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Realities and treatment of rape

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Realities and treatment of rape

Abstract

One in three women have experienced a sexual assault. The impact of sexual assault can affect numerous aspects of a woman's life including: sexual health, cognitions, behaviors, emotions, interpersonal relationships, and self-perceptions. The healing journey for a rape victim is often initiated with the aid of a counselor. For this reason alone, it is crucial for counselors to have a basic knowledge of the symptoms as well as the various treatments for rape victims.

REALITIES AND TREATMENT OF RAPE

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by

Alison Brennan

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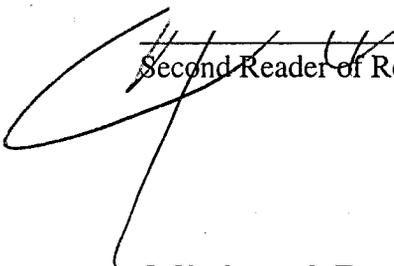
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ABSTRACT

One in three women have experienced a sexual assault. The impact of sexual assault can affect numerous aspects of a woman's life including: sexual health, cognitions, behaviors, emotions, interpersonal relationships, and self-perceptions. The healing journey for a rape victim is often initiated with the aid of a counselor. For this reason alone, it is crucial for counselors to have a basic knowledge of the symptoms as well as the various treatments for rape victims.

One in three women have experienced a sexual assault (Conyers-Boyd, 1992; Gilmartin, 1994). Unfortunately, a victim of sexual assault not only has to bear the actual incident but also the symptoms that effect their thoughts, relationships, work, and health. Strong, De Vault, and Sayad (1999) defined sexual assault as sexually related behaviors in which one (or more) person(s) forces upon another person(s). Conyers-Boyd (1992) elaborated on this general definition by categorizing sexual assault behaviors on a continuum from mild to severe. Table 1 demonstrates this range.

Table 1

Sexual Assault behaviors from mild to severe:

Suggestive Comments or Gestures	Obscene Phone Calls or Comments	Flashing; Voyeuristic Behavior	Unwelcome or Unsolicited Touch	Attempted Rape or Rape
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This paper will address the far right of the continuum dealing with attempted rape and rape.

The definition of attempted rape is a person attempting to sexually penetrate another by force but not completing the penetration. The traditional definition of rape is a male forcing penile-vaginal or penile-anal penetrations against a woman's will (Strong et al., 1999). However, rapists do not always use penises. Rape can also include object-vaginal or object-anal penetration against

the victim's will. Other examples of objects that have been used include broom handles, guns, or knives.

Rape does not always occur between a male and female. Males can rape other males and females can rape females or males. Nonetheless, most statistics regarding rape indicate that generally rape victims are women. Therefore, the focus of this paper will be based on the female populations who have been raped by acquaintances or strangers at least once in their lives. Male victims are excluded from this paper as well as spousal assault.

Even if a woman tries to forget the assault the symptoms she experiences may cause her to seek help from a friend, doctor, or mental health professional. Draucker (1999) reported that about half of the women who have been sexually assaulted seek support by engaging in counseling. Most women seek help from counselors soon after the assault or two years following the incident (Calhoun & Atkenson, 1991). The main purpose of this paper is to review treatment modalities that are utilized by mental health professionals to facilitate recovery for sexual assault victims. However, before treatment modalities can be addressed, an understanding of victims, offenders' profiles, and the impact of rape will be examined. The next section summarizes the characteristics of rape victims.

Profile of Victims

Nonwhite, poor, women between the ages of sixteen and twenty-four have a three times greater probability of being raped than other women (Wells &

Johnson, 1997; Zweig, Crockett, Sayer, & Vicary, 1999). Those women who use drugs and/or alcohol are also more susceptible to rape (Wells & Johnson, 1997). Rapes are more prone to occur at the victims home or home of an acquaintance between the hours of 6 p.m. and 6 a.m. (Strong et al., 1999). The myth that victims wanted to be raped is untrue and irrational. The majority of victims attempt to stop the rape by fighting, screaming, or trying to escape (Wells & Jacobsen, 1997). Regardless of age, race, socioeconomic status, or sexual desires women do not wish to be victims of rape.

Our society continues to point blame towards the victim rather than the offender. As a result, many women lack the courage to reveal their sexual-assault experiences to friends, family, and the legal systems (Ullman, 1996). When women do choose to tell their support systems, they are usually bombarded with questions about their behaviors and actions preceding the assault. Their actions are often judged as unsafe behaviors by society thus causing the victim to be subjected to more shame and self-blame.

Some women do not realize what they endured was sexual assault which additionally accounts for low reports of sexual assault. This is especially true for women who have been raped by someone they know. Women rarely report acquaintance rapes, rather it is the stranger rapes that are most often reported (Strong et al., 1999). Therefore, for every one rape reported three to ten rapes go unreported (Warshaw, 1994). Rape is a serious crime that is often ignored by society because of the type of crime and the low reports. Repeatedly many

women, "Believed they were a victim of a serious miscommunication or a victim of a crime other than rape" (Layman et al., 1996, p.127). Victims often believe that a sexual assault by an acquaintance is not considered rape. Unfortunately, more than seventy five percent of rapes are acquaintance rapes (Strong et al., 1999; Warshaw, 1994;). A female is four times more likely to be raped by someone she knows than being assaulted by a stranger. When the offender is an acquaintance, victims are more reluctant to seek out professional help (Draucker, 1999; Layman et al., 1996; Stermac, Du Mont, & Dunn, 1998; Warshaw, 1994). The only difference between acquaintance rapes and stranger rapes are that stranger rapes have the tendency to be more violent (Cascardi, Riggs, Hearst-Ikeda, & Foa, 1996). The warning is women need to be just as cautious around men they know.

Once a woman has been raped her chances of suffering another assault increases. Her revictimization may be in the form of sexual assault, physical abuse, and/or emotional abuse by an acquaintance, partner, or stranger (Proulx, Koverola, Fedorowicz, & Kral, 1995). Sadly, more than a third of women will endure attempted rape or rape by the time they have reached the age of eighteen (Gilmartin, 1994). As a result, one third of females who have reached the age of eighteen are already prone for additional sexual assaults or other types of abuses by men they know.

Profile of Offenders

As previously mentioned, offenders are acquaintances as well as strangers. There are no common physical characteristics that rapists share. What they do have in common is that they are mostly male. Research based on offenders who are in prison and have committed more than ten rapes found that the average age of the offender's first attack is 21.5 years old and his last rape typically occurs around the age of 29. From this population they discovered that 54% of offenders normally have a stable job, 71% are married or have been married at least once, and 78% do not live alone. They uncovered that high percentages (76%) of offenders were sexually abused as children (Allison & Wrightsman, 1993; Wells & Jacobsen, 1997).

Offenders attempt to exercise their power and anger through rape and assault behaviors. Offenders consider their victims as nothing more than objects that they are overpowering. Rapists, "Rarely if ever, consider the thoughts or feelings of their victims, no matter how well acquainted they may be" (Conyers-Boyd, 1992, p. 273). Offenders use sexual behaviors to execute power, anger, and violence (Conyers-Boyd, 1992; Warshaw, 1994). Therefore, rapes cause women to associate sex with violence and lack of control (Zweig et al., 1999). Victims have the tendency to confuse their painful emotions regarding the rape with their beliefs of sex and sexual identity.

Allison and Wrightsman (1993) suggested that offenders normally believe in the traditional sex roles and are accepting of violence towards women. They

are often impulsive people who are frequently involved in physical aggression. They use sex as an outlet for their anger and needs of dominance. Strong et al. (1999) reported that rapists have difficulty dealing with hostile feelings and are more accepting to using force when frustrated. Considering these characteristics, sexual relationships are not the priority for offenders. Victims need to be aware that rape is not about sexual relations, rather it is about offenders' feelings of inadequacy.

It is not unusual for offenders to boast about the rape to his friends. If the offender acknowledges that he attempted or completed a sexual assault he will frequently tell friends that the victim was a willing participant (Warshaw, 1994). The offender uses this strategy to protect himself in case the victim is motivated to speak about the rape. Disappointingly, the chances a victim will report a sexual assault decreases after she knows the offender bragged to others that she was a willing partner. The negative emotional impact and dysfunctional reactions also increase once the victim discovers that the offender rumored her as a willing partner. Regardless if the victim chooses to report the incident or not she must cope with the impact of rape.

Impact of Rape

One of the first emotional reactions after an assault is the sensation of being unsanitary. Women survivors feel as if, "They would never get clean again" (Warshaw, 1994, p. 68). Other emotional effects that promptly follow the incident include denial and dissociation. Warshaw (1994) described dissociation

as a state in which women feel as if they are not physically and mentally present. Both are utilized as a way of protection against their internal pain during and after the assault.

Coping strategies for women can range from denial to seeking support. Proulx et al. (1995) defined coping as a way or attempt to manage internal and/or external stress. However, due to the severity of being sexually assaulted and not always conceptualizing the incident as sexual assault, coping strategies for most victims are dysfunctional. Although these coping strategies initially serve an emotional purpose for victims, they do not necessarily lead to recovery. Impact of sexual assault can affect numerous aspects of the woman's life including: sexual health, cognitions, behaviors, emotions, interpersonal relationships, and self-perceptions.

Sexual Health

Depending on the severity of the rape and the age the female was at the time of the assault, many women experience physical damage and pain after a sexual assault. Some women have reproductive problems, pelvic pain, sexually transmitted diseases, pelvic inflammatory disease, frequent yeast infections, and may need early hysterectomy due to harm of the assault (Golding, 1996).

Along with the physical reproductive problems, victim frequently experience sexual dysfunctions soon after and years following an assault. Golding (1996) reported that 39-67% of victims developed a sexual dysfunction following an assault. Victims report higher incidents of painful intercourse,

sexual indifference, more pain during menstruation, menstrual irregularity, and lack of sexual satisfaction when compared with nonassaulted women (Golding, 1996).

Some women become promiscuous after an assault while the majority of victims experience sexual abstinence. The sexual abstinence is due to the victim's fear of sex, confusion, and possible flashbacks when attempting intimacy (Gilmartin, 1994; Golding, 1996). These sexual problems increase when the victim has been revictimized, assaulted by manipulation rather than physical threat, and/or had completed intercourse during the assault (Golding, 1996).

Calhoun et al. (1991) reported that complaints regarding sexual dysfunctions differ greatly for non-assaulted women and victims of sexual assault. Non-assaulted women's complaints focus on the intensity and number of orgasms during sex. They also discussed enduring increased boredom through out sex (Calhoun et al., 1991). Whereas sexual assault victims' complaints center on lack of initial sexual responsiveness, lack of desire, inability to relax, and fear of sex. Women who have been revictimized and are victims of child sexual abuse have higher rates of nonorgasmic sex than single assault victims and non-assaulted women. After an assault, some women have feelings of disgust about their own body. Others are sensitive to any physical touch and withdrawal when their partner attempts any type of physical intimacy (Calhoun et al., 1991; Kulkoski & Kilian, 1997; Warshaw, 1994). These sexual problems are products of the

victims' psychological disturbances and can continue to influence their psychological health.

Post Traumatic Stress Disorder (PTSD)

Post traumatic stress disorder is a common disorder for sexual assault victims. Research reports that at least 35% of victims experience PTSD (Calhoun et al., 1991). More than 90% of rape victims felt terrified and/or felt as if they had encountered a life-threatening experience during the assault (Calhoun et al., 1991). These feelings of terror are central causes of PTSD.

Anger, hostility, disturbed sleep, hypervigilance, impaired memory, nightmares, difficulty concentrating, unreasonable fears, loss of security, and loss of safety are some of the symptoms they may endure which are criteria for PTSD (Conyers-Boyd, 1992; Gilmartin, 1994; Warshaw, 1994). An additional symptom often experienced by victims is flashbacks of the incident. Flashbacks can cause the victim to feel as if the incident was transpiring again. She may try to avoid stimuli that could remind her of the rape and that could cause flashbacks and painful memories. These flashbacks can occur at any time causing victims to re-experience their fear and emotional pain. Flashbacks often appear during voluntary sexual encounters causing the victim to be distracted and uncomfortable (Zweig et al., 1999).

Cascardi et al. (1996) researched some of the factors during an assault that could lead to an increased chance for PTSD. They discovered that victims who experienced the assault in a safe environment developed more PTSD symptoms

than victims who were assaulted in dangerous environments. If the offender seemed dangerous (ex-lover, ex-spouse, male stranger, group strangers) the victims had more severe PTSD symptoms than those who were victimized by perceived safe offenders (uncle, male friend, boyfriend, acquaintance, or date rape). They noted that those who endured an assault in a safe place (one's own home) by a dangerous assailant (stranger) suffered the most intense PTSD symptoms. Thus, they suggested that intensity of the intrusion has an effect on women's perceptions of safety and may determine the severity of PTSD (Cascardi et al., 1996).

Layman et al. (1996) reported that the more violent the incident correlated with the higher rate of PTSD symptoms. They also indicated that women who acknowledge that they are rape victims have higher levels of PTSD symptoms when compared to women who are unaware that they were involved in a situation that would be defined as rape. Therefore, therapists need to be sensitive when assisting a victim with defining the incident as rape due to the fact that she may begin to develop PTSD symptoms.

Depression and Anxiety

As well as PTSD, depression and anxiety are also common problems victims may acquire. Depressive symptoms develop more frequently for victims who endured sexual intercourse during the assault when compared to those who were victimized only by physical contact (unwanted kissing or petting) (Zweig, Barber, & Eccles, 1997). Suicidal ideation, fatigue, inability to concentrate, lack

of pleasure, feeling worthless, disturbed sleep, weight loss/gain, and lack of energy are some of the symptoms women encounter that relate to depression (Gilmartin, 1994; Warshaw, 1994). These symptoms of depression are a direct result of the victims' minds and bodies trying to cope with trauma.

For victims of sexual assault the ability to trust others weakens after the incident. Their fears that are results of the rape cause women to frequently engage in avoidance behaviors. During the rape, power and control was taken from them. Thus distortions about power and control are common outcomes. Their desire to gain any type of control leads to controlling their environment as much as possible. Thus phobias such as fears of being in crowds can be a product of the rape. Other phobias such as being alone or near men are typical consequences rape victims may encounter (Gilmartin, 1994). Physical anxiety symptoms such as jumpiness, shakiness, and hot or cold flashes are also experienced by victims (Warshaw, 1994).

Eating Disorders

Any positive self-perceptions about a woman's body significantly decreases after a sexual assault (Zweig et al. 1999). Also after the assault a woman may believe that she has inadequate control over her life. Viviano and Schill (1996) reported that self-defeating behaviors such as an eating disorder can be a consequence of poor body image and desire to establish control. Seeking any type of control in their lives is imperative. Eating disorders permits women to establish this power and control that they are craving. Behaviors such as bulimia

are common for child sexual abuse victims. Research completed by Baldo, Wallace, and O'Halloran (1996) indicate that, "Any history of sexual assault appears to increase greatly the likelihood of disturbed eating" (p. 535). They further reported that female incest victims have a higher chance of developing an eating disorder (Baldo et al., 1996).

Self-Blame

An additional perception that is fueled by a sense of powerlessness is self-blame. Self-blame is a typical reaction for victims (Gilmartin, 1994; Kulkoski & Kilian, 1997). Women may feel as if they have been, "Betrayed by their own judgement" (Warshaw, 1994, p. 56). Self-blame is a dangerous reaction victims' feel. Due to self-blame, women become even more reluctant to tell of the assault. They may think that they were partially to blame for the assault thus others will think less of their character and also blame them.

Unfortunately, a large majority of our society quickly places blame on victims of sexual assault attributing it to their dress, attractiveness, or intoxication level. This idea of blaming the victim instead of the offender feeds into increasing self-blame and deteriorating self-esteem. Many men and women are not aware that in several states legal consent cannot be granted if the woman is intoxicated. A woman's inability to give consent due to intoxication does not allow a man to have sex with her.

The fact is that women do not choose to have sexual intercourse forced on them regardless of their behaviors. Forcing behaviors are wrong when the sexual

incident is not an exchange of equal control. It is essential for society and counselors to acknowledge that these women were victims regardless of their appearance, alcohol consumption, or behaviors. Our society needs to realize that they are not enhancing the abilities for these women to recover after rape when they support self-blame. Counselors can use treatment modalities more successfully if a woman sees herself as a victim of a crime rather than a person whose behaviors caused a man to rape her.

General Treatment Modalities

The main goal of sexual assault treatment includes enhancing victims' abilities to feel and develop a sense of control and satisfaction about their lives. It is also the counselor's obligation to help the clients get out of the victim stage of feeling helpless and confused and learn to live as a survivor (Gilmartin, 1994). Some treatment approaches strive towards victims regaining a similar life to the life they had prior to the assault. However, most treatments encourage women to include the assault as part of their lives.

Trying to get a woman back to where she was before the assault seems valid yet at times unrealistic. Not recognizing the rape as a serious life-altering event can aid to dysfunctional denial. Acknowledging the rape, healing the pain, and learning to cope in a healthy manner is an achievement of successfully conquering a life obstacle. A woman may perceive that she is a survivor of this obstacle and has an inner strength she did not have before the assault. This means

the woman is to develop the capability to utilize the assault as a way to reshape and possibly give a new definition of who she is.

There are several different models utilized to treat a victim of sexual assault. Earlier treatment modalities concentrated primarily on crisis intervention. This is still a common approach to sexual assault treatment. The counselor has about three to four contacts with the victim. During the sessions the focal point is based on the "here and now" and short term reactions. The counselor's goal is to let the victim know that her symptoms are normal. Other focuses during crisis interventions are medical cares, legal advocacy, and development of a support system (Gilmartin, 1994). More recent models of treatment are longer-term modalities and focus on perceptions and feelings.

Rape Trauma Syndrome

Before the publication of the DSM-III, the "Rape trauma syndrome" was developed to help facilitate treatment. Rape trauma syndrome is not a specific diagnosis rather it encompasses the numerous symptoms a rape victim could possess. The first stage of this treatment is directed primarily of the woman's symptoms. During the second stage, the therapist is to help the woman reorganize her perceptions and structure her life back to "Pre-rape level of functioning" (Gilmartin, 1994, p. 190).

Forman's Five-Stage Model of Recovery

Forman's Five-Stage Model of Recovery was utilized during the early 1980s. Again the consideration was on the victim's symptoms and resolution.

However, Forman also gave attention to the client's feelings. The first stage focuses on shock and the second on denial. Feelings that the woman tolerates during the rape are addressed in the third stage. Anger emotions including hopelessness and shame are discussed during the fourth stage. The final stage concentrates on client resolution and accepting the rape as part of her history (Gilmartin, 1994).

Social Learning Model

More recent models that have been employed are the Social Learning model, Eclectic model, and the "Self-Help Plan." The Social Learning model views rape as an example of classical conditioning. The beliefs are that cues remind women of the rape and thus evoke fear and anxiety symptoms. The goal of the counselor utilizing this model is to help the client unlearn her fears regarding the rape (Gilmartin, 1994). Counselors expose clients to cues that evoke negative symptoms. Then the counselor aids the client to associate non-anxiety feelings with these cues such as relaxation or a sense of control. The goal is that the woman will eventually associate only positive or neutral feelings to these cues.

Eclectic Model

The Eclectic model perceives the women experiencing four different phases from pre-rape to resolution. The first phase is called, "Anticipatory Phase." This occurs before the actual rape when the woman recognizes that she is in a situation that may be dangerous. The "Impact Phase" includes the sexual

assault incident and the emotions that occur immediately following the incident (i.e., intense fear). The "Reconstitution Phase" is the third phase in which the woman attempts to regain structure and control in her life. The last phase, "Resolution, " is when the victim resolves the emotional impact the assault caused. She does this by accepting and learning to reframe her reactions to the rape. The goals for the Eclectic counselors are to assist the client with reducing her symptoms, learning to accept her emotions, relearning to trust others, and acquiring some type of meaning to her life as a survivor (Gilmartin, 1994).

Self-Help Plan

The "Self-Help Plan" facilitates the victim's ability to acknowledge her pain that was caused by the rape. Then she becomes aware about her ideas of safety and sexuality. Next, the victim is to develop insights about herself, life, and relationships. Finally, the victim is to let go of her pain by acknowledging that the rape does not have power over her life. She then regains her sense of control to have a good life (Gilmartin, 1994).

These models are broad examples of treating rape victims. Many do not address how counselors could work on more specific issues victims encounter. Factors such as sexual dysfunction, posttraumatic stress disorder, anxiety, support issues, and self-blame are these aspects counselors will need to focus on with rape clients. These specific areas could be problems for the victim at any point during her healing process. As mentioned before, the basic knowledge of symptoms is

essential yet using reliable treatment methods is crucial for the client and the counselor.

Specific Treatments

Sexual Dysfunction Treatments

Treating sexual dysfunctions can be a difficult task. Many issues need to be considered during this process. One of the first steps is helping the client to identify her lack of desire, fear, and inability to orgasm. A counselor should educate her about common symptoms she could encounter. This normalizes the victims' feelings.

Counselors should encourage the client to establish control when initiating sex with her partner. Emphasizing good communication habits is crucial. Clients may need assistance from the counselor to express to her partner that when or if she rejects his sexual advances that it is not a personal rejection directed towards him. Teaching assertive communication will eventually help the client feel more in control of her sexual experiences. This will also improve her partner's understanding of her desires (Calhoun et al., 1991).

Calhoun et al. (1991) discussed nine steps that can be applied as a guide when dealing with regaining sexual health when working with these clients. The first step is providing information and establishing goals. Discussing, understanding and encouraging positive body imagery is the next stage (i.e., insight on how the victim perceives her body). Promoting the client to experiment with her partner without having the goal of sex but rather

rediscovering where she may experience sexual pleasure is the next step. Aiding the client to learn way not become distracted during intimacy is the forth step. Utilizing sexual fantasies, refocusing, stopping intruding thoughts, and reading fantasy materials are ways to prevent distractions. The next stage deals with the client's specific sexual dysfunctions. The sixth and seventh stages includes an understanding her physiological responses and remaining anxieties about sex. As mentioned before, re-educating and emphasizing good communication with her partner is imperative during all of the stages. The final stage is evaluating her achievements and assessing areas she still needs to continue improving.

Conyers-Boyd (1992) recommended that the victim's sexual partner whispers his and her name during intimate moments to decrease the chance of detachment or flashbacks. They suggested open communication and having the victim direct what she wants. They reminded victims that are unable to have an orgasm that their inability is normal. Counselors need to advise sexual assault clients that an orgasm is not the ultimate goal to be intimate with a partner. Rather the goals are to relearn how to become trustful, comfortable, and gain a sense of equal control.

Post Traumatic Stress Disorder Treatment

Post Traumatic Stress Disorder (PTSD) treatment is widely used by many counselors because it addresses a variety of emotions and issues the client may be experiencing. Gilmartin (1994) reported that the PTSD model effectively explains the initial symptoms and the long-responses of victims. PTSD treatment

quickly addresses the acute symptoms of the woman and attempts to reduce them while continuing the therapeutic process.

The PTSD treatment modality stresses the importance of developing a trusting environment due to the fact the client may have distorted beliefs about trust. The counselor begins by normalizing her feelings and educating her about her stress and the recovery process. Next the counselor aids the client through stress management by utilizing imaginal flooding, thought stopping, and cognitive restructuring. Often the victim is asked to "re-experience" the trauma to understand and gain insight on her emotions. The final phase is to help the client integrate her perceptions of the negative and positive aspects regarding who she was before, during, and after the rape with her current more stable self definition (Gilmartin, 1994).

Assisting the client with awareness of "triggers" is advantageous for the healing process (Warshaw, 1994). Triggers are reminders of the rape such as a cologne, song, time of day. Often triggers set off flashbacks for assault victims. If the client is aware of her triggers she will be able to understand, expect, and control the feelings associated with them.

Luckily, it is common for flashbacks to decrease in number and intensity with time and healing. Conyers-Boyd (1992) suggested that victims keep a note card with the statements, "I'm in a safe place; I was okay before the assault; I survived during the assault; I'm surviving now. And, I can survive my healing process," (p. 280) with them at all times. This note card and messages are to be

used as positive affirmations when victims are having flashbacks. It helps victims remind themselves that they are safe, healing, and in control.

One of the symptoms of PTSD is outburst of anger. Examples for healthy coping skills when dealing with anger include: hitting a pillow, going to a safe isolated place and screaming, engaging in a challenging physical task, and writing an angry letter (Conyers-Boyd, 1992). Releasing the anger ceases a build up of draining emotions that can exaggerate feeling powerless. Reframing anger into the core feelings of fear and pain can help victims gain insight and control. Thus, the victim will not feel as if someone else (i.e. the rapist) is controlling her life.

Stress Inoculation Training for Decreasing Anxiety

Resembling anger, anxiety can internally upsurge causing feelings of being out of control. Calhoun et al. (1991) recommended teaching clients specific skills to decrease anxiety symptoms. These are often new coping skill tools for the victim. The first skills to be taught are muscle relaxation and breathing control. Covert modeling is the third skill. During covert modeling the client is to visualize her fear and learn successful ways to confront and cope with her anxiety provoking fears. The next step is practicing her new coping strategies through role-playing. "Guided self-dialogue" and "thought stoppage" (cognitive restructuring) are the final skills to be taught and practiced (Calhoun et al., 1991).

Preventing Re-victimization

Layman et al. (1996) discovered from a study they conducted that a third of victims continued relationships with their offenders. They also found that one-

forth of the women continued to have sexual relationship with their offenders following the rape. They concluded that the majority of women who resumed sexual relations with their offenders had not conceptualized that they had been “raped” by this man. Therefore, it is imperative that the counselor assists the victim with defining the incident appropriately to cease future victimization. However, research conducted by Draucker (1999) reported that even when women realize they have been raped they do not want their counselors to encourage them to end the relationship. Rather they would like to control their own decisions about discontinuing their relationship and feel as if their opinion is valued.

As previously mentioned, sexual assault survivors have a higher likelihood of being in abusive (physical, sexual, or emotional) adult relationships. Gilmartin (1994) considered the possibility that women who continue to perceive themselves as "victims" and not as “survivors” will have a higher chance of becoming victims of abuse again due to this self-fulfilling prophecy. If they believe they have no control over their lives then their probability of enabling someone else to have control over them increases.

The process of becoming a survivor instead of living the life as a victim is emotionally difficult task to achieve. This is a crucial process. The victim must not only survive the assault incident but also survive the re-examination of her emotions and life changes. Developing healthy coping skills and accepting this life change is a step towards becoming a survivor (Conyers-Boyd, 1992).

Defining and believing that oneself is a survivor and no longer a victim is a personal choice and a significant step for a woman.

Other Considerations

There are many other issues after an assault that victims must deal with throughout daily life. Periods of healthy and dysfunctional adjustment may cycle. Perceptions of safety and trust are often recalculated after an assault. Victims may also have to redefine and readjust to intimate relationships and supporting relationships because of control and trust issues. Sexual assault does not only interrupt the life of the victims but also the lives of the victims' close friends, family, and partners. Most often, victims first tell their stories to these people.

Secondary victims. Friends, family, and spouses are examples of secondary victims. Allison et al. (1993) encourages secondary victims to be caring and supportive to the primary victims. Women who reported having support systems who listened to them had a better recovery and less psychological symptoms. Strong et al. (1999) reported that victims who have empathetic partners have a decreased chance of developing a sexual dysfunction. Victims want significant others to acknowledge feelings of shock and anger. Secondary victims should not direct anger, blame, or guilt towards the primary victim. They must allow the victim to express her feelings and never minimize the meaning of her emotions. Trying to distract the primary victim from experiencing her feelings leads to psychological symptoms and a difficult recovery. Secondary victims should also seek support and not feel ashamed about other family and/or

friends finding out about the incident (Allison et al., 1993; Ullman, 1996). Remer and Ferguson (1995) recommend that secondary victims try to acknowledge their own need to emotionally heal while the primary victim learns to deal with her experience. They suggested that secondary victims read information about sexual assault survivors.

Remer et al. (1995) believes secondary victims experience six stages of adjustment and healing. The first stage is life that exists before the rape. Trauma awareness is the second stage, however this stage may not correlate with the primary victim's trauma event. This is due because many primary victims will not speak of the assault for many weeks, months, or years later. Experiencing crisis and disorientation is the third stage for the secondary victims. At this time shock, denial, and confusion may occur. An outward adjustment is the fourth stage in which the secondary victim may try to, "Superficially return to what was the status quo before the traumatic event" (p. 410). The fifth stage is complete recognition of the emotions and support for the individual and relationship healing process. The final stage is integration and resolution. This is the time that the assault event has been accepted as a part of one's history. Remer et al., (1995) reported that the last four stages can overlap and may transpire several times. They remind both primary and secondary survivors that they need to seek support from each other to promote the healing process. An additional consideration is to allow both primary and secondary victims permission to withdraw from others when needed (Conyers-Boyd, 1992). Through all the

stages and considerations communication is essential for both the primary and secondary victims.

Counselors. Draucker (1999) conducted research regarding counselors' qualities that victims desire when seeking mental health counseling. Thirty-three female subjects identified the therapeutic relationship as extremely important. They also concluded that they value their counseling experience when the counselor identifies and encourages the client to use her strengths towards her own recovery. Draucker (1999) emphasized therapeutic support and use of client empowerment for successful counseling, "Many women in this group wanted to be told that the assault was not their fault, and they did not ask for it" (p. 5).

Ninety percent of victims experienced the feelings of helplessness during their assault (Calhoun et al., 1991). The counselor is to help her gain awareness that actions of others are beyond her control, but she can have control over her own life (Gilmartin, 1994). Assertion training is very useful to help the client regain her confidence and enhance her self-empowerment (Calhoun et al., 1991). Draucker further concluded that victims want counselors to be nonjudgmental, empathetic, and facilitate the ideas of hope towards recovery and change.

Pseudoadjustments. A victim may encounter periods of "pseudoadjustment" in which the woman seems to look and act as if she is better. Unfortunately this is often a time in which the woman is denying the reality of her sexual assault (Gilmartin, 1994). This time of pseudoadjustment should not be ignored. Rather, counselors must carefully help the victim reassess her healing

process. Counselors may need to encourage clients to schedule time to get more rest while they are recovering. Her energy level may seem depleted so it is also important for the victim to eat healthy meals (Conyers-Boyd, 1992).

Control. Control is an enormous consideration when working with sexual assault victims. Counselors need to aid clients with personal realization of what they do have control of and what they do not have control of. The idea that they did not have any control during the assault is an extremely scary thought. Due to their lack of control because of the assault, many victims try to gain complete control in other areas of their lives. The goal for many victims is discovering, "What factors you can control and then exercising that control" (Conyers-Boyd, 1992, p. 276). It is important for secondary victims not to make decisions for the victim when helping her with healing. When someone attempts to make choices for victims they have a tendency to feel less in control of their lives (Ullman, 1996).

Worthlessness. An exercise to help with decreasing feelings of worthlessness is having the client write down names of people who they believe love them. Then encouraging the victim to contact those people in different ways. For example, call three people on the list and ask them if they love you. Hug two people on the list. Write a note to four people on the list (Conyers-Boyd, 1992). The goal is for the victims to realize that they can still be cared about and loved regardless of being a sexual assault victim.

In summary, topics related to sexual assault have been addressed. Profiles of both victims and offenders were examined to aid counselors with educating themselves, victims, and society. The general impact of rape and the symptoms that follow such as post traumatic stress disorder, sexual dysfunctions, and self-blame were also reflected upon. Most importantly, treatment modalities were explored to help deal with symptoms and issues that victims endure.

Many of the treatment models seem redundant because they include similar techniques and rationalizations when working with victims of sexual assault. Some of the common similarities include: validating her feelings, encouraging her to tell her story and express her feelings, reinterpreting the event (cognitive restructuring), helping her to gain insight about the ways the incident is impacting her present life, aiding her to learn better coping skills, and assisting her to accept being a survivor of sexual assault. These treatment concerns are emphasized because they are of great importance when treating rape victims. All are significant interventions and educational information counselors can utilize when facilitating recovery.

Conclusion

Women have wondered while walking to their car, spending a night alone, or sipping a drink at a party, if they could be the next victim of a sexual assault. Women know of the horror they would endure during and after the assault. They know that the legal systems have not given justice to women who have been

victims. They see media, friends, and family blaming victims. They hear of unsuccessful attempts towards healing.

Hopefully, this paper has provided valuable information to counselors who seek to better the lives of women. Learning about the basic rape information and treatment modalities is crucial. Promoting the healing process and encouraging a life free of revictimization not only helps the victim but also secondary victims (husbands, fathers, and children). Optimistically, not only women but also men will realize the rippling effects of rape on lives. We know that men are the majority of offenders. Anger and power motivate their assault behaviors. A goal of preventing these men to force their pain on others is the next and most important step for healing this epidemic.

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