Rape: Reactions of the Victim

NATURE OF SEXUAL ASSAULT

Characteristics of the Assault Experience

Sexual assault is a sudden, arbitrary, unpredictable event. The victim* has no time to prepare. Assaults my occur in many different types of situation. The assailant may break into the victim's home, or accost the victim in a parking lot or on the street. Sometimes sexual assault occurs in the context of a social relationship or sexual encounter that was initially voluntary but then goes beyond the victim's consent. Regardless of the particular circumstances, these assaults have one major common element -the victim is unable to prevent or escape the assault because the assailant uses force and/or threatens harm for noncompliance.

The assailant controls the situation. He may use weapons (guns, knives), restraints (ties, gags, handcuffs), direct physical force (punching, choking), threats of harm (death, mutilation), and/or other types of intimidation (such as threats to the victim's children). In many cases, subjugation is accomplished without the actual use of physical violence. The assailant's threats and his apparent ability to carry them out may be the only means he uses to force compliance.

Most victims employ several coping strategies in an attempt to dissuade the assailant. They may reason, physically resist, distract, plead, bargain, and/or try to negotiate. When these attempts fail, the victim is rendered helpless and powerless to prevent the sexual assault. Sensing that her survival is at stake, she submits, hoping to avoid severe physical injury or death. As a result, she is forced to participate in genital, oral, and/or anal sexual acts and is often subjected to other forms of degradation and abuse.

Regardless of the assailant's method or means of control, the victim usually fears death. After an assault, almost all victim's say, "I thought I was going to be killed." Most victims, however, manage to avoid serious physical injury by not resisting. They may nevertheless, suffer other possible physical consequences, such as pregnancy, venereal disease, and somatic symptoms arising out of the psychological impact of the assault.

Almost all rape victims suffer severe and long-lasting emotional trauma. This is true even of victims of attempted rape. Thus the sexual aspects of the crime are not the most significant factors that cause this psychological trauma. The major causes appear to be a combination of five distinct features of the assault experience:

1. It is sudden and arbitrary.
2. It is perceived as life-threatening.
3. Its apparent purpose is to violate the victim's physical integrity and/or render her helpless (rather than to steal money).
4. The victim is forced to participate in the crime.
5. The victim cannot prevent the assault or control the assailant; her normal coping strategies fail. Thus, she becomes a victim of someone else's rage and aggression.

The nature of a sexual assault is defined by the particular circumstances and by the characteristics of the victims's experience. In addition to being a violation of the victim's physical self. sexual assault violates the victim's basic beliefs and assumptions about the environment (safe, predictable), about other people and relationship (trust, mutual respect), and about herself (competence, self-confidence, and self-esteem). The victim comes face to face with her personal vulnerability to serious harm. Thus sexual assault usually results in severe personal losses for the victim: safety, control, trust, autonomy, integrity, and self-esteem.

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* The focus here is on the adult, female victim. Some of the specific approaches outlined in this chapter would have to be modified to meet the distinct needs of child and adult male victims. The basic principles, however, guide sensitive and appropriate care for all sexual assault patients.

Crisis Reactions

The nature of sexual assault, including the losses and the threats to the victim, generally result in her having a crisis reaction. Therefore, crisis theory provides a useful framework for understanding the impact of this event on the victim. It explains the relationship between the victim's experience of the assault and her subsequent reactions.

According to crisis theory, several interrelated factors may produce a crisis. These factors include a hazardous, stressful event; perceived threats to basic needs or significant losses; and the inability of the person to respond with adequate coping. Thus crisis is a subjective reaction. It is determined by the meaning of the vent to the person. Some life experiences, such as sexual assault, are more likely than others to produce a crisis reaction. Both the assault experience and its aftermath impose extremely difficult coping tasks and involve highly threatening issues, such as survival, autonomy, and control. During the assault, the victim's coping strategies fail. After the assault, these strategies may be unavailable (immobilized) or inadequate to handle the intensity, unfamiliarity, and/or threatening nature of the sequelae. The victim's crisis, therefore, relates to her inability to cope and function effectively subsequent to the assault.

The crisis reaction is a distinctly upset state. It is experienced subjectively by the person and is often observed by others as a change in the person's "normal" state. It is evident in cognitive, affective, and behavioral disruption. For example, the victim may be troubled by her inability to immediately and accurately recall details of the assault. She may remember that her hands were bound, but she may not remember whether they were tied in front of her or behind her.

Crisis reactions are often further differentiated in terms of how the person perceives or experiences the meaning of the precipitating event. These perceived meanings have corollary emotional reactions. An event that signifies a threat to instinctual needs or to physical and emotional integrity often precipitates anxiety. In contrast, experiences that represent losses often produce an emotional reaction of depression. Because sexual assault victims may experience both threats and losses, they frequently evidence both anxiety and depressive reactions. Often the anxiety is more evident in initial responses, whereas depression is reflected in the long-term psychosocial impact of the assault.

A final major feature of crisis reactions is that they are characterized by a series of temporal phases. The phases associated with a given crisis reaction are related to the nature of the precipitating event, in this case the sexual assault. The nature of the event also determines the problem-solving and coping tasks and the treatment and/or support needs to be addressed in each phase. Each phase is identified by the predominance of certain symptoms and concerns.

Stages of Reactions

There are two phases of victim reactions that are especially relevant to the tasks and roles of hospital personnel. The first phase, initial reactions, occurs immediately following the assault. This is when the victim is usually seen at the hospital, and her reactions during this period are therefore the ones that hospital personnel deal with directly in the care process.

The second phase, subsequent reactions, occurs in the days and weeks following the assault. The hospital's role in this phase is to help the victim anticipate and prepare for the reactions they are likely to experience after they leave the hospital.

There are certain reactions specific to each of these phases that almost all victims experience. This set of reactions had been termed the "rape trauma syndrome." However, individual differences among victims may moderate the intensity., duration, and manifestation of these common reactions. Certain issues will be more important for some victims than for others. These variations usually are related to differences in social supports available to the victim, immediate care the victim receives, cultural background, age, and other relevant characteristics.

Since most victims do experience the rape trauma syndrome to at least some degree, an understanding of it will help the social worker plan and provide care.

Initial Reactions: During the period when rape victims are receiving hospital care, one of the most striking characteristics of their presentation is the relative "invisibility" of the severe psychological trauma they

have sustained. This most serious and significant impact of the assault is masked by the psychological defenses victims usually employ to cope with the consequences of the assault.

The most common initial reaction is shock. Rape victims experience numbness and disbelief. They may seem stunned or dazed and may appear outwardly calm, subdues, and contained. They may be very quiet, or they may verbally express their shock in statements such as, "I can't believe this happened to me," or "It doesn't seem real." During this period, victims also have difficulty with concentration and decision making. They appear confused and unsure and frequently have flashbacks in which they relive parts of the assault. Thus they seem preoccupied, inattentive, and distracted. These are typical crisis reactions and reflect cognitive, affective, and behavioral disruption. Some of these responses also may be heightened by the unfamiliarity of the hospital setting and the demands imposed on the victim by the complex procedures during the hospital care process.

Rape victims have strong needs to block out and deny the experience and the feelings it produces. As a result, they often resist talking about the assault. They may be silent or engage in routine, unrelated conversation. Some victims state directly, "I just want to forget that it happened." These defenses can be adaptive and protective. By postponing the feelings, victims give themselves time to prepare for them. This pattern of denial and postponement may also be reflected in the victim;s activities prior to coming to the hospital. For example, many victims actively try to rid themselves of the experience by bathing and douching. Others may engage in very routine, habitual types of activity, such as cleaning up the house or eating a meal. Performing routine tasks is a way to reaffirm one's sense of self and/or normalcy; it is a way to regain mastery and control.

Some victims show more visible emotional upset during this initial period. They may be agitated, hysterical, volative, and/or angry. However, emergency department personnel most frequently see the controlled style of behavior described above. This characteristic presentation is highly significant for several reasons. First, it is contrary to most people's expectations. Second, it obscures the emotional trauma the victim has sustained. Third, coupled with the usual absence of visible signs of the physical force and violence used during the assault, it reinforces the tendency to suspect or disbelieve the victim. and, finally, it puts the victim at risk because her needs for psycho-social support and intervention may be overlooked.

When supportive care is provided in the hospital setting, victims begin to express feelings related to the assault. As these feelings are released, victims usually experience marked anxiety. They may tremble and often cry. Frequently they express relief in statements such as, "I'm just glad I'm alive." They also begin to feel the physical effects of the assault, including soreness and fatigue. Most victims are exhausted because of the tremendous energy expended coping with the assault. Other feelings commonly expressed are self-blame, guilt, shame, embarrassment, and vulnerability. Some of these reactions may also be observed in nonverbal behavior. For example, shame may be evident in avoidance of eye contact and other forms of withdrawal.

There are several other concerns that victims commonly express during this initial period. These are immediate, pragmatic, and realistic concerns. They reflect the physical, social, and emotional impacts of the assault and some of the particular issues raised during the hospital care process. These concerns include: pregnancy, venereal disease, whom to tell about the assault and how to tell them, how others will react, financial impact, retaliation by the assailant, the nature and seriousness of any physical trauma, implications of reporting, future safety, effects of the emotional trauma sustained, the extent and duration of life style disruption that may result, and immediate situational needs.

Subsequent Reactions: The second phase of reactions covers the days and weeks following discharge from the hospital emergency department. The initial reactions already noted may continue to be expressed during this stage because many of these feelings and concerns take time to resolve. There also are new issues and experiences (physical, social, and psychological) that characterize this later period. Hospital personnel help the victim anticipate and prepare for these reactions, but even with preparation most victims experience considerable stress and disruption in their usual life style. Their reactions continue to be reflected in cognitive, affective, and behavioral aspects of functioning.

In the first days and weeks following the assault, most victims have somatic symptoms regardless of whether or not they sustained physical injuries. Somatic responses can reflect the effects of physical violation and/or emotional trauma. These symptoms include disturbances in sleep patterns and appetite, changes in energy level (often fatigue), soreness, aches, gynecological problems, and specific effects of any injuries.

Fear continues to be a pervasive and unsettling feeling. Fear may be generalized (such as feelings of vulnerability to harm and danger), or it may be specific to particular circumstances (such as the location of the assault or characteristics of the assailant). Almost all victims are fearful of being alone and of revictimization by the assailant.

Victims show a variety of other emotional reactions that indicate their stress and upset: anxiety, mood swings, crying spells, outbursts, agitation, and feelings related to depression. Often they report a loss of their sense of humor.

The open or direct expression of anger or rage is noticeably absent in most victims. If anger is expressed at all, it is usually a delayed response. Sometimes indirect expressions of anger are noted, such as irritability, complaints about treatment, or depressive symptoms.

Other psychological reactions that characterize this phase include recurrent flashbacks, dreams with violent content, and pre occupation with thought about the assault.

One of the most universal victim reactions is a "why me?" response. The arbitrary nature of the assault leads the victim to search for a reason to explain why the assault occurred. This search for a reason or an explanation for the assault accounts for some of the victim's preoccupation with the experience. She repeatedly reviews the event and the surrounding circumstances. Most victims struggle with exaggerated feelings of personal responsibility, guilt, and self-blame. They feel that they could have or should have successfully escaped, resisted, or avoided the assault. Usually these feelings are not rational reactions to the actual circumstances of the assault. For example, a woman who was raped at gun point in her home during a nighttime break-in, under the threat of harm to her children in the next room, might feel that she should have resisted more than she did.

This struggle to discover why the assault occurred may be seen as an adaptive response. It is a psychological working through of the event. It may be a way to undo what happened. It is also an attempt to regain control. If the victim can establish how and why the assault occurred, she can prevent it from happening again.

There are two other factors that determine the victim's self-blame. The first has its origin in our historical, traditional, and cultural misconceptions about rape and rape victims. Most people believe that rape only happens to women who ask for it or let it happen, and victims impose these judgments upon themselves. The fact of having participated in the assault, even though participation was forced, compounds the self-blame and the shame. Another aspect of this struggle with feelings of personal responsibility is that it represents a choice among alternative explanations for why the assault occurred. The fact that rape is a random and arbitrary event is perhaps a far more disturbing conclusion than the alternative of self-blame. The fact that life is uncertain and people are vulnerable to chance events means that victimization could happen again.

The effects of the assault on the victim's sexual functioning are complex. Perhaps more than some of the other consequences, these effects are related to pre-assault individual differences and to existing and subsequent relationships with others. Generally, victims initially withdraw from sexual activity. Sexual encounters trigger painful flashbacks of the assault and the panic over loss of control. This withdrawal usually is not indicative of a generalized negative reaction to males, sex, and/or intimacy. Rather, it represents a need to draw inward to reaffirm the sense of self, of boundaries, and of autonomy. Thus the victim may avoid situations that impose intrusive demands.

Although victims may not wish to be sexually active for a while, they still have the need and desire for physical comfort and closeness. It is important that people close to the victim recognize and understand this. Often they mistakenly think the victim needs distance; the victim misreads their distance as blaming and rejecting.

Some victims do withdraw from sexual relationships and intimacy because they feel contaminated or ruined as a result of the assault. An individual reaction of this type usually is related to relatively uniquely cultural definitions and stigmas assigned to rape victims.

All of the physical, social, and psychological sequelae to sexual assault result in considerable disruption in the victim's life style. In most cases, many areas of functioning are affected, including relationships, activities, and feelings. These affects are characteristic and predictable.

The nature and extent of the more lasting effects of rape trauma are variable and, as yet, largely unstudied. They appear to be influence by individual characteristics and experiences, such as age and developmental stage, personality and coping skills prior to the assault, the immediate care the victim receives after the assault, and the supports that continue to be available to her. In general, the long-lasting effects will be determined by the victim's resolution of the issues raised and the losses sustained.

Sexual assault usually precipitates a reexamination of one's view of life and of the self. It revives independence-dependence conflicts. Many victims experience long-lasting feelings of vulnerability and concern about safety, though the intensity of these feelings diminishes over time. These feelings may be expressed in life style changes, such as moving, or in more generalized behavior patterns. Many victims feel that sexual assault affects their spontaneity and imposes a cautiousness in their approach to people and situations. For a few victims, however, the fact of surviving a sexual assault may result in a strengthening of the self and a deepening appreciation of the value of life and of the present.