traumaclinic
counselling

Special Issues of Rape Trauma

Gerrit van Wyk, Brett Pentland–Smith, Kelly Hunt, Megan Barber,
traumaClinic Emergency Counselling Network, Cape Town

Course outcomes:

When you have completed this course you will have an understanding of:

- The variety of special issues related to sexual assault and rape trauma.
- Definitions and contexts of sexual assault and rape.
- The history of rape research with regards to: Rape Trauma Syndrome (RTS) and Rape Related Posttraumatic Stress Disorder (RR-PTSD).
- Specific reactions that victims can have during and after sexual assault or rape.
- Various methods and theories for the treatment of rape trauma.

CONTENTS

Special Issues in Rape trauma

A note on the learning and teaching approach

This course is built on the principles of supported open learning pioneered by the UK Open University and developed by the South African Institute for Distance Education (SAIDE) and The SACHED Trust. Course participants (Students) are asked to do all the tasks as they appear in the text in order to take full value from the course. There are three kinds of tasks:

Fact check – to memorise key knowledge items

Reflection and analysis – to take time to actively engage with the ideas in the course

Assignments – a chance for an extended written task to consolidate your knowledge and express your views

1. INTRODUCTION TO RAPE TRAUMA

South Africa has one of the highest rates of rape in the world, with over 68 000 sexual offences reported during April 2009 – March 2010 (South African Police Services, 2010). It has been suggested that a woman is raped every 17 seconds in South Africa, which results in approximately 500 000 rapes annually.

While researchers estimate that only 10% of rapes get reported to the police, amongst those only 15% result in convictions (Rape Statistics, 2010). This shocking statistic is a result of rape being a complex and sensitive subject for everyone involved; the victim, perpetrator and the community (Rauch & Foa, 2004). Although in recent years there has been ample research conducted on the impact of rape, there are still many questions surrounding the reactions and treatment of rape survivors. This course aims to introduce the learner to the intricate and complex nature of rape trauma, the history, social context, common reactions experienced and specific treatment for rape survivors.

2. DEFINITIONS AND CONTEXT OF RAPE

Sexual violence, as defined by Martin (2010; 34), "is a term used to encapsulate the various acts of violence against women." Thus rape is one part of a range of offences that are perpetrated towards females; such as molestation, indecent exposure and incest to name a few. Although Martin (2010) defines sexual violence as being gender specific, both males and females can be victims of such crimes.

Rape is a crime that involves both the social and legal sphere. The South African constitution reformed the definition of rape in 2004 to be: "Any person ("A") who intentionally and unlawfully commits an act of sexual penetration with another person ("B") without such person's consent is guilty of the offence of rape" (Burchell & Milton, 2005: 718). This definition uses gender neutral terminology, thus allowing for both male and females to be perpetrators and victims of the offence, as well as accounting for a range of sexual activities. Therefore this definition broadens the legal parameters of rape, accounting for more instances of sexual offences.

However, despite this legal step forward, there are still relatively few rapes that are being reported in South Africa. One explanation of this is the prevalence of rape myths. Rape myths are beliefs and stereotypes that lead to a false perception of rape, involving both the rape survivor and the rapist. According to Burt (1980; 217), rape myths are defined as "prejudicial, stereotyped or false beliefs about rape, the rape victims, and the rapist – in creating a climate hostile to rape victims." These beliefs narrow the definition of rape to include only the more traditional view of rape; that it is violent, only involves women, and attributes blame towards the rape victim while absolving the rapist (Eyssel, Bohner & Siebler, 2006).

Examples of such attitudes are statements that dispel rape claims (e.g. it wasn't really rape) or when people point out that rape happens to only specific types of people (e.g. only promiscuous women, or women who dress suggestively get raped). Brownmiller (1975) identified four fundamental rape myths: all women want to be raped; no woman can be raped against her will; she was asking for it; and if you are going to be raped you might as well enjoy it. These four classifications of rape myths illustrate how the responsibility of the incident lies with the survivor, which in turn pardons the perpetrator.

By believing that the responsibility of the rape lies with the rape survivor, people are able to maintain a safe and positive view of the world, which protects the belief that the world is a 'just place' where good things happen to good people, and bad things only happen to bad people (Lonsway & Fitzgerald, 1994). Rape myths also function as a way to justify male aggression against women, as explained above. In instances of male rape the assault would be explained away as it does not fit into the traditional view of rape as a crime that only happens to females (Newcombe, Eynde, Hafner & Jolly, 2008).

These beliefs can cause rape victims to be resistant to reporting incidents to the police in order to protect their own and others' beliefs about themselves. This is supported by research that shows that people who were raped in terms of the traditional definition, by a stranger and violently, are more likely to report it to professionals (mental health professional, doctors or the police). This skews the statistics of rape as they suggest that the majority of women get raped by a stranger. For example, in the USA 64% of people who have been raped and have reported it, were raped by strangers (Martin, 2010). Therefore, despite the change in the legal definition of rape, the impact of this has not trickled down to the common understanding in society. This has resulted in the traditional definition of rape being maintained by the general public, which adds to the complicated cycle of myths surrounding rape.

These beliefs are further reinforced as those members of the public who are most vulnerable to rape are young women, adolescents, the poor, those living in violent areas, sex workers, and people with disabilities or living in institutions (Welch & Mason, 2007). However, rape can, and does, happen to all members of the population; each rape looking somewhat different as there are a variety of categories of rape, ranging from incest, statutory rape, marital rape, date rape, gang rape, to the more traditional stranger rape (Martin, 2010).

When a person is raped the survivor is confronted with various decisions to make: whether to report the incident, whether to seek medical attention, and whom to tell (Rauch &Foa, 2004). This begins to lay the foundations of the complex nature of rape, as there are many factors that contribute and influence the rape survivor's reactions: societal beliefs on the matter, the beliefs of close family and friends towards the rape survivor, the legal attitudes, and acceptance of rape by authority figures such as the police, doctors, etc. This is discussed under the heading specific reactions after trauma.

Fact check 1

Question 1

Explain how the change in the legal definition of rape has expanded the legal understanding of the crime.

Question 2

What are rape myths, give two examples of your own.

List four reasons why rape is a complicated crime.

3. HISTORY OF RAPE RESEARCH

Although rape has been in existence since the beginning of mankind, the study of the reactions to rape is a rather recent phenomenon. The first such study was done by feminist researchers who started to explore the reactions of women to rape, by allowing women to talk about their experiences. This culminated in Burgess and Holmstrom's study exploring reactions and coping strategies after rape, from which the term Rape Trauma Syndrome (RTS) was coined. It was designed to explain the typical phased reaction of women who experienced rape: the acute and the reorganization phase (Burgess & Holmstrom, 1974; Stefan, 1994).

3.1 Rape Trauma Syndrome (RTS)

The acute phase, also known as the disorganisation phase, involves somatic and emotional reactions. The somatic reactions are various physical ailments that commonly develop following a

rape, such as physical trauma, skeletal and muscle tension, gastrointestinal irritability and genitourinary disturbances. The emotional reactions involve a variety of feelings that range from fear of physical violence to feelings of self-blame and guilt (Burgess & Holmstrom, 1974).

During the second phase, reorganization, there are three main clusters of symptoms: changes in motor activity, nightmares and traumatophobia. Changes in motor activity is when the survivor undergoes some form of physical change, like moving home, or changing telephone numbers. This is done as a way to protect themselves and prevent any future trauma occurring. Nightmares and extremely vivid dreams are a common reoccurring reaction following a rape, and can cause significant distress to the survivor. Traumatophobia is the fear of situations surrounding a traumatic incident that develops as a defence mechanism by the survivor. Burgess and Holmstrom (1974) found that the most common phobic reactions were, fear of indoors, fear of outdoors, fear of being alone, fear of crowds, fear of people behind them, and sexual fears.

RTS began to address the impact that rape has on a person's life, and how it infiltrates many facets of a person's everyday functioning. At a later stage RTS was expanded to include three phases: acute, outward adjustment, and resolution. Unlike the earlier definition of RTS this focuses solely on the psychological and coping strategies of rape survivors. During the acute phase, which presents after a few days or weeks, the rape survivor experiences a range of emotional reactions such as shock, fear, anger, shame, loss of trust, sadness and anxiety. These can present in one of two ways: expressively (when the person talks, acknowledges, and expresses these emotions overtly), or denial (when the survivor avoids or ignores these emotions and the impact of the rape) (Lauer, 2006; Martin, 2010).

The outward adjustment phase usually happens between three to six months after the initial incident. There are five common reactions: minimization (i.e. everything is fine), dramatization (i.e. persistent talking about the event), suppression (i.e. denial or ignoring the event), explanation (i.e. analysing the event), flight (i.e. attempts to escape the current reality such as changing jobs, houses etc). This demonstrates the range of coping strategies that can be adopted by rape victims. The last phase, the resolution phase, is when the survivor no longer focuses on the assault, and has been able to integrate the incident into their lives (Lauer, 2006; Martin, 2010).

Although the development of RTS sparked a range of research in the specific nature of rape trauma and gave professionals a more in-depth understanding of the impact of rape, the diagnosis was never included in the Diagnostic and Statistical Manual (DSM). Consequently, most rape survivors are given various diagnoses included on the DSM-IV-TR, the majority being Posttraumatic Stress Disorder (PTSD), but can also be Generalised Anxiety Disorder, Major Depressive Episode, and Substance Abuse Disorder.

Fact check 2

Question 1

Design the diagnostic criteria for RTS as if it was to be included in the DSM-V.

Question 2

True or false: People who are raped always develop RTS.

3.2 Rape-Related Post-Traumatic Stress Disorder (RR-PTSD)

PTSD (as discussed in other courses) first appeared in the DSM III in 1980 (Psychiatric Disorders, 2009) as a new psychiatric diagnosis arising from the social context of returning Vietnam War veterans. The key diagnostic criterion is exposure to:-

a) traumatic event(s), involving a further five diagnostic criteria summarized here;
b) re-experiencing symptoms;
c) avoidance symptoms;
d) increased arousal symptoms;
e) all the aforementioned should occur at a clinically significant level, and
f) have been evident for at least one month (American Psychiatric Association, 2002; Boeschen, et. al., 1998; Fact Sheet, n.d.; Murdoch, et. al., 2003; Trowbridge, 2003).

Clinical professionals generally consider RTS to fall under the umbrella diagnosis of PTSD and the diagnosis, as defined in DSM-IV-TR, is accepted as a valid diagnosis (Maw et. al., 2008). PTSD describes the symptoms that can be experienced by the rape survivor and it has been shown that sexual violence is one of the highest predictors of PTSD, with 76% of rape victims meeting the criteria for PTSD within the first year following the incident (Murdoch et. al., 2003; Rothbaum, Foa, Riggs, Murdock & Walsh, 1992). Amongst professionals working with rape survivors a subsection of PTSD called Rape Related PTSD (RR-PTSD) has been developed. Although this is not recognised on the DSM-IV-TR it helps identify the symptoms of PTSD that can be related to survivors of rape.

RR-PTSD has four different clusters of symptoms: re-experiencing, social withdrawal, avoidance (behaviours and actions) and hyper-arousal. Re-experiencing for rape survivors is usually extremely realistic in the form of vivid flashbacks, or nightmares about the incident. These are essentially uncontrollable intrusive thoughts, memories and emotions that are extremely difficult to stop, and cause the rape survivor great distress, as they may feel a lack of control over these images and thoughts (Martin, 2010).

Withdrawal symptoms include active withdrawal and involuntary withdrawal. The latter refers to a sense of numbing and lack of interest in activities that previously would have pleasurable to the survivor. It can be described as a form of numbing and a feeling of being emotionally dead, where they feel a very narrow range of emotions. The rape survivor may feel an increase in fear and anger, however. Active withdrawal refers to conscious avoidance of places, people, situations or associations related to the traumatic incident. The diagnosis of RR-PTSD differs from the standard DSM-IV-TR in that the RR-PTSD diagnosis makes a clear distinction between numbness (feeling a narrow range of emotions) and avoidance. In the DSM-IV for PTSD these categories of symptoms are combined under the heading avoidance. This is being revised for the DSM-V (Martin, 2010).

The group of avoidance behaviours indicates that the survivor may physically avoid any scenario/reminder of the rape, such as not walking near the location of the assault or even going out at the same time of the incident. It also addresses the psychological symptoms of avoiding anything to do with the rape, including any thoughts or feelings connected to the incident, as these could trigger overwhelming emotions connected to the incident.

Hyper-arousal includes both hyper-vigilance and hyper-alertness, meaning the person is in a constant state of arousal, and highly aware of external stimuli that could cause danger, such as sights and sounds. This commonly leads to sleeping disorders (Resnick, Kilpatrick & Lipovsky, 1991).

Careful diagnosis of rape survivors is particularly important since over-diagnosis may pathologise survivors unnecessarily, on the one hand, but on the other hand Rothbaum, Foa, Riggs, Murdock and Walsh (1992) have shown that early detection of RR-PTSD leads to an increase in recovery rate. A careful assessment of the rape survivor is imperative, before the survivor is diagnosed or treatment initiated.

Fact check 3

Juxtapose PTSD, RR-PTSD and RTS, listing the pros and cons of the various diagnoses.

4. SPECIFIC REACTIONS AFTER RAPE

According to Rouch and Foa (2004), many survivors of rape and sexual assault suffer from psychological difficulties such as PTSD and depression. Although PTSD is a common disorder that follows many traumatic experiences, epidemiological studies have suggested that the prevalence of PTSD following sexual assault accounts for about a third of all PTSD cases (Breslau et al., 1998). A survivor of rape related trauma will most likely face physical, psychological, and emotional reactions, reactions that can become symptoms of Posttraumatic Stress Disorder once the criteria for a diagnosis has been met (American Psychiatric Association. 2002).

Some common physical reactions to rape include pain, bruising, irritation and tenderness in the vaginal area, vaginal and anal bleeding and possibly tears to the vaginal-rectal area (Rautio, 2008; Macey and Gates. n.d). Depending on how violent the rape incident was, the survivor may also have abrasions, bruises, broken bones etc. Physiological reactions could be pregnancy, infections, sexually transmitted infections (STI's), insomnia, eating disorders, hyperarousal, hypervigilance, gynaecological, cardiovascular and gastrointestinal problems (Kansas State University. 2011; Macey and Gates. n.d). Cardiovascular and gastrointestinal problems could also be related to psychological or psychosomatic problems. (Macey and Gates. n.d.).

Psychological reactions usually relate to the survivor's way of dealing with the incident and trying to integrate the incident into their psyche and/or worldview (Kansas State University, 2011). These

reactions can affect the survivor's day-to-day activities as well as relationships with friends, family and partners. Some of the more common psychological reactions include: suicide ideation, flashbacks, nightmares, difficulty with problem-solving, somatic reactions, depression, psychological disorders, substance abuse and lack of self–esteem (Kansas State University, 2011; Martin, 2010).

Emotional reactions to rape or sexual assault are diverse and differ in terms of duration and intensity (Martin, 2010). The most common reactions are:

- Anger
- Fear of being alone, leaving home or returning to the site of the incident
- Humiliation
- Feelings of degradation and powerlessness
- Mood swings
- Irritability
- Decreased self-esteem/self-worth
- Suspiciousness
- Emotional numbness (Martin, 2010; Macey and Gates, n.d; Lifeline, n.d; Rautio, 2008.)

Survivors' reactions and coping mechanisms to rape or sexual assault are unique. There is no right or wrong way to behave, think or feel during or after the incident. Like other traumas, survivors of rape or sexual trauma usually adjust or learn to cope with their experience in phases (Martins, 2010). These patterns of adjustment vary greatly from person to person, but there are three main themes/stages that have been observed throughout the adjustment process (Lifeline, n.d.). These stages are:

1. **Shock:** This usually takes place directly after the incident and can last anywhere from a few minutes to a few weeks. During this phase, survivors may suffer from guilt, fear, shame, embarrassment, hypervigilance and some observable reactions ranging from hysteria to numbness. The survivor's self-perception may be challenged and survivors may become doubtful of their memory of the incident (Gates and Macey, n.d; Martins, 2010; Lifeline, n.d.).
2. **Denial:** Denial is a defence mechanism linked to disassociation which occurs in the face of trauma. In this stage, the survivor attempts to "forget the whole thing" or just brush it off and move on with their life as if nothing happened. They may also feel like it was a dream and did not really happen (Gates and Macey, n.d; Martins, 2010; Lifeline, n.d.).
3. **Integration:** This stage is characterized by the realization of the survivor that the incident has affected their life more than they had previously believed. Symptoms of PTSD become evident in this stage, such as recurring nightmares, flashbacks, uneasiness about the environment and difficulties in personal relationships. Prolonged effects of the incident may in fact force the survivor to re-evaluate the incident and its impact on their life in a healthy way (Gates and Macey, n.d; Martins, 2010; Lifeline, n.d.).

Listed below are some of the most common reactions to rape and sexual assault:

<u>Frozen Fright</u>: During a sexual assault, some people "freeze" or "tense up" and are unable to move.

This is a physiological response that our bodies use to survive a life threatening situation and is completely normal.

Dissociation: This occurs during a traumatic event. The mind tries to separate from the trauma occurring on the body. During an assault, the survivor may try to dissociate by focusing on details of something not related to the incident, e.g. reciting a poem in their head or focusing on the environment around them. After an assault, many people report feeling that they are in a dream-like state.

Memory Loss: Sometimes survivors are unable to recall specific details about the incident or are unable to recall the details of the incident in a chronological order. This is because our brains function differently under trauma, and often this can be misconstrued by some to mean the survivor is not telling the truth.

Denial: Survivors may have a hard time believing that the assault occurred. Sometimes people report that the assault "felt like a dream," or that it could not have really been rape.

Shock: Survivors often appear to be calm and collected and are able continue with their day-to-day lives as if nothing has happened. Sometimes outsiders misinterpret this behaviour to mean that the survivor made up the sexual assault. It is important to remember that this often is not the case, and a survivor's ability to "go on with life" could really mean that they are in a state of shock and disbelief.

Guilt/Self-blame: Survivors may blame themselves for the assault. They may blame it on their own behaviours before or during the attack. They may also minimize the assault as not a "real" rape, because they feel responsible.

Withdrawal: A survivor may isolate from others as well as stop engaging in activities they once enjoyed.

Change in sexual activity: A survivor may abstain from sexual activity altogether or seek out sexual encounters as a way to try to "forget" the assault (Common Reactions after Rape. n.d.). Survivors may also have problems with intimacy with their partners in the future as a result of the assault.

Destructive behaviours: Some survivors may use drugs or alcohol to cope with the assault. Others may engage in self-harm (i.e. cutting) or develop eating disorders (Martins. 2010; Sexual Assault Interagency Counsel. n.d.).

4.1 Revictimisation

Revictimisation (also known as secondary victimisation) refers to the negative experiences which involve behaviours and attitudes of social service providers that are "victim blaming" and insensitive (Campbell & Raja, 1999). Institutional practices that place the needs of the organisation above the needs of the clients or patients are implicated in the problem (Steyn & Steyn, 2008). This happens

when providers subjugate the needs and psychological boundaries of rape survivors to the agency's needs, which leaves the survivor feeling violated (Steyn & Steyn, 2008). For example when an organisation demands that the rape survivor lay charges against the assailant for statistical purposes when they do not want to. The feeling of violation occurs most often when the survivor's needs are disregarded by service providers, as this can closely mimic the survivor's experience at the hands of his or her assailant (Campbell and Raja 1999). The survivor may feel that this treatment "hurts as much as the rape itself" (Campbell et al., 1999).

The most common encounter of revictimisation occurs when the survivor interacts with the police and the legal system (Vetten 1997; Moore 1998; Campbell et al., 1999). It is thought that the legal process may inflict additional demands on the survivor, which in turn can keep them in the victim role (Steyn & Steyn, 2008). The medical system is also reported to be quite traumatising when, for example, the invasive forensic examination takes place (Campbell *et al*., 1999).

When a rape occurs, it does so in a context that is particular to that event. No two rape situations are the same (Steyn & Steyn, 2008). There are factors present in the event proceeding, during and after the assault, which have an influence on how the survivor will respond (Steyn & Steyn, 2008). Such factors include the belief system of the survivor (how they personally define rape); the way in which the assault happens (by a stranger or someone known to the victim; violently or not), the way that the survivor's social network responds to the incident, how the professionals handle it, and the result of the legal system handling the perpetrator all influence the prognosis of recovering from a rape incident.

Research suggests that adults, particularly women, who were victimised as children are at risk of re-victimisation in later life (Mouzos & Makkai, 2004). Findings from the Australian component of the International Violence Against Women Survey (IVAWS) indicated that 72% of women who experienced either physical or sexual abuse as a child also experienced violence in adulthood, compared to 43% of women who did not experience childhood abuse (Mouzos & Makkai, 2004). In a prospective study by Widom and colleagues (2008), it was found that all types of childhood victimisation (physical abuse, sexual abuse, emotional abuse and neglect) were associated with an increased risk of lifetime revictimisation. These findings indicate that childhood victimisation increases the risk for physical and sexual assault/abuse, kidnapping/stalking, and/or having a family friend murdered or commit suicide (Widom et al., 2008). Women who experience childhood violence or who have witnessed parental violence could be at risk of being victimised as adults as studies show that they are more likely to have low self-esteem and they may have learnt that violent behaviour is a normal response to dealing with conflict (Mouzos & Makkai, 2004).

Case Study:

> At the age of 23, a female college student, who we will call Sally, was at a house party drinking alcohol. When she was heavily intoxicated she was taken advantage of and raped. Her memory of the incident is not entirely intact and details are blurry but she does know that she did not want to have intercourse with the man in question. She kept the story to herself as 'these things happen when you drink too much" and tried to forget about it. Over the next few months, Sally's marks dropped, she put on 10kg in weight, she became isolated from her friends and family and was also put on anti-depressants by her GP due to the various signs of depression that she was showing. She

found it difficult to be open and honest with anyone, particularly males. It wasn't until her father had an affair and left the family that she decided to seek help from a psychologist. During their sessions, it became apparent to Sally that the rape incident (which was about 2 years ago) affected her a lot more than she had previously thought.

What coping mechanisms did she use? How would you go about getting Sally to face the reality of the situation and to move past it?

4.2 Coping Mechanisms

Sexual assault survivors' coping mechanisms are of interest to both psychologists and fellow survivors alike, as these strategies may be able to aid in developing, or enhancing current and future interventions with other sexual assault survivors.

Martin (2010) identified two ways of coping with sexual trauma; problem-focused coping and emotion-focused coping. Problem-focused coping involves the survivor's active involvement in dealing with the trauma, while emotion-focused coping is typically characterised by avoidance of the rape trauma, and suppression of any emotions connected to the trauma by the survivor (Lazarus and Folkman, 1984).

C. R. Synder and Kimberley Pulvers (2001) developed a model similar to Lazarus and Folkman's (1984) model on rape trauma coping strategies, using the works of Susan Folkman (1984). This model defines two strategies; Approach coping and Avoidance coping (Martin, 2010). As the titles suggest, approach coping involves actively dealing with the rape trauma by appraising the situation and determining what coping resources are available and where these resources need be applied (Martin, 2010). Avoidance coping relies on mechanisms such as denial and avoidance to cope with the rape trauma, and often substance abuse is employed as a method of avoidance and escapism. Alcohol and drug usage initially decrease post-assault emotional distress, which is the desired goal of all trauma survivors (Martin, 2010).

Both models appear to be theoretically dichotomous; survivors either proactively confront any tangible or emotional problems at hand, or they avoid any physical or emotional problems resulting from the rape trauma using whatever methods that may be necessary. There are advantages and disadvantages to each method. While avoidance can initially assist survivors in dealing with post-assault stress, avoidance strategies can lead the survivor to become hypersensitive to any environmental triggers that my cause distress. This hyper-alertness causes disruptive thoughts and emotions, hindering their ability to cope effectively with the event (Synder and Pulvers, 2001, cited in Martin, 2010). Dealing with the rape trauma head-on may be more challenging to survivors, but this strategy has proven to be a more sustainable method of coping, promoting improved adjustment and recovery after sexual trauma by expressing themselves, and reorganising their cognitions about the rape trauma (Runtz and Schallow, 1997).

4.2.1 SOCIAL SUPPORT

Ullman postulated that 'support' may be a misnomer for positive and negative reactions received from others and began to explore positive and negative social reactions (Martin, 2010). Positive

reactions include listening to the survivor and negative reactions include any form of blame attributed to the survivor (Martin, 2010). According to Campbell, Ahrens, Sefl, Wasco and Barnes (2001), whether or not the support is negatively or positively intended by others may be irrelevant. It is in fact the perception of that social reaction by the survivor that determines the impact of the reaction on their recovery (Campbell et al., 2001).

Ullman (1996b) found that survivors with fewer symptoms of rape trauma, including but not limited to emotional distress and physical injuries, are more likely to receive positive social reactions (Martin, 2010). The converse of this finding is also true; survivors with great emotional distress and physical injury are more likely to receive negative social reactions. This could be the result of outsiders struggling to comprehend the very nature of the sexual assault on the survivor. By attributing blame to the survivor others are perhaps able to maintain their existing perceptions and respective worldviews. However, outsiders should remain mindful of the fact that their reaction may be a contributing factor to the recovery of a sexual assault survivor and that victims may be better off receiving no support at all, rather than receiving reactions that they perceive as negative, according to Campbell et al. (2001)

4.2.2 COPING THROUGH FOOD

Eating is one of the many ways that people, women most frequently, use to cope with trauma in their lives. Thompson (1992) noted a wide range of trauma that women associated as the root of their eating problems, including emotional, physical and sexual abuse (Martin, 2010).In Thompson's 1992 study, through which Thompson sought to discover the factors mediating eating disorders among African-American, Latino and White woman, it was found that binge eating is one of the most common coping strategies after a trauma because food is easily accessible to most survivors and also because binging helped women to numb their feelings. "One of the physiological consequences of binge eating is a numb state similar to that experienced by drinking. Troubles and tensions are covered over as a consequence of the body's defensive response to massive food intake. When food is eaten in that way it effectively works like a drug with immediate and predictable effects" (Thompson, p. 61, 1992).

Survivors of sexual assault often believe that their physical appearance and weight were responsible for the assault, and that by changing their physical appearance by means of extreme weight loss or weight gain, they will become unattractive to the perpetrators, and so binge eating or starvation becomes a coping mechanism and offers control and emotional and physical safety (Martin, 2010).

4.2.3 COPING WITH SPIRITUALITY

Spirituality is often confused with religion. There is, however, a difference. Religion refers to regular and repetitive activities which are often collective and are based on a set of combined beliefs. Similarly, spirituality also refers to a belief in a higher power but is based on a more individualized set of beliefs or practices (Martin, 2010).

According to Drescher and Foy (1995) a spiritual approach to coping after a sexual assault is beneficial to survivors, because it has the potential to restore hope. Having hope after any traumatic event is vital as it motivates survivors to persevere in the recovery process. Khouzan and Kissmeyer

(1977) maintain that a spiritual acceptance or awakening can often contribute to relieving trauma survivors of many of their post traumatic symptoms and possibly most importantly their guilt. Spirituality "is often descriptive of a force that gives meaning and direction" (Martin, p. 84, 2010) and in so doing, leads individuals to search for a greater purpose and meaning in their lives, which would provide survivors with a more balanced view of the world and their experiences in it (Drescher and Foy, 1995).

Fact check 4
Question 1

What are some of the other, less common, reactions to rape?

Question 2

True of False: There are mainly two ways to cope with a sexual assault incident.

5. TREATMENT OF RAPE TRAUMA

5.1 ASSESSMENT

Rape survivors often present with different disorders (such as substance abuse, depression and anxiety disorders) and struggle to connect the impact that the rape has on their presenting psychological problems. It is suggested, therefore, that clinicians use various assessment tools such as *structured interviews* (Structured Clinical Interview for Diagnosis (SCID), Diagnostic Interview Schedule (DIS) and Anxiety Disorder Interview Schedule revised (ADIS-R)), and *self-reporting tests* (Derogatis Symptom Checklist, State-trait anxiety Inventory, or Impact on Events Scale) to establish if the client has been raped, and the extent of the impact (Braunstein, 2007; Resnick, Kilpatrick & Lipovsky, 1991).

An initial assessment should include a detailed history of the client, examining the social support available, available resources, previous trauma, coping skills, as well as the client's functioning before and after the rape. An evaluation of the extent to which the client's life was threatened, or injured during the incident should be conducted as these factors lead to an increase in the likelihood of developing PTSD. Research suggests that professionals should avoid using legal terms such as rape during the assessment, as this can limit the response, due to the client's perception of the incident. Therefore questions should be asked in relation to direct behavioural terms, such as 'has anyone forcibly touched you in any way?' Breaking the incident down into smaller segments can help the client to talk about the event, and feel safer doing so, which could result in greater disclosures of rape (Falsetti & Bernat, 2000; Resnick, et. al., 1991).

The assessment should be multimodal, meaning that it covers emotional, physiological, cognitive and behavioural symptoms (Resnick et. al., 1991). Once a thorough assessment has been completed a clinician can begin mapping out intervention strategies that can be used with the client.

Fact check 5

Question 1

Design your own questions (minimum 4) to assess if one of your clients presenting with depression has been raped.

5.2 PSYCHODYNAMIC THERAPY

According to the Psychodynamic therapy perspective, traumatic memories are stored in 'pieces'. These 'pieces' of memories are behind the symptoms that a client will present with in therapy. These symptoms indicate that the client is struggling with control due to the traumatic event and the memories associated with it. Therefore the aim is to integrate the traumatic memories into the 'normal' memories so that the client can feel a reduction in their symptoms. One technique is Hypnotherapy (Braunstein, 2007).

5.2.1 HYPNOTHERAPY

Hypnotic therapy allows the client an opportunity to look at the memories of the traumatic event that have been avoided; a process called abreaction. While under hypnosis the therapist begins to associate the negative memories and symptoms, such as hyper-arousal, vivid flashbacks, intrusive thoughts with more positive associations such as being calm, relaxed and in control. This helps the client to discuss such matters in normal consciousness with less emotional overspills, which ultimately means that the experience of talking is less traumatic for the client. This process aids the client in overcoming the avoidance behaviour and symptoms. The overall aim of hypnotherapy in treating rape survivors is to replace the physical symptoms with verbal labels, helping the memories to be integrated so that the client can move beyond the rape. However, the effectiveness of this therapy is uncertain with very few studies and little empirical evidence to confirm the anecdotal evidence that has been reported (Braunstein, 2007).

5.3 COGNITIVE BEHAVIOURAL THERAPY (CBT)

Cognitive behavioural therapy is based on the assumption that PTSD is a learned reaction to a traumatic event. Despite the fact that the reactions are considered normal they become problematic when they overwhelm and threaten the wellbeing of a person. There are several behaviourally based interventions that can be used to treat psychological trauma in rape survivors,

namely, Stress Inoculation Training (SIT), Prolonged Exposure (PE), Cognitive Processing Therapy (CPT) and Multiple Channel Exposure Therapy (MCET) (Braunstein, 2007; Resnick et. al., 1991).

5.3.1 STRESS INOCULATION TRAINING (SIT).

Stress Inoculation Training, commonly known as SIT, was developed by Meichbaum in 1974. It was later adapted by Kilpatrick, Vernon and Resich in 1982, to treat PTSD following sexual assaults and rape. SIT focused on the fear and anxiety symptoms often experienced by rape survivors. These symptoms are addressed in three phases: Education, Skill building and Application (Braunstein, 2007; Falset & Bernat, 2000; Foa, Rothbaum, Riggs, & Murdock, 1991).

Education Phase:
This phase focuses on understanding the fear and anxiety symptoms. The mental health worker initially teaches the client how fear is a learned reaction to the traumatic event. For instance, if a person was raped while they were drunk, walking alone in an alley at night, they may develop a fear of being alone in public spaces. In treatment the client is then challenged to identify cues and triggers that provoke the fear reaction. Continuing on from the example used above, when the client walks down a quiet road during the day he/she may begin to feel anxious. The trigger in this instance would be the quiet public place. When the client is able to identify what sparks off the fear reaction, they are able to get a better grasp of their anxiety and fear symptoms. The last part of this phase is teaching muscle relaxation techniques, to help the client reduce the physical reaction to these symptoms. This is based on the principle that a person cannot feel both anxiety and relaxation simultaneously (Falset & Bernat, 2000; Foa, et. al., 1991).

Skill Building Phase:
The skill building phase aims to control the fear reactions discussed above. SIT aims to reduce physiological reactions by teaching various breathing exercises such as Progressive Muscle Relaxation (PMR) and diaphragmatic breathing. PMR is the process in which a person slowly contracts each muscle in their body from their feet to their head and then releases the constricted muscle, while maintaining focus on their breathing (Ankram, 2009a).

Diaphragmatic breathing is a technique of breathing that results in the body getting up to 10 times more oxygen. It requires a quick breath in through the nose, and then slowly releasing the air through the mouth (Bharah, n.d.). These techniques teach the client to relax the body, which helps reduce the overall anxiety of the client, as a person cannot experience two opposing emotions simultaneously such as anxiety and relaxation. By focusing on relaxation the client will automatically reduce their physiological arousal (Braunstein, 2007).

The second step in this phase is helping the client to master control of their thoughts. This is done through various techniques such as thought stopping, mental rehearsal, guided self-talk and role play. These techniques are based on the principle that your thoughts directly affect your emotions (Braunstein, 2007).

Thought stopping is a technique used to interrupt negative thoughts. The client is required, when having a negative thought, to say, "stop" and change the thought into something positive (Ankram, 2009b). Mental rehearsal is a technique often used in sport psychology, which requires one to visualise the desired response. In the instance of rape trauma treatment the professional will encourage the client to find alternative endings to a flashback or nightmare, for instance, visualising fighting back and beating the perpetrator, instead of being overpowered (McTaggart, 2008).

Guided self-talk helps the survivor capture uninhibited thoughts that cause one to automatically cross to the other side of the street to avoid walking past someone. Many thoughts would precede the physical actions, for example, 'that person looks scary', triggering negative associations. Although this concept is similar to thought stopping, it allows the survivor to start challenging and looking at their thinking more objectively (Nauert, 2011). Role play is used to practice and learn these above skills. Using all these techniques, or a combination, should enable the survivor to have the appropriate skills to help reduce their anxiety and fear reaction after the rape; however they have yet to be applied to this specific setting.

Application phase:
During this phase, the survivor is challenged to apply their new skills in various situations which provoke anxiety. They are instructed to engage with what they have been avoiding. For instance, someone who has developed agoraphobia and avoids going out in public, is pushed to confront this by going out in public and employing the skills they have learned in previous sessions. This phase should consolidate and allow the survivor to practice their new skills in the frightening reality. The aim is to gain control over self-criticism, and to manage their avoidance behaviour. Clients are encouraged to set goals and reward themselves for making progress (Falsetti & Bernat, 2000).

SIT takes between 10-14 sessions, and has been shown to reduce the symptoms of fear, intrusive thoughts and avoidance behaviours connected with anxiety after being raped.

5.3.2 PROLONGED EXPOSURE (PE)

Prolonged Exposure is another method of treating rape trauma, and is said to be more effective than both SIT and regular counselling (Foa et. al., 1991). Prolonged Exposure (PE), commonly known as flooding, is similar to the application phase of SIT in that it focuses on the confronting of fears.

PE has two steps: imaginal exposure and in vivo exposure. Imaginal exposure is the process in which the survivor describes the rape incident in detail to the clinician. This narrative is repeated several times in the safe environment, with the aim of reducing the fear surrounding the memories of the rape. Once this is mastered they move into the in vivo exposure, during which the client is required to confront non-dangerous situations that are associated with the trauma. For example if a person has developed a fear response around being in a car following the rape, they would be required to confront this, by being in a car. This is a very focussed and practical application of SIT (Braunstein, 2007; Foa, et. al., 1991).

Foa et. al. (1991) found that both PE and SIT were more effective in the treatment of RR-PTSD than supportive counselling and a control study. PE results indicated that it was a more successful long term treatment of RR-PTSD, while SIT lead to more immediate reductions in symptoms. It is, therefore, proposed that an effective treatment model combines both methods of treatment.

5.3.3 COGNITIVE PROCESSING THERAPY (CPT)

CPT was developed by Resick and Schnicke (1992) and is based on an information processing model, combining aspects of exposure therapy and cognitive restructuring. The information processing model explains how people retain certain pieces of information that are relevant to their belief system and values. For example a person who is interested in birds will notice and remember the types of birds on a walk, while someone else on the same walk will retain different information such as the view. Therefore our interest and value systems govern the way we interpret events and visual stimuli, which in turn influences the way rape victims interpret the cues during a rape incident.

When a person experiences a traumatic event these memories are stored in 'fear networks' which hold the traumatic stimuli, responses and their meaning. These networks are designed to encourage avoidance and to protect the person from further danger. These fear networks account for the survivor's beliefs and cognitive appraisals of the sexual assault, which are influenced by the cognitive schemata. Schemata are those beliefs that the survivor holds about sexual assault prior to the incident. These can be similar to rape myths or beliefs about rape. Due to these prior views of rape the client will remember information that upholds and supports these schemata. Therefore the survivor will do one of two things; either assimilate or accommodate these beliefs into their cognitive schemata (Falsetti & Bernat, 2000; Resick & Schnicke, 1992).

Assimilation is when a person changes the meaning of the event to fit into their prior beliefs about such events. For example 'promiscuous women get raped. I am not promiscuous, therefore it wasn't rape'. While accommodation is changing the belief to accept that this instance was rape, such as 'sometimes bad things happen to good people'. It has been shown that the people who struggle to integrate these beliefs develop more severe emotional reactions to the incident such as guilt, humiliation, fear and shame (Falsetti & Bernat, 2000; Resick & Schnicke, 1992).

The goal of CPT is to integrate the processing of emotions as well as cognitive distortions. This is done in three different phases; exposure, education and cognitive strategies (Braunstein, 2007; Resnick, et. al., 1991).

Exposure phase:
This phase is similar to the imaginal exposure phase during PE. Here the client is required to write a narrative about the rape and then read this aloud in the therapeutic session. The client would also be required to write about the meaning behind the rape and discuss this. During this phase the focus is on five major themes: safety, trust, power, esteem and intimacy. These aspects are explored within the therapeutic relationship (Braunstein, 2007; Falsetti & Bernat, 2000).

Education Phase:

Although SIT also has an education phase, the CPT education phase deals with fundamentally different aspects. This phase is exploring the emotions and feelings surrounding the rape. The therapist encourages the client to find the connections between self-esteem and emotions. They then identify those points in which the client is 'stuck'; these points can usually be identified by the clients' avoidance behaviours or symptoms. For example if the client is struggling to walk around in public alone this anxiety of being alone in public will be a 'stuck' point (Braunstein, 2007; Falsetti & Bernat, 2000).

Cognitive Strategies:
Cognitive strategies challenge the maladaptive beliefs that have developed as a result of the rape. These are the beliefs or thoughts that result in the client's ' stuck points', such as, "only promiscuous women get raped. I am not promiscuous, therefore it was not rape". The therapist will challenge these beliefs directly and discuss alternatives to them. This phase attempts to help the survivor deal with the incident in productive and healthy ways, while maintaining a balanced view of the world. These strategies will help the client accommodate the event into their belief system which leads to an acceptance of the incident (Braunstein, 200).

This intervention can be done in both individual and group settings and should last for approximately 12 weeks. Research has indicated that this method is effective in the treatment of RR-PTSD (Falsetti & Bernat, 2000).

5.3.4 MULTIPLE CHANNEL EXPOSURE THERAPY (MCET)

MCET is adapted from CPT, with more of a focus on the panic attacks and the symptoms of PTSD. MCET was originally designed to treat domestic violence and other civilian trauma, but can be adopted to treat survivors of rape trauma. MCET combines the three different treatment options described above. This model consists of three different phases, education, structural exposure exercises and CPT (Falsetti & Bernat, 2000).

Education:
MCET uses the education phase to teach the survivor about the various panic symptoms. This is based on the fact that exposure therapy can cause the client distress due to the increase in physiological responses when exposed to triggers that are related to the sexual assault. By teaching the client about the panic attacks and related psychological and physiological reactions, the client is eased into treatment. The therapist then teaches the client diaphragmatic breathing as a relaxation technique to counteract the physiological responses. The client is also taught ways to counter negative and distorted thoughts (see SIT for more detail) (Falsetti & Bernat, 2000).

Structured Exposure Exercises:
This phase introduces the client to various situations that are anxiety provoking, while slowly increasing the intensity of these experiences, teaching the client that the physiological reactions to anxiety are not life threatening. Initially, the therapist might get the client to tense their muscles or hold their breath, which teaches the client that these physiological reactions are not dangerous, but rather that the reactions are merely interpreted as such (Falsetti & Bernat, 2000).

CPT:
The last phase takes the client through the whole CPT process described above, allowing the client to emotionally process the rape.

Although more research is needed to examine the exact effects of MCET, research does suggest that it is effective in the reduction of panic attack symptoms as well as aiding the emotional processing of the trauma. MCET can be conducted in both a group and individual setting and requires approximately 12 weeks. .

5.4 PHARMACOLOGICAL THERAPY

Serotonin re-uptake inhibitors (SSRI) have been shown to be an effective drug therapy in the treatment of PTSD, and RR-PTSD. Fluoxetine and Sertraline when used together show a 53% reduction in symptoms of arousal and re-experiencing in rape victims, although there is no evidence that they reduce avoidance symptoms (Rothbaum, Ninan & Thomas, 1996). Lauer (2006), however, proposes that a combination between pharmacological and another therapy (mainly cognitive behavioural therapy) is the most effective treatment for RR-PTSD.

Although in this course we have discussed many methods to treat RR-PTSD, there is little research that has shown the effectiveness of each treatment method, as specific to RR-PTSD. Bisson and Andrews (2009), in a review of psychological treatment of PTSD, found that the most effective treatments to reduce symptoms were trauma focused cognitive behavioural therapy and eye movement desensitisation and reprocessing (EMDR). These findings, however, were not specific to RR-PTSD. Further research needs to explore treatment of RR-PTSD, the effects of EMDR on RR-PTSD, as well as empirically testing treatments already proposed to treat RR-PTSD.

CONCLUSION:

In this course we have addressed the complex nature of rape trauma. Although rape is usually seen as involving only two parties, the perpetrator/s and the victim, it actually also involves an external system of perception, beliefs and legal definitions that play a significant role in the trauma of rape. These external influences contribute to the complex nature of rape trauma that is experienced by the survivor. Although we have made great strides in South Africa to address some misperceptions of rape by altering the legal definition, this has not trickled down to the everyday individual on the ground level, resulting in the old stereotypical ideas about rape being maintained.

Psychological research has also attempted to address this by exploring common reactions after rape, such as RTS, PTSD and RR-PTSD. However this can also lead to over pathologising survivors of this crime.

In this course we discuss both the short and long term reactions to rape, exploring all the physical, emotional and psychological reactions that have been identified following a rape trauma. We discuss the importance of assessing clients for rape as they often are unable to connect their psychological problems to the incident. There are also varying options for treating rape trauma, such as psychodynamic, cognitive-behavioural therapy, and pharmacological treatment. Although cognitive behavioural therapy has the most empirical evidence to support it, more research needs to be done on the different treatments to allow for a fuller understanding and practical implementation of these methods, specifically for rape survivors.

CASE STUDIES:

A 14 year old girl called Tracey (name has been changed for confidentiality purposes) in grade 9 at high school, lives with her mom, stepfather and her two younger half-siblings. A teacher noticed that her marks had begun to drop and that she was becoming more defiant at school, back-chatting to teachers, refusing to follow simple instructions and not completing her homework. Her mother noticed that she had started to ignore her instructions and refused to comply with house rules. Tracey began to argue about attending church (which she had always attended without any trouble). The teacher referred Tracey to the school counsellor for an assessment where it was discovered that she had been sexually abused for the past 3 years by her stepfather. It also came out that the child had told her mother 10 months prior to the child meeting with the counsellor. After the mother had initially found out about the abuse she confronted the stepfather which resulted in the abuse stopping for 7 months. However for the past 3 months the abuse had begun again.

After Tracey had disclosed the abuse it had to be reported to the relevant parties, social services, the police and her parents. The counsellor called the parents in for a meeting and informed them about what had been going on, the biological father immediately questioned the child trying to ascertain if she was telling the truth. After the initial meeting the social worker had a meeting with the parents about the abuse, where they were informed that charges had to be laid against the stepfather. Tracey was also informed that her mom would be charged with neglect due to the fact that she had not reported the abuse when she was initially informed about it 10 months prior. Tracey was very upset at this point and was dragged to the police station to begin the long process involving the legal system.

On arriving at the police station the social worker and the counsellor informed the officers what they were there to do, to which the police officer screamed out, 'where is the rape victim?' and insisted that they all move around the various areas of the police station before being informed that we have to go to another facility to lay charges. They then went on to the next facility and were asked to wait for an available social worker. After an hour the biological parents, the social worker, counsellor and Tracey were called into a room where the social worker began to question Tracey about what happened. The social worker again brought up the fact that the mom would be charged, which resulted in Tracey becoming very distressed and upset. The new social worker then requested to speak with Tracey privately, which took another hour.

After two months charges had still not been laid and the stepfather although having moved out was still visiting the home in which Tracey lived. On a couple of occasions she was home alone when he arrived, which caused her much distress and anxiety. She is concerned that everyone in her area is going to find out about the abuse and that she is no longer a virgin (especially people in her church). She feels responsible that her half-siblings would not have a father, and her mom and stepfather would be separated.

At this point police officers arrived at school in unmarked cars and without uniforms to take Tracey's statement, during which Tracey was preparing for her final year exams. Tracey was required again to tell her story.

- Identify all the instances of secondary trauma/ revictimisation that Tracey had to experience, offer alternate ways that the case could have been managed to avoid any secondary traumatisation.

- Create a treatment plan to help Tracey deal with what is going on and process the above events.

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