, therapists need to assess the victim's needs and resources, and accept her wishes about the level of therapeutic involvement she desires. By showing respect for the victim and being genuinely concerned about her, the victim may decide to return to treatment at a later time, if she initially is not interested in treatment. It is important to inform the victim that although she may recover quite satisfactorily without services, that it is normal and common to experience problems later on and that she may want to seek treatment at that time. Inclusion of significant others in the initial contact allows the therapist to offer information about what to expect as well as advice about how to respond to the victim. Significant others will be better able to steer the victim towards services if they are needed at a later time. Many victims experience fear symptoms and feelings of loss of control. The therapist can offer specific information and techniques to help the victim regain some sense of safety and control by helping her make decision, clarify important issues and goals, and helping her to accept what has happened without self-blame.

Helping the victim deal with feelings of anger or revenge is a crucial step in readjustment. The victim may be unable to accept the rape and her own reactions to it because she did not deserve what happened and feels she has no control over her self or her life. Intense feelings of anger may be especially disturbing to women who have not experienced such strong affect before. It is important to help the victim accept and express these feelings, and direct them in appropriate ways. Helping the victim to develop assertive behaviors can foster increased self-confidence and reassurance that she can take care of herself without losing control. Physical activities may reduce tension, improve motivation and release aggressive impulses which frighten the victim when unreleased.
Attention to communication style can facilitate the victim's ability to seek and utilize support from others and reduce possible misinterpretations of other's behavior.

Some women may find that involvement in support groups or volunteering to help others gives them a sense of sharing their experience in a way that helps others as well as themselves, and decreases the sense of isolation or alienation from others. Other women may benefit from becoming activists for social issues and problems by participating in activities for change.

Sexual difficulties should be approached with special attention to how the victim evaluated her sexual relationships prior to the rape, and how she defined the rape, as a sexual act or one of violence. Attitudes towards men may have changed drastically since the rape or responses from partners may have been perceived as negative. Since most women experience difficulties with intimacy for a time following the rape, couples counseling may be indicated.

Program Recommendations

King and Webb (1981) have noted that the stigma of seeking mental health services is greater than the stigma of being a rape victim. Given the combination of these two stigmatized "labels," programs must attempt to minimize the obstacles that can prevent victims from obtaining help. One way to do this is to set up a separate program that is identifiable without contributing to the stigma attached to receiving services.

Programs should be sincerely interested in providing services to victims and ideally function independently so that their purpose is not compromised by the objectives of the host agency. Staff must be experienced professionals in order to be competent in dealing with the various kinds of needs victims may have and be versatile in the kind of approaches they are trained to use. Forman and Wadsworth
(1981) reported that many centers servicing rape victims were staffed with untrained counselors. While funding limitations may make staffing needs difficult to meet, the credibility of the program depends upon high quality service, and the possible damage to the victim's health is certainly not an acceptable result. Programs must respond to the particular needs and attitudes of the communities where they exist and maintain good community relationships.

A comprehensive center for victims of assault would reduce the gaps in service availability and variation in service delivery. Such a center could provide information, referral, crisis intervention, short and long-term specialized treatment for victims and significant others, and support groups. Active consultation and education of the community and linkage with other agencies, such as police, hospitals and mental health centers and courts, would enhance the ability of all to serve their purpose in helping victims and reducing failures to prosecute.

Continued funding and credibility of the center depend upon quality service, visibility, and active dedication and participation in the difficult process of protecting our communities from the impact of rape and other violent crimes.
The research protocol entitled "THE IMPACT OF RAPE ON THE FEMALE VICTIM, HER MALE SIGNIFICANT OTHER, AND THEIR RELATIONSHIP: COPING WITH VICTIMIZATION", by Patrick McKenry, Deborah Emm

(Family Relations & Human Development
(Department & College)
315 Campbell, 1787 Neil Avenue
(Campus Address)

Presented for review by the Human Subjects Review Committee to ensure the proper protection of the rights and welfare of the individuals involved with consideration of the methods used to obtain informed consent and the justification of risks in terms of potential benefits to be gained. The Committee action was:

☐ APPROVED
☐ APPROVED WITH CONDITIONS BELOW
☐ DEFERRED - COMMENTS BELOW
☐ DISAPPROVED
☐ NO REVIEW NECESSARY

(Signature of Committee Member)

CONDITIONS/COMMENTS:
Subjects were deemed AT RISK and the protocol was unanimously APPROVED WITH THE FOLLOWING CONDITIONS:
1. Provide letter from M. Miller, Franklin County Prosecutor's Office, indicating that research has been approved and that he is willing to provide the information requested.
2. Tapes must be erased at the completion of the study.
3. Subjects should be informed about the use, disposition and erasure of the tapes.
4. If subjects choose to withdraw, they should have the opportunity to have tapes erased prior to transcript.
5. Provide script for obtaining consent of the "significant other".
6. Inform Committee of the possibility that these data may be subpoenaed for trial purposes, and if this should happen, what steps will be taken to protect subjects.

If you agree to the above conditions, please sign this form in the space(s) provided and return it with any additional information requested to Room 205, Ohio State University Research Foundation, 1314 Kinnear Road, Campus, within one week. Upon such compliance, the approval form will be mailed to you. (In the case of a deferred protocol, please submit the requested information at your earliest convenience. The next meeting of the Committee is two weeks from last meeting date.)

Date _______________ Signature ________________________________

(Principal Investigator)

Date _______________ Signature ________________________________

(Chairman, Behavioral and Social Sciences Human Subjects Review Committee)
With regard to the employment of human subjects in the proposed research entitled *THE IMPACT OF RAPE ON THE FEMALE VICTIM, HER MALE SIGNIFICANT OTHER, AND THEIR RELATIONSHIP: COPING WITH VICTIMIZATION*

Patrick C. McKenry, Deborah Emm is listed as the principal investigator. Family Relations & Human Development

The Social and Behavioral Sciences Review Committee has taken the following action:

☑ Approved
☐ Disapproved
☐ Approved with conditions*
☐ Waiver of Written Consent Granted

*Conditions stated by the Committee have been met by the Investigator and, therefore the protocol is approved.

It is the responsibility of the principal investigator to retain a copy of each signed consent form for at least four (4) years beyond the termination of the subject's participation in the proposed activity. Should the principal investigator leave the University, signed consent forms are to be transferred to the Human Subject Review Committee for the required retention period. This application has been approved for the period of one year. You are reminded that you must promptly report any problems to the Review Committee, and that no procedural changes may be made without prior review and approval. You are also reminded that the identity of the research participants must be kept confidential.

Date JAN 11 1985 Signed: ____________________________

(Chairperson)

cc: Original - Investigator File

HS-025B (Rev. 7/81)
Dear ______________:

The Office of the Franklin County Prosecuting Attorney maintains a policy of non-disclosure of addresses for all sex-crime victims. However, this office is also willing to cooperate with these same victims when they have personal needs/requests associated with the case.

You will find enclosed a packet of materials describing a research project on the subject of rape. Ordinarily, this office would never become directly involved in such a project. However, the researcher herself is a rape victim and therefore we have agreed to distribute the materials (rather than releasing addresses).

Your receipt of this letter should in no way be interpreted as an endorsement of the research project. This office is merely assisting a rape victim with a personal request, while at the same time protecting the privacy of other victims. The decision of whether to participate should be yours alone. If you have any questions, please feel free to contact Ms. Barbara Young at (614) 462-3555.

Sincerely,

(signed)
Edward W. Morgan
Senior Assistant Prosecuting Attorney

(signed)
Barbara Young
Victim/Witness Assistant

Enclosure: Research materials

Office of the Prosecuting Attorney
Hall of Justice 369 South High Street Columbus, Ohio 43215 (614)462-3555
Dear [Name of Survivor]:

I am a licensed psychologist and victim of rape. I am planning to conduct research on how the experience of rape affects victims and their recovery.

I hope that this study will provide much needed information about how rape affects individuals so that practitioners can provide better care to other victims of rape and those close to them.

Your name has been provided to me by Michael Miller, Chief Franklin County Prosecutor. I would greatly appreciate your participation in this study so that I can generate important information on the effect of rape on victims and others important to them.

If you choose to participate in this study, all identifying information will be held strictly confidential. Your name will never be associated with any of the information you provide. If, at any time, you change your mind about participating, you may withdraw from the study. Of course, confidentiality will apply to the identity and information that you provide. You will be interviewed at your convenience. The interviews will be tape-recorded. I personally will be interviewing victims.

As a rape victim and psychologist, I realize the subject of the study may be difficult for you to talk about. Others who have participated in studies of this nature have found they were better able to understand their experience or felt they benefitted from discussing it. I hope you and others who participate feel your valuable contribution to research is worth any temporary discomfort.

I will be calling you within a week to discuss your interest in participating in this study. Please feel free to call me before then, if you have any questions.

Your consideration of my request for participation in this project is greatly appreciated.

Sincerely,

Deborah Emm, M.A.
Psychologist
Ohio License #2175

My phone is 614/267-5851
CONSENT TO SPECIAL TREATMENT OR PROCEDURE

FACSIMILE

I, ______________________, hereby authorize or direct ____________________ or associates or assistants of his or her choosing, to perform the following treatment or procedure and such additional services as they may deem reasonably necessary in its performance (describe in general terms): participate in tape-recorded interviews, and complete questionnaires, upon ______________________.

(myself or name of subject)

The experimental (research) portion of the treatment or procedure is: to complete interviews and questionnaires. This is done as part of an investigation entitled: The Impact of Rape on the Female Victim.

1. Purpose of the procedure or treatment: To gather information about subjects' perception of rape, its effect upon victim and male significant other, their relationship and recovery process. To describe feelings, attitudes, and behavior which subject or investigator believe are related to the rape crisis.

2. Possible appropriate alternative methods of treatment: To not participate in the study.

3. Discomforts and risks reasonably to be expected: Tension, crying, anxiety or fatigue associated with topic of discussion, are to be possible risks for some subjects. Risks are temporary.

4. Possible benefits for subjects/society: Subjects may benefit from increased understanding and self-esteem; there may be a therapeutic effect from talking about the subject. Improved treatment and prevention approaches may benefit society.

5. Anticipated duration of subject's participation: 2-3 hours.

I hereby acknowledge that Deborah Emm has provided information about the procedure described above, about my rights as a subject, and he/she answered all questions to my satisfaction. I understand that I may contact him/her should I have additional questions. He/She has explained the risks described above and I understand them; he/she has also offered to explain all possible risks or complications. I understand tapes will be erased after completion of study, or before transcription if I decide to withdraw.

I understand that the information obtained from me, or from the person I am authorized to represent, will remain confidential unless I specifically agree otherwise by placing my initials here ______. I understand that, where appropriate, the U.S. Food and Drug Administration may inspect records of this research project. To maintain confidentiality, no identifying information will be attached to tapes, or reports in this study.

I understand that I am free to withdraw my consent and participation in this project at any time after notifying the project director without prejudicing future care. No guarantee has been given to me concerning this treatment or procedure.
In the unlikely event of physical injury resulting from participation in this study, I understand that immediate medical treatment is available at University Hospital of The Ohio State University. Questions about this should be directed to the person named above. I also understand that the costs of such treatment will be at my expense and that financial compensation is not available. I understand that at my request, I will be provided with names of competent counselors should I wish referral following participation.

I have read and fully understand the consent form. I sign it freely and voluntarily. A copy has been given to me.

Date: __________________________ AM Time: ________ PM Signed: __________________________ (Subject)

Witness(es) ____________________________

If Required ____________________________ (Person Authorized to Consent for Subject - if Required)

I certify that I have personally completed all blanks in this form and explained them to the subject or his/her representative before requesting the subject or his/her representative to sign it.

Signed: _____________________________ (Signature of Project Director or his/her Authorized Representative)

Form HS-028A (Rev. 12/5/81)
APPENDIX E
List of Practitioners

Patricia James, Ph.D.
5701 N. High Street
Worthington, Ohio 43085
614/438-0044

Meg Metts, Ph.D.
1959 Willoway Court N
Columbus, Ohio 43220
614/451-4891

Pat Semmelman, Ph.D.
North Central Mental Health Center
1301 N. High Street
Columbus, Ohio 43201
614/299-5600
APPENDIX F
### Subject Background Data

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<th>Educational background:</th>
</tr>
</thead>
<tbody>
<tr>
<td>less than high school ____</td>
</tr>
<tr>
<td>high school graduate ____</td>
</tr>
<tr>
<td>technical school ____</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employment status at time of assault:</th>
</tr>
</thead>
<tbody>
<tr>
<td>full-time ____</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current employment status:</th>
</tr>
</thead>
<tbody>
<tr>
<td>full-time ____</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Did you report rape to police:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes ____</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>When did you report it?</th>
<th></th>
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</table>

<table>
<thead>
<tr>
<th>Were physical injuries sustained during the assault?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes ____</td>
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</table>

<table>
<thead>
<tr>
<th>Did you receive any treatment at a doctor's office or hospital?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes ____</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Have you received any counseling since the rape?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes ____</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Did you testify in one of the trials?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes ____</td>
</tr>
</tbody>
</table>
APPENDIX G
Pre-Crisis Stressor Checklist

During the one year period prior to the rape, did you experience? (place a check mark on the lines to indicate a positive response)

Death of a child or spouse (husband, wife or mate)?
Death of a child or spouse (husband, wife or mate)? (2nd)
The death of a parent, brother or sister?
The death of a parent, brother or sister? (2nd)
The death of a parent, brother or sister? (3rd)
The loss of a close friend or important relationship by death?
The loss of a close friend or important relationship by death? (2nd)
Legal troubles resulting in being held in jail?
Financial difficulties?
Being fired or laid off?
A miscarriage or abortion (patient or spouse)?
Divorce, or a break up with a lover?
Separation from spouse because of marital problems?
Court appearance for a serious violation?
An unwanted pregnancy (patient, wife or girlfriend)?
Hospitalization of a family member for serious illness?
Unemployment more than one month (if regularly employed)?
Illness/injury kept in bed for week or more, hosp. or emerg. room?
An extra-marital affair?
The loss of a personally valuable object?
Involvement in a lawsuit (other than divorce)?
Failing an important examination?
Breaking an engagement?
Arguments with spouse (husband, wife or mate)?
Taking on a large loan?
Troubles with boss or other workers?
Separation from a close friend?
Taking an important examination?
Separation from spouse because of job demands?
A bid change in work or in school?
A move to another town, city, state or country?
Getting married or returning to spouse after separation?
Minor violations of the law?
Moved home within the same town or city?
The birth or adoption of a child?
Being confused for over 3 days?
Being angry for over 3 days?
Being nervous for over 3 days?
Being sad for over 3 days?
Spouse unfaithful?
Attacked, raped or involved in violent acts?
APPENDIX H
Female Interview Guide Questions

1) How do you feel discussing the subject of rape?

2) How do you define rape?

3) Before you were assaulted, what did you think of a woman if she had been raped? Has your opinion changed?

4) Who did you first talk to about the rape? Why did you choose this person?

5) Would your describe how you felt and what you did immediately following the rape? How long did these feelings last? Did you feel differently about yourself?

6) How did people close to you react when they heard you had been assaulted?

7) How did you cope with your reactions to the assault? (includes counseling sessions, or visits to minister)

8) If you had a relationship with a man at the time of the assault, how did he find out, if he did?

9) How would you describe his reaction to the rape, to you? Did you feel differently or act differently toward him than you usually did? Do you feel he treated you differently? How?

10) Did you want him to do anything special for you, did you ask him for support or did he offer any?

   If not, why and how did you feel about that?

11) As time passed, how were you coping with the assault? Were there any problems with relationships because of it, or problems with other aspects of your life, like work?

12) Right now, do you feel you have fully recovered from the impact the assault had upon you?

13) Are there others close to you who you feel were affected in some way by the assault? How? Did this affect your relationship with them?

14) Have your feelings, behavior or attitudes about men, or specific men, changed in any way?

15) Have your feelings about sex changed since the assault?

16) Do you think your philosophy of life or beliefs about humanity have changed since the assault?
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