Running Head: PSYCHOLOGICAL EFFECTS

Psychological Effects of Rape

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Abstract

At some point in their life all people experience some type of trauma. A trauma may stem from a loss, a natural disaster, violence, or injury. Most people recover from a traumatic experience quickly with no long term effects while others suffer long term or even permanent effects. Rape is one of the most traumatic experiences a person can encounter and a majority of the time it results in posttraumatic stress disorder, depression and anxiety disorders. Rapid response by crisis workers and the effectiveness of treatment often determines the severity and duration of symptoms and effects.

Psychological Effects of Rape

All people are exposed to some form of trauma in their lifetime. A traumatic event involves a single experience or repeating events that overwhelm an individual's ability to cope or integrate the ideas or emotions involved. Separation from a mother during early childhood when the mother returns to work and places a child in childcare can be traumatic for a child but the majority of the time it is resolved without lasting effects. The death of a parent or spouse is another common traumatic event experienced by people usually with moderate to severe short term effects lasting from one to two years with a reduction in symptoms (James, 2008).

Rape is one of the most severe traumas a person can suffer causing multiple, long-term negative outcomes including Posttraumatic Stress Disorder (PTSD), depression, substance abuse, suicide, repeated victimization, and chronic health problems (Campbell, Dworkin, & Cabral ,2009). Those with PTSD often represent with high rates of depression comorbidity (Taft, Resick, Watkins, & Panuzio, 20069). Rape victims have extensive needs following the assault and turn to many agencies for assistance. 26% to 40% seek police assistance, 27% to 40% seek medical assistance and 16% to 60% seek mental health assistance (Campbell, 2008).

The manner in which the various agencies react can have a profound effect on the victim's recovery. All too often victims are treated with disbelief, endure humiliating interviews and examinations, are oftentimes treated as if they caused the assault and in a majority of cases are discouraged from reporting the crime due to lack of prosecution, the necessity of having to repeatedly retell their story/relive the crime and being led to believe they had some part in causing the crime which has come to be termed "'second rape" (Campbell, 2008 p. 703). Often the crime is perpetrated by someone the victim knows, up to 80%, which further discourages

them from reporting the crime (Campbell, 2008). At a time of extreme susceptibility, victims turn to their support systems, families or communities and risk further harm. Rape trauma reaches out far beyond the actual assault and intervention techniques need to address these difficulties (Foa, Rothbaum, Riggs, & Murdock, 1991).

Rape prosecution is a complex, multi stage process with few making it through the criminal justice process (Campbell, 2008). A victim's first contact is most often with a law enforcement officer who many times is not educated in the delicacies of dealing with rape victims. They often ask the victim to describe the assault in detail numerous times. The case is then referred to a detective or investigator who in turns contacts the victim with more questions and many victims have reported that these investigators give graphic details of what prosecuting the perpetrator will entail such as the cost of the court proceedings, the necessity of appearing in court to face the assailant, the humiliation of cross-examination and the chance that the case may get dismissed (Campbell, 2008). Due to this type of treatment, many victims self-blame (Koss, Figueredo & Prince, 2002). They may blame external forces, controllable features of their behavior, and uncontrollable features of themselves.

Victims are often asked what they were wearing, implying that their dress may have caused the assault, what they doing or saying, if they were drinking or using drugs, sexual history and whether they responded sexually to the assault (Campbell, 2008). Unfortunately, alcohol and/or drug use increases the chances that the case will be not be prosecuted. Multiple research studies have shown that 43% to 52% of victims who reported contact with the legal system rated the experience as unhelpful or hurtful (Campbell).

Contact with medical systems has been shown to have the potential of causing second rape (Campbell, 2008). Victims are usually given a brief, sketchy account of what a medical examination will entail. Most victims are shocked when told they will have to submit to a pelvic examination immediately following an assault and view it as a further invasion of their bodies (Campbell, 2008). The exams and evidence collection are often done incorrectly as well ;further adding to revictimization due to lack of education of hospital personnel. To combat this revictimization, the Sexual Assault Nurse Examiner (SANE) program was founded in the 1970's (Campbell, 2008). This program resulted in having trained nurses, not doctors, providing crisis intervention and medical care to victims. SANE programs focus on treating victims with dignity and respect to decrease post assault distress. Many of these programs work with rape crisis centers by obtaining advocates for victims that support the victims through the legal, medical and recovery process.

Recent research has shown that eye movement desensitization and reprocessing (EMDR) is very beneficial (Corbett & Milton, 2011). EMDR uses a structured approach to address past, current and future aspects of disturbing memories. It is an eight phase process in which eye movements are used to desensitize distressful memories and replace them with more positive memories (Corbett & Milton).

The way in which a person behaves during a disaster or traumatic experience may have an important impact on their survival. Prior experience and any training plays a role in determining chance of survival. Positive coping strategies are also very effective in recovery (Valentier, Foa, Riggs & Gershuny, 1996). Emotional reaction will influence the ability to respond in an adaptive way (Atkinson, Martin & Rankin, 2009). A person's state of mind will also have a tremendous impact on the way the memory is stored and processed. Dissociation is

thought to be important in the development and maintenance of PTSD primarily due to the interference with the integration of traumatic memories in a person's existing memory network (Taft, Resick, Watkins, & Panuzio, 2009). Distress is a normal reaction to a traumatic experience and the typical pattern is restitution and not the development of Posttraumatic Stress Disorder (PTSD). In the few that do develop PTSD, it is often resolved in two-thirds of those people (McFarlane, 1998).

The neurobiology of a person's stress response, the capacity for self-modulation, the ability to tolerate fear, the threat the trauma brings and the ability to cope are some of the factors that influence the outcome of recovery (McFarlane, 1998). A history of psychiatric illness is another risk factor. This type of interpersonal violence causes a severe threat to schematic beliefs that the world is for the most part a good place, that people are generally good and can be trusted (Littleton & Grills-Taquechel, 2011). Individuals can resolve these challenges to the schema presented in three ways; assimilation, accommodation and over accommodation (Littelton & Grills-Taquechel). Assimilation minimizes the severity by theorizing the event as a more nonthreatening experience such as a miscommunication. Accommodation alters the schema to accommodate the trauma such as most can be trusted but a few cannot. Over accommodation however; is maladaptive, the world is a very dangerous place and no one can be trusted.

There are characteristics that can protect an individual or promote recovery. Research has shown that survivors who disclose their assault to others decrease the likelihood of developing PTSD (Paul, Gray, Ethai, & Davis, 2009). However, negative reactions by support systems have serious detrimental effects (Paul, Gray Ethai & Davis). It is far more destructive for an individual to have their support system give a negative reaction than the positive benefit of the same support system giving a positive reaction.

Group counseling is also another form of treatment that is very successful. Group counseling provides members with opportunities to learn from others, be better able to understand their own thoughts and behaviors and those of others. Other people may also see attitudes, beliefs and behaviors that one may not see in there self. Group counseling also provides a way to receive support, honest feedback and useful alternatives from peers (Maheshwari, Yadav, & Singh, 2010).

When dealing with psychological trauma religious and spiritual issues are present most of the time (Grame, Tortorici, Healey, Dillingham & Winklebaur, 1999). They struggle with spiritual issues such as the meaning of life, suffering, good versus evil, guilt, forgiveness, the use of rituals, relationships with clergy, relationships with other members of the church and hypocrisy within the church. Many times therapists do not address these issues and in doing so a strong resource for processing the traumatic event (s) is lost. Traumatic events can break attachments, shatter the self, undermine belief systems, and violate a person's faith in a divine order which impacts their spiritual life. Often doctors and mental health workers have different beliefs based on science than victims about what causes a traumatic event to happen (Grame, Tortorici, Healey, Dillingham & Winklebaur). This can cause further harm to victims as well. Psychotherapists and doctors need education about dealing with the spiritual issues of trauma victims and how to include a person's clergy in their recovery.

Clergy can be the first person a victim of trauma goes to for help but lack of training in mental health issues of clergy can be detrimental (Grame, Tortorici, Healey, Dillingham & Winklebaur, 1999). For example, a clergy member may imply that sin has caused the person to become the victim of an assault, when in fact this is quite untrue, which can have serious

consequences to the person. It is important that clergy receive education in dealing with trauma victims in order to avoid further harm.

Many people that experience trauma recover without ever seeking assistance. The ability to recover from extreme trauma, deprivation, threat or stress is called resilience. The concept of resilience can be important to health care professionals because it is important in the onset, coping and recovery of traumatic events (Martin & Rankin, 2009). The United States military has used resilience training for many years (Martin & Rankin). Research has shown that building resilience can be beneficial in the treatment of PTSD (Martin & Rankin).

In some cases the old adage "if it doesn't kill you it will make you stronger" rings true. Research has shown that positive life changes can be the result of experiencing trauma (Frazier, Conlon, & Glaser, 2001). The areas in which an individual shows positive change are increased strength and maturity, increased closeness to others, changes in life priorities, and increased empathy towards others' suffering (Frazier, Conlon & Glaser). In one study survivors of sexual assault reported positive changes as early as 1 week after their assault (Frazier, Conlon, & Glaser). In these cases positive support by family members, clergy, and other support systems were vital. The period between 2 weeks and 2 months after the assault seems to be the most critical (Frazier, Conlon, & Glaser).

Whichever course of treatment a trauma survivor seeks, the most important aspect of treatment provided is a loving, caring manner. Any reference to blame on the part of the victim can result in life long negative effects. In addition, approaching a trauma victim in a negative, aggressive, hostile manner will only further damage the person involved.

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