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A CONCEPTUAL ANALYSIS OF RAPE VICTIMIZATION

Long-Term Effects and Implications for Treatment

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Recent prevalence studies have suggested that 15–22% of women have been raped at some point in their lives, many by close acquaintances, although few victims seek assistance services or professional psychotherapy immediately post-assault. Surveys have revealed that 31–48% of rape victims eventually sought professional psychotherapy, often years after the actual assault. These observations suggest that the primary role of clinicians in the treatment of rape victims is the identification and handling of chronic, post-traumatic responses to a nonrecent experience. However, it is concluded that most of the existing literature on rape treatment addresses only the target symptoms that represent the immediate response to rape. In this article, contemporary theoretical and empirical discussions of stress, cognitive appraisal, cognitive adaptation, and coping are used to conceptualize the long-term impact of rape and the process of resolution. Directions for future research on the clinical treatment of rape are suggested.

> None of us can help the things that Life has done to us . . . They're done before you realize it, and once they're done they make you do other things until at last everything comes between you and what you would like to be, and you've lost your true self forever.
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> *A Long Day's Journey into Night*
> Eugene O'Neill

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Recent prevalence studies have indicated that 15–22% of women have been raped at some point in their lives (e.g., Koss, Gidycz, & Wisniewski, 1987; Koss & Oros, 1982; Russell, 1984). The majority of victims are raped by acquaintances and most are unable to define the event as a rape. Rape victims rarely seek help or utilize formal assistance immediately post-assault. Only 5% of college student rape victims indicated that they obtained victim assistance services from a rape crisis center or professional psychotherapist immediately post-assault (Koss, 1985, in press). Less than one-half of 3-month post-rape adult victims, who were judged to need treatment, agreed to accept psychotherapy (Kilpatrick, Veronen, & Resick, 1979a). Just one-quarter of victims, who entered an immediate post-rape treatment program, completed a 14-hour course of therapy (Frank & Stewart, 1983). Clinical trials have failed to demonstrate convincingly the effectiveness of treatment during the immediate post-rape periods (e.g., Kilpatrick et al., 1979a). Resick (1983) concluded: "Rape victims are frequently unwilling to receive any type of therapeutic intervention within the first few months after the assault. They (and their families) often express the hope that if they don't talk about the assault and try not to think about it, they will forget it and recover" (p. 131).

Unfortunately, evidence from long-term follow-up studies with rape victims suggests that rapid recovery doesn't characterize the majority of victims. More than 40% of rape victims reported continued sexual difficulties, restricted dating, suspiciousness, fear of being alone, and depression 1 to $2^1/_2$ years post-assault (Nadelson, Notman, Jackson, & Gornick, 1982). Problems in long-term sexual functioning (e.g., Becker, Skinner, Abel, & Treacy, 1982; Burgess & Holmstrom, 1979) and in marital adjustment also have been reported (Miller, Williams, & Bernstein, 1982). Kilpatrick, Veronen, and Resick (1979b) concluded that only 25% of rape victims were free of significant symptoms on standard psychological tests 1 year after the assault. As a group, victims still scored one standard deviation above nonvictimized women on a fear survey. Burgess and Holmstrom (1979) interviewed rape victims 4–6 years after sexual assault and asked them if they "felt back to normal, that is, the way you felt prior to the rape." The responses indicated that 37% of the victims had felt recovered within months; 37% felt recovered only after several years, and 26% did not feel recovered. Thus, it is not surprising that among samples of women raped 1–16 years previously, 31–48% stated that they eventually sought psychotherapy (Ellis, Atkeson, & Calhoun, 1982; Koss, in press).

Because few women seek psychotherapy immediately post-assault, because intervention during the initial post-assault period lacks clearcut evidence of efficacy, and because a sizable number of victims seek psychotherapy often months to years after the assault, clinicians must be prepared to address the needs of the nonrecent victim. However, much of the existing literature on rape treatment addresses only the symptoms that represent

the immediate traumatic response to rape. In this article, after briefly reviewing symptomatic patterns with rape, contemporary theoretical and empirical discussions of stress, cognitive adaptation, and coping are used to develop a model of the long-term impact of rape and the process of resolution. Based on this model, guidelines for future research on the clinical treatment of rape are outlined.

Symptomatic Responses to Rape

Most prospective empirical studies of the symptomatic responses to rape have focused on the time period from 1 month to 1 year post-rape. Extensive reviews of this material are available elsewhere (e.g., Ellis, 1983; Holmes & St. Lawrence, 1983). What is known is that most victims experience an immediate post-rape distress response that for some victims, fails to resolve and develops into a chronic, though heterogeneous, symptom pattern that may persist for a variable length of time (Ellis, 1983). The core features of these long-term symptom patterns appear to be a set of fear/avoidance responses, affective constriction, disturbances of self-esteem/self-efficacy, and sexual dysfunction. A number of factors may modify the intensity of a victim's response to rape including: characteristics of the crime (Frank & Stewart, 1983; McCahill, Meyer, & Fischman, 1979), locus of control (Janoff-Bulman, 1979), coping ability (Burgess & Holmstrom, 1979), life stress (Ruch, Chandler, & Harter, 1980), personality variables and social network (Atkeson, Calhoun, Resick, & Ellis, 1982), and developmental stage (Burt & Katz, 1987; Notman & Nadelson, 1976). No isomorphic relationship between trauma and symptom has been observed. The nature of the interactive effects and why some victims develop more chronic patterns is not yet understood.

Currently, most extant research on post-traumatic responses to rape use a behavioral/conditioning framework to account for the development of symptoms. Sexual and fear-related symptoms are explained on the basis of classical conditioning (e.g., Becker & Skinner, 1983; Kilpatrick, Veronen, & Resick, 1979a). Higher-order conditioning effects are suggested to account for the observed diffuseness, persistence, potency, and individual variations of rape-induced after-effects. However, the key to understanding such chronic patterns may have more to do with the kinds and consequences of the particular cognitive appraisals used by the victim than with simple or complex conditioning effects. Although some behavioral treatment programs (Kilpatrick & Veronen, in press) for rape acknowledge the importance of cognitions, little attention has been paid to identifying the specific cognitive–emotional processes through which rape resolution occurs. To this end, recent work on the processes of cognitive adaptation is considered next.

COGNITIVE PROCESSES AND THE TRAUMATIC IMPACT OF RAPE

In order to appreciate and understand the long-term effects of rape and the complexity and variability in the occurrence and course of symptomatic responses to such victimization, cognitive processes of appraisal and the mediating role of these processes on stress and coping must be considered (Lazarus & Folkman, 1984). Conditioning models, while having some heuristic value for immediate fear responses, do not address the individual variability in responses nor provide much conceptual utility for understanding coping processes adopted spontaneously by victims or provided through treatment interventions.

Cognitive appraisal (Lazarus & Folkman, 1984) is a key concept of considerable value in accounting for the variations in sensitivity and vulnerability to stressors as well as the differences in adaptation. Cognitive appraisal refers to the process by which an individual evaluates a particular stressor (e.g., Lazarus & Folkman, 1984). Stressors may be appraised as benign, irrelevant, harmful, threatening, or challenging. The amount of psychological stress experienced by an individual is not determined by the stressor alone but by the relationship between the person and the environment. Cognitive appraisal mediates stress-response levels and is a transactional process; re-appraisals are made on the basis of new information from the environment. While appraisal is often thought to be a conscious and deliberate process, in fact, individuals may be unaware of any or all of the elements of an appraisal. Lazarus and Folkman (1984) reviewed the considerable empirical support for this conceptual model. As they summarized their review, "Taken as a whole, these studies left little doubt about the powerful role played by cognitive appraisal processes in the stress response to diverse stressors." Furthermore, their analysis of this model provided a useful framework for consideration of long-term effects of rape victimization.

Appraisals are influenced by both situation factors (e.g., predictability, duration, and ambiguity of the stressor) and person factors: that is,

> commitments—what is important to the person; . . . beliefs—personally formed or culturally shared . . . preexisting notions about reality which serve as a perceptual lens; . . . and existential beliefs—faith in God, fate, or some natural order . . . that enable people to create meaning out of life, even out of damaging experiences, and to maintain hope. (Lazarus & Folkman, 1984, pp. 58–77)

In the remainder of this article, in the context of reviewing the literature, we will provide a theoretical analysis for understanding sexual victimization and its resolution based on a cognitive framework. Central to this analysis will be the value of understanding the manner in which rape is both similar to and different from other traumas. By so doing we intend

to identify the unique factors influencing the appraisals and coping of rape victims.

Cognitive Responses to Rape

Rape, like other traumatic events, such as natural disasters and disease, contradicts beliefs that have been developed and confirmed over many years and, therefore, are not readily assimilated. The beliefs most affected by traumatic experiences are the belief in personal invulnerability, the perception of the world as meaningful, and the positive view of ourselves (e.g., Janoff-Bulman, 1985; Taylor, 1983). Victims experience a "loss of equilibrium. The world is suddenly out of whack. Things no longer work the way they used to" (Bard & Sangrey, 1979, p. 14). Victims are no longer able to say, "It can't happen to me"; they cannot see themselves any longer as safe and secure in a benign world and must confront this challenge to their beliefs that bad things happen only to bad people (Janoff-Bulman, 1985).

Despite these similarities, there are several critical differences between rape and natural disasters. Common to most of these differences are two factors that have profound implications for a psychological understanding of the stressful impact and consequent process of adaption involved in sexual victimization. These two factors are: (a) the interpersonal nature of the sexual victimization; and (b) the pervasive, malevolent social context of rape (Burt & Katz, 1987).

Directed, focused, intentional harm involving the most intimate interpersonal act—that is the nature of rape. Because rape is fundamentally an interpersonal act, victims have to resolve the most central identity questions, "What will people mean to me and what do I mean to others?" It is not just that nameless forces caused a natural disaster; rather, people, represented by an assailant, who is usually known to the victim, are now the source of threat and degradation. The social context of rape—that is, the understanding provided by cultural norms and beliefs—provide few resources for resolution. According to Just World Theory (Lerner, 1980), rape is what happens to bad women who, thus, cannot count on cultural support, but instead may experience isolation and shame.

The power of these two interacting factors in thwarting resolution of rape trauma can be identified in all sexual victimizations. However, in examining acquaintance rapes, these factors are placed in bold relief. The victim, participating in a social context assumed to be at least benign, is suddenly exposed to a malevolent, personally directed event. Moreover, the social response does not affirm the victim's emotional experience in that her assailant as well as the general social environment is likely to interpret the outcome as "no big deal." One woman, after her companion had sexually assaulted her, reported that her assailant asked if he should walk her back to her apartment for her protection! This woman, who was

participating in a study on acquaintance rape, had been unable to acknowledge her victimization until 2 years after the event. Victims frequently report that the conflict between their subjective experience and the response of their external and internal social environment leads to a sort of cognitive–emotional paralysis wherein their only recourse is to simply deny that the experience really happened.

THE PROCESS OF RESOLUTION

The resolution of a traumatic experience has several components. For example, Pasewark and Albers (1972) suggested that gaps in knowledge must be filled in to allow correct cognition and perception, affect must be expressed and managed appropriately, and new behavioral patterns of coping must be developed. Janoff-Bulman emphasized re-defining, finding meaning, changing behavior, and seeking social support: "Coping with victimization involves coming to terms with these shattered assumptions . . . entails the establishment of an assumptive world which incorporates one's experiences as a victim . . . involves reworking one's assumptions about oneself and the world so that they 'fit' with one's new personal data" (Janoff-Bulman, 1985, pp. 22–23).

Taylor (1983) suggested that the cognitive re-adjustment process involves three important themes. The first theme is the search for meaning, which is an attempt to answer questions such as: "What is the significance of the event?" "What caused it to happen?" "What does my life mean now?" The second theme involves attempts to gain mastery and control through answers to questions such as: "How can I keep this or similar events from happening again?" "What can I do to manage now?" The development of self-blame among rape victims, which intuitively seems like a negative development, has been linked to enhanced feelings of control among some rape victims (Janoff-Bulman, 1979). However, whatever the immediate gain in sense of control, it may be offset by the long-range consequence of self-blame on self-esteem. In fact, in a recent study, Meyer and Taylor (1986) found that coping strategies following a rape based on self-blaming attributions were linked to negative adjustment outcomes. These data suggest that above all, victims need to be disabused of the stigma of responsibility for their victimization. Moreover, our hypothesis is that until victims can be affirmed in the reality of victimization—that is, that they are not to blame for their injury—they cannot complete the emotional process of transforming guilt to anger and depression to grief. The third theme observed in the process of cognitive re-adjustment is an attempt to promote self-enhancement which is often accomplished through downward comparisons that minimize one's trauma compared with others. Other maneuvers that appear to be directed at self-enhancement include redefining the event, creating hypothetical worse worlds, construing benefit from the

experience, and manufacturing normative standards of adjustment (Janoff-Bulman, 1985).

Horowitz (1980) maintained that people have a "completion tendency" which is a predisposition "to integrate reality and schemata" (p. 249). Before new information is integrated, it is stored in active memory. While in active memory, the information often intrudes on mental life through dreams, memories, and uncontrollable, emotionally distressing images. Numbing, which can alternate with intrusiveness, represents the individual's attempts to slow down cognitive processing and reduce the anxiety associated with intrusive representations. Most rape victims (89%) who sought help from a crisis center were still experiencing rape-related intrusion and avoidance 3 years post-rape (Kilpatrick, Veronen, & Best, 1985). Because cognitive schema function as anticipatory mechanisms that determine what people attend to in their encoding of reality (Greenberg & Safran, 1981), the form of rape-induced cognitive alterations has important and long-lasting implications for victims.

Successful Resolution: From Victim to Survivor

Successful cognitive re-appraisals emphasize positive attributes, including the discovered ability to cope, adapt, learn, grow, and become self-reliant, and produce a greater sense of strength, depth, maturity, sensitivity, honesty, and self-confidence (Finkel, 1975). There is no empirical evidence whether the specific content of a re-appraisal makes any difference. Many of the cognitions on which all of us base meaning, mastery, and self-enhancement are to a great extent illusory (Taylor, 1983); however, we suggest that there would be differences in the long-term emotional effects of particular kinds of re-appraisals, particularly those not affirming the validity of the victim's sense of victimization.

Through the process of cognitive re-appraisal, several positive outcomes are possible including: healthy questioning of beliefs about the meaning and direction of one's life, discovered ability to maintain a sense of competence even under trying circumstances, heightened sensitization to horror and dehumanization, and development of strong convictions (Scurfield, 1985). Burt and Katz (1987) studied the positive ways in which women grow after sexual assault. A factor analysis of 29 psychological measures revealed four growth outcome factors including improved self-concept and self-directed activity as well as reduced passivity and stereotyped attitudes. On 15 of 28 statements on a Change Scale that reflected growth outcomes, 50% or more of the respondents felt that they had changed in a positive direction, and fewer than 15% felt that they had changed in a negative direction. Examples of positive changes were statements such as, "I know myself better," "I value myself more," "I trust myself more," "I know who my real friends are" (p. 14).

Veronen & Kilpatrick (1982) suggested three ways in which rape can be

assimilated as a positive event: as a consciousness-raising experience ("I wasn't much of a feminist before my rape but it kind of crystallized for me the way women are treated in our society"), as a life appreciation lesson ("During the rape I said to myself, 'If I come out of this alive, there's a lot of things I'm going to change in my life and I'll be grateful for every minute of every day I live'"), and as a challenge to overcome ("I've always been a strong person. I realize that now that I'm a survivor"). The new beliefs allow assimilation of the traumatic experience and function to restore previous meaning, mastery, and self-esteem. To the extent that new beliefs were "born of a trial by fire," they may be more realistic and resilient than those they replaced. All of these positive growth responses reflect an acceptance and transcendence of the two themes unique to rape trauma.

The extent to which growth outcomes occur among untreated rape victims has not yet been determined and the experience of sexual assault poses formidable barriers to resolution. However, among women who had been incest victims an average of 20 years previously, over 80% reported that they were still searching for a way to make sense of their incest experience (Silver, Boon, & Stones, 1983). Women who had made sense of their experience, compared with those who were still searching, reported less recurrent, disruptive, intrusive, and painful ruminations, lower levels of psychological and social distress, and higher self-esteem.

Accommodation Versus Resolution

Because rape is done to a woman by another human being, it poses unique challenges, including removing her control over that part of herself that she learned in childhood to guard, and puts her in a situation in which she is treated as if she has no human rights, needs, or physical boundaries (Burt & Katz, 1985). Resolution may be hampered further by the fact that close to half of sexual assault victims do not disclose their sexual assault to anyone (Koss, 1985). Davis and Friedman (1985) believe that talking about the victimization is therapeutic and important to recovery. They found that 4 out of 5 crime victims were still talking about their experience 4 months afterward and concluded that this must represent "self-therapy." Inability to confide in friends subsequent to trauma has also been associated with increased health problems (Pennebaker & O'Herron, 1984).

Furthermore, victims of sexual assault must contend with a culture in which socially transmitted myths about rape support a belief in the woman's responsibility for rape (Burt, 1980). In this climate, the cognitive reappraisals that lead to trauma resolution are not likely to occur. Rather than supporting a redefinition of rape as "bad luck," or "not your fault," or "no reflection on you," these cultural myths may reinforce feelings of unworthiness in a raped woman. Burdened by a belief in her responsibility

for sexual outcome, a woman will find it difficult to obtain validation of the reality of her status as a victim and to rebuild her shattered assumptions. Likewise, the acquaintance-rape victim is compromised by her culture and her own socialization in attempting to resolve her trauma. Led to believe that she is responsible for any sexual outcome and faced with an unsupportive social environment (including an assailant who may even ask her to go out with him again), the woman experiences herself as having only the choice of responsibility and self-blame, or denial. It may not be until years later through a chance remark or exposure to similar circumstance that she will recognize her own victimization and her accommodation to it.

Without the opportunity to develop a positive or, at least, strengthening reinterpretation of her experience, the rape victim may assimilate degradation and helplessness into her beliefs and behavior. To the extent that a victim sees herself as damaged and unworthy, she may become compromised in her ability to see herself as powerful and able, or even willing, to affirm her dignity. Symptomatically, such beliefs could lead to a clinical picture that varies from a constricted, fear-dominated, withdrawn person to a person who acts out her sense of unworthiness and powerlessness by repeated involvement in abusive relationships.

Because the highest rates of rape are recorded in the 17–25-year-old age group, many victims are unlikely to have reached a mature adult level of cognitive development that might mitigate the effects of sexual assault. Rape during adolescence may be particularly shattering because it is during this period that girls formulate their generalized views of the world as well as their specific views of men, authority figures, and themselves (Silver et al., 1983). Estep, Burt, and Milligan (1977) found, based on the interviews with 170 women, that unwanted sexual activities in adolescence were more influential on adult sexual identity than similar experiences in childhood. "Adolescents are alert to the issue of human accountability. They seem compelled to judge the courage of their own actions and reluctant to criticize the behavior . . . of others . . . they are exquisitely sensitive to their own imperfections and are painfully cognizant of what others might think, often fearing being stigmatized by their peer group" (Eth & Pynoos, 1985, pp. 47–48). In this context the adolescent victim may be, therefore, even more likely to rely on the malevolent social myths about rape as the source of her cognitive appraisals for her victimization thus increasing her vulnerability to guilt, self-blame, and a sense of helplessness and unworthiness.

In addition to the direct effects of the accommodation process (Summit, 1983), the victim's idiosyncratic coping response has important clinical implications. To deal with the direct trauma of the assault as well the psychological consequences of the stigmatization and powerlessness attendant to the victimization, victims turn to previously learned styles of coping. Sometimes, a coping response is selected because of its use in a similar,

previous context. For example, one of our clients, who had been sexually abused as a child, was the victim of a gang rape as a young woman. As a child, her only way of coping with the sexual abuse of her father was, every night, to wrap herself up tightly in the covers and pretend to be asleep. No matter what he did to her, as long as she was "asleep" it was as if "it didn't happen so badly." When she was gang raped, as an adult, she pretended to be dead. Again, the dissociative quality of this behavior allowed her to survive the trauma of the multiple assaults. However, coping styles adopted during times of overwhelming stress become "stamped in"; thus, victims' responses to new crises often are rigid, stereotyped, unadaptive, and, thus, unsuccessful. It was not surprising that after her rape, she began to have significant interpersonal difficulties, most of which were associated with her difficulty in being emotionally present in relationships.

DIRECTIONS FOR FUTURE RESEARCH

A primary need in rape victim research is to develop a better understanding of the nature of the long-term cognitive-emotional responses associated with sexual assault. This should be a high priority for research. However, the establishment of relationships between remote events and current cognitions is complicated by the temporal distance from the trauma, the inability of victims themselves to connect early trauma with current functioning, the inaccessibility of all elements of appraisals to conscious recall, the relatively high percentage of multiply-victimized women, and the fact that the highest risk ages for rape coincide with the occurrence of extensive normative developmental change. A final difficulty is that the long-range impact of rape may involve changes not evident in the immediate post-rape picture since some impacts may emerge only after cognitive changes made by the victim to accommodate the trauma, the response of the social network, and feedback from post-rape life changes have exerted their influence.

Even though many factors deter spontaneous rape resolutions, the process should be studied prospectively among victims. Additionally, retrospective comparisons of symptoms, cognitive appraisals, and coping strategies of low-symptomatic and high-symptomatic nonrecent victims may reveal information about trauma resolution with important therapeutic implications (Gottman & Markman, 1978). For example, Burgess and Holmstrom (1979) described several styles of thinking about rape that occurred spontaneously and seemed to be associated with more immediate recovery. They included suppression ("I don't think about it at night"), minimalization ("Compared to what a young girl would experience after a rape, my experience wasn't bad"), rationalization ("He was a sick man who needed help and it was just a one in a million chance that he broke into my house"), and dramatization (i.e., repeatedly expressing the memories of

the experience and thereby dissipating the anxiety associated with it). Clearly, however, long term follow-up of these coping strategies is necessary to determine if the beneficial effects are lasting and no negative second-order effects arise.

Because few empirical studies have attempted to describe the after-effects of rape beyond a 1-year period, it is not surprising that most treatment studies have focused only on those symptoms that have been observed immediately post-rape. (Extensive reviews of this material can be found in Ellis, 1983; Holmes and St. Lawrence, 1983; and Resick, 1983). The bulk of the published literature on rape treatment evaluation consists of behavioral case studies where a single intervention is directed at a focused symptom (e.g., Becker & Abel, 1981; Blanchard & Abel, 1976; Wolff, 1977). The few large-scale outcome studies of multimodal rape treatment, also, have involved the victim immediately post-assault (e.g., Frank & Stewart, 1983; Kilpatrick et al., 1979b).

Therapy durations in most studies were brief (4–10 sessions) and were administered immediately postassault. These interventions may be too early and too short to facilitate a therapeutic process of rape resolution. They do not seem to take into account the magnitude and types of changes that must occur to resolve a trauma. Treatment effects may be demonstrable only after the therapeutic process has guided the victim into positive life experiences which reinforce a changed cognitive appraisal of the sexual assault. Such changes require time. While a large number of treatment sessions may not be needed, it may be prudent to space them out in time and arrange for a longer period of followup post-therapy before the final verdict on therapy effectiveness is rendered.

Moreover, the scope of treatment goals of many rape treatment studies may be too limited. Most treatment procedures have focused on fear symptom reduction, often to the relative exclusion of cognitive mediating processes or the inter- and intrapersonal effects of victimization. Given the present conceptualization of the reaction of the rape trauma as involving multiple levels of cognitive/emotional processes, it follows that treatment, particularly of non-recent trauma, should involve multiple levels of intervention.

Furthermore, the failure of treatment research to be framed by theoretical notions of the necessary treatment components prevents the development of generalizable treatment protocols. Our analysis of the dynamics of rape resolution indicates that in addition to general therapeutic factors, specific attention must be directed to the process of cognitive appraisals and the consequent accommodations made to the victimization. Of particular importance is the identification of the undermining of interpersonal competence and worth through the pathogenic effects of social myths about rape. By assimilating the experience without accommodating to its pathogenic forces, victims do not lose their true selves and can become true survivors.

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