
Mental Health Services for Rape Survivors

Current Issues in Therapeutic Practice

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Abstract

This paper reviews three critical issues for mental health practitioners working with rape survivors. First, current research suggests that victims experience a variety of negative mental health effects from sexual assault, including, but not limited to, post-traumatic stress symptoms. In addition, rape survivors may be struggling with how family and friends are reacting to the assault and may be coping with secondary victimization experiences they encountered in post-rape help seeking. Mental health practitioners must be aware of the wide variety of issues rape survivors may present in therapy. Victims may need to process not only the rape itself, but also post-rape experiences with their informal and formal support providers. Second, empirical evaluations of therapeutic techniques suggest that cognitive behavioral therapies (CBT) can be effective in reducing short-term post-rape fear and anxiety symptoms. Feminist therapies tend to focus on survivors' longer-term problems with guilt and self-blame. Although more evaluation research is needed, available data suggest feminist therapy may be an effective approach as well. Finally, it is not uncommon that mental health practitioners who work with rape survivors experience distressing emotions similar to those of the survivors. These symptoms are called secondary traumatic stress (STS), compassion fatigue (CF), or vicarious traumatization (VT). STS/CF/VT is more common among therapists with higher caseloads of sexually traumatized clients. Self care strategies are particularly important for therapists engaged in this kind of work.

Introduction

Since the 1980s, researchers and practitioners have sought to understand how rape affects survivors' psychological health and to develop effective therapies for promoting recovery. Much of the early research in the sexual assault literature documented the kinds of post-assault psychological problems rape survivors experience, and more recent work has built upon that foundation to develop clinical interventions. This paper reviews research findings on three critical issues for mental health practitioners working with rape survivors: 1) What are rape survivors experiencing and what issues may they present in counseling/therapy; 2) What therapeutic methods and techniques have documented effectiveness in promoting recovery; and 3) What are the effects of working with rape survivors on mental health providers.

Throughout this review, the terms "victim" and "survivor" will be used interchangeably. Some researchers and advocates have called for using the term "survivor" rather than "victim" to emphasize the inherent strength required to recover from rape; others recommend using the term "victim" to

refer to those who have been recently assaulted and the term "survivor" to refer to those further along in recovery. In this paper, these terms are used interchangeably to reflect both the violent nature of this crime (hence "victim") and the long-term work of recovering from such violence (hence "survivor"). In addition, this review focuses on female victims of sexual assault. Although epidemiological data suggest both females and male are raped, females are at substantially higher risk for assault. As a result, most research to date has focused on female rape survivors, so it is not known if the research findings summarized in this paper apply to populations of male victims.

Before reviewing these three critical issues in therapeutic practice, it is important to first note that relatively few victims seek mental health treatment following sexual assault. Rates of mental health services utilization vary across studies, but it appears that approximately 25%-40% of victims seek treatment (1998 Campbell, 1998 ; Campbell et al., in press ; George, Winfield, &Blazer, 1992 ; Golding et al., 1989 ; note Ullman's (1996) 60% utilization rate as an exception). Furthermore, it appears that white women may be more likely than women of color to seek mental health services (Campbell et al., in press), and African American women in particular are more likely to turn to their family and friends for assistance than to formal systems (Wyatt, 1992). Current research has not provided definitive explanations for these low utilization rates, but two general possibilities have been considered. First, individual-level explanations focus on how the trauma of the assault causes severe anxiety, depression, and self-blame, which can interfere with proactive attempts to seek therapeutic services (Foa & Rothbaum, 1998 ; Herman, 1992). Second, other researchers have focused on extra-individual factors. Institutionalized racism and classism in social systems may deter women of color and working class women from seeking services (Fine, 1984 , 1989). In addition, there is growing evidence that community service providers, including mental health workers, may engage in victim-blaming behaviors that significantly exacerbate victims' distress (Campbell et al, 1999). Concerns about the helpfulness of mental health services may prevent some victims from seeking assistance. Although the reasons for low service utilization are not well understood, both individual and extra-individual factors probably contribute to victims' decisions to seek mental health services. In addition, it is possible that some women may not seek mental health services because they do not feel they need such assistance due to their own resiliency and/or support they receiving from their informal networks. As a result, it should be remembered that those who do obtain counseling/therapy are a self-selected group and may differ in unknown ways from others in the population of rape survivors.

What Are Rape Survivors Experiencing and What Issues May They Present In Therapy

To date, most research has focused on documenting and explaining the traumatic effects rape has on victims' lives. Recent findings also suggest that survivors struggle not only with how the assault has directly affected them, but also with how it is affecting those close to them (e.g., husbands, significant others, friends). Moreover, a growing body of literature suggests that victims' post-assault interactions with community service providers (e.g., police, prosecutors, doctors, nurses, mental health professionals) may be traumatizing in their own right. These findings suggest that victims may present a wide range of issues in therapy and practitioners must be aware of the diverse negative effects of rape.

With respect to the impact of the assault on victims, rape comes as a devastating shock, destroying victims' abilities to maintain the important illusion of personal safety and invulnerability, and threatens many assumptions and beliefs survivors may have about themselves and the world around them (Katz, 1991 ; Koss et al. 1994). Not surprisingly, most victims exhibit high levels of psychological distress in the first week after the rape. This distress peaks in severity three weeks post-assault, continues at high levels for one to two more months before finally abating two to three months post-assault (Davidson & Foa, 1991 ; Koss, 1993 ; Rothbaum, Foa, et al., 1992). Throughout this process of recovery, victims experience guilt, shame, fear, anxiety, tension, crying spells, an exaggerated startle response, depression, anger (both generalized and specifically toward men), discomfort in social situations, impaired memory and concentration, and/or rapid mood swings (Burgess & Holmstrom, 1979 ; Goodman, Koss, & Russo, 1993a ; Hanson, 1990 ; Katz, 1991 ; Resick, 1993). Even when evaluated several years after the assault, survivors are more likely to have a serious psychiatric diagnosis, including major depression, alcohol abuse and dependence, drug abuse and dependence, generalized anxiety, obsessive-compulsive disorder, and post-traumatic stress disorder (Burnam, et al., 1988 ; Kilpatrick et al., 1985 ; Koss, 1993).

These varied psychological symptoms are typically viewed as a manifestation of post-traumatic stress (see Goodman, Koss, & Russo, 1993b ; Herman, 1992). PTSD (post-traumatic stress disorder) is a clinical diagnosis that captures the psychological aftermath of both chronic and one-time violence and trauma (American Psychiatric Association, DSM IV, 1994). Victims respond to these traumatic experiences through alternating sequences of intrusions and avoidance. Intrusions are the reliving of the trauma: flashbacks, nightmares, and repeated thoughts that won't leave one's mind. Avoidance refers to how victims isolate themselves from reminders of the traumatic event to prevent becoming emotionally overwhelmed: emotional numbing, withdrawing from others, intellectualizing, distracting themselves by engaging in drug/alcohol use or other high-risk behaviors. Other responses common with PTSD include dissociation, increased arousal, irritability, angry outbursts, hypervigilance, sleep disturbances, and other physical health problems. Foa, Steketee, and Olasov (1989) reported that rape victims constitute the largest single group of PTSD sufferers. Despite the utility of the PTSD framework to practitioners and researchers, feminist scholars have raised important questions about the implications of this model (see Brown, 1994 ; Goodman, Koss, & Russo, 1993b). The PTSD clinical framework is based on the assumption that this psychological distress is a normal reaction to an unusual event. These psychological reactions occur because the traumatic event is outside normal human experiences (e.g., war, violent crime). Virtually anyone would find such occurrences distressing, hence PTSD is viewed as a normal, albeit distressing, reaction to abnormal events. Violence against women is not an out-of-the-ordinary experience in American culture; it is quite common affecting at least 20% of adult women (see Koss et al., 1994 for reviews of prevalence studies). Feminist researchers raise concern that the PTSD framework mislabels a societal problem as an individual one-the trauma of rape is a psychological problem with societal roots. Nevertheless, whether the PTSD framework is wholly accurate, there is substantial evidence to suggest that rape indeed has a profoundly negative effect on women's health. Mental health practitioners should be aware of both the utility and criticisms of the PTSD approach.

The ways in which sexual assault negatively affects the survivor may not be the only issue presented in therapy. Research in psychology, nursing, and social work has demonstrated that husbands/significant others, family, and friends of rape survivors are also detrimentally affected

by sexual assault (Holmstrom & Burgess, 1979 ; Davis, Taylor, & Bench, 1995 ; Remer & Elliott, 1988). For example, Ahrens and Campbell (2000) found that rape stresses victims' friendships with others because their friends often have difficulty understanding how and why survivors cope as they do with the assault. This effect is magnified for male partners of female victims. Barkus's (1997) case study of a therapy group for male partners of female victims of abuse found that these men exhibited symptoms that mirrored the experiences of female partners of war veterans. Specifically, men felt isolated, confused, angry, powerless, and frustrated living with their partners' extreme emotional reactions, which ranged from depression to withdrawal to rage. Other studies with larger samples of men have found similar results: partners of rape victims have significantly higher distress symptoms than partners of non-victims (Veronen, Saunders, & Resnick, 1989). Rape survivors may be struggling not only with their own reactions to the assault, but also with how it is affecting those close to them.

Finally, rape survivors may need mental health practitioners to help them work through their post-assault disclosure experiences. The process of disclosing a rape, either to family and friends or community service providers, can be a difficult process and victims are not always met with supportive responses. Ullman (1996) documented that rape survivors experience a variety of negative social reactions from informal and formal help sources (e.g., being doubted, being blamed). With respect to seeking post-rape community services, a growing body of research suggests that rape survivors are often denied help by their communities, and what help they do receive, often leaves them feeling blamed, doubted, and re-victimized (Campbell, 1998 ; Campbell et al., 1999 ; Cluss, Boughton, Frank, Stewart, & West, 1983 ; Frohmann, 1991 ; Madigan & Gamble, 1991 ; Martin & Powell, 1994 ; Williams, 1984). These negative experiences have been termed "the second rape" (Madigan & Gamble, 1991), "the second assault" (Martin & Powell, 1994), or "secondary victimization" (Campbell & Raja, 1999 ; Campbell et al., 1999 ; Williams, 1984). Campbell et al. (1999) found that victims of non-stranger rape (e.g., acquaintance rape and date rape) were at particular risk for secondary victimization, which was related to increased psychological distress and delayed recovery. Campbell and Raja (1999) found that many mental health professionals may be engaging in harmful counseling practices in their work with rape survivors. These research findings suggest that victims' well-being may be affected not only by the violence itself, but also by help-seeking interactions post-assault. Additional training for community service providers may be needed to address the problem of secondary victimization. An important resource for such training is the instructional video created by the Long Island College Hospital and Junior League of Brooklyn (1998), "Restoring Dignity: Frontline Response to Rape." This video was designed to teach service providers about the beneficial and detrimental effects they may have on rape survivors.

What Therapeutic Methods Have Documented Effectiveness In Promoting Recovery

If survivors do seek counseling services, victims may obtain individualized therapy or group therapy from mental health practitioners in private practice or clinic/hospital settings, or they may receive these services at community-based rape crisis centers. Practitioners may use a variety of therapeutic models in their work with rape survivors, with the most commonly used approaches being cognitive-behavioral therapy (CBT) and feminist therapy. It is important to note that there can be conceptual

overlap between therapeutic models and many practitioners use a variety of techniques in their work (Campbell, Raja, &Grining, 1999). Most research to date has focused on CBT and feminist techniques provided by practitioners in private practice or clinic settings. There have been far fewer evaluations of feminist therapy as compared to CBT, but current research findings suggest both approaches can promote effective recovery outcomes. However, it is important to note that this evaluation research has been conducted primarily with white women, so it is unknown if and how these therapeutic approaches work for women of color. Similarly, it is not known how these treatment models respond to the needs of women of varying social classes, sexual orientations, and levels of ability/disability. Thus, the therapeutic approaches reviewed here may not be as effective for all types of rape survivors, and further research is needed to understand for whom which forms of treatment are helpful and why.

Although there are specific forms of CBT (e.g., systematic desensitization, flooding, prolonged exposure treatment, stress inoculation training), in general these approaches involve systematic exposure to traumatic memories and cognitive reinterpretation of these events (Foa, Riggs, & Gershuny, 1995). Helping clients to remember and visualize feared situations can help them gradually reduce their anxiety (Foa, Steketee, & Rothbaum, 1989). Cognitive techniques, such as challenging automatic thoughts, may also be employed to diminish guilt, fear, and depression. Didactic and behavioral therapy techniques, including educating survivors about rape myths and teaching them anxiety reduction techniques may also be helpful (Foa & Rothbaum, 1998). Evaluations of CBT techniques demonstrate their effectiveness in reducing fear-related symptoms (Foa et al., 1991 ; Frank et al., 1988 ; Resick et al., 1988 ; Resick & Schnicke, 1992). To date, researchers have not found conclusive evidence that one specific form of CBT (e.g., systematic desensitization, stress inoculation training) works better than others. It is also important to note that other factors critical to rape recovery, such as reducing self blame and increasing social support, are not primary foci of CBT approaches and it is not clear the extent to which CBT is effective in addressing these issues. Nevertheless, CBT has demonstrated effectiveness for short-term reduction in fear-related symptoms.

In contrast to CBT's focus on immediate post-rape symptoms of fear and anxiety, feminist therapeutic approaches focus on longer-term symptoms of guilt, shame, and self blame (see Goodman, Koss, & Russo, 1993b). Feminist therapeutic approaches emphasize integrating the social causes of rape into the client's world-view and reducing self-blame and guilt following sexual assault (Enns, 1993 ; Koss & Harvey, 1991 ; Lehmann, Rabenstein, et al., 1994). A key goal of feminist therapy is helping survivors understand that the problem of rape is a societal problem, not merely an individual problem. Analysis of gender roles, particularly in intimate relationships, is a critical component of feminist approach to sexual assault counseling (Wyche & Rice, 1997). Because many feminist therapists focus on self-blame following rape, group therapy is often a preferred treatment choice as a group setting can break down post-rape isolation, promote sharing of experiences, and develop supportive relationships (Koss & Harvey, 1991). However, group therapy may not be appropriate for individual with pre-existing psychological problems that may interfere with their ability to participate in group (Sprei & Goodwin, 1983). Although evaluation data are scarce, the few published studies on feminist therapy suggest positive results. Hutchinson and McDaniel (1986) compared women in feminist therapy to those in traditional counseling and found that those in feminist therapy showed more improvement in the reduction of guilt and self blame.

However, the design of this study did not provide a control group and the self-selected nature of the sample tempers these conclusions. Morgan (2000) compared recovery outcomes of 40 female survivors of childhood sexual abuse in feminist therapy to 40 women in a control group. Analyses suggested that those participating in feminist therapy showed more progress after 20 weeks on outcome variables (depression, social adjustment, self blame, and post-traumatic stress) than did the control women. More evaluation research is needed to assess the effectiveness of feminist therapeutic models. As mentioned previously, it is not uncommon for practitioners to combine feminist therapeutic models with CBT to address both immediate distress as well as longer-term self blame. Further research is also needed to evaluate the effectiveness of these dual model approaches.

What Are the Effects of Working With Rape Survivors On Mental Health Providers

Therapists, counselors, and social workers who treat rape survivors experience many of the same reactions as do victims: anxiety, fear, depression, exaggerated startle response, difficulty sleeping, nightmares, and physical health problems. This trauma of treating survivors of violence is most commonly referred to as secondary traumatic stress (STS), compassion fatigue (CF) (Figley, 1995) or vicarious traumatization (VT) (McCann & Pearlman, 1990 , 1993); Pearlman, & MacIlan, 1995 ; Pearlman & Saakvitne, 1995 ; Saakvitne & Pearlman, 1996). STS/CF/VT is the mirror image of PTSD: repeatedly thinking about the traumatic events, feeling numb, becoming reluctant to work on traumatic cases, experiencing addictive or compulsive behaviors, having increased physiological arousal, and enduring impairment in day-to-day functioning. The DSM-IV (APA, 1994) diagnosis for PTSD clearly allows for indirect effects of trauma. Learning about unexpected or violent death, serious harm, or threat of death or injury experience by others can produce post-traumatic stress symptoms (Diagnosis Criterion A1). This emphasizes "that people can be traumatized without actually being physically harmed or threatened with harm. That is, they can be traumatized simply by learning about the traumatic event" (Figley, 1995 , p. 4). Pearlman and Saakvitne (1995) noted that VT produces a "transformation in the inner experience of the therapist that comes about as a result of empathic engagement with clients' traumatic material . . . we view it as an occupational hazard, an inevitable effect of trauma work" (p. 31). Thus, PTSD reflects the effects of trauma on primary victims (e.g., rape survivors), and STS/CF/VT refers to the impact on those close to the victims (e.g., partners, family, community service providers). STS/CF/VT is a set of parallel emotional reactions, diminished in intensity and less likely to require formal psychological intervention, but is also a component of trauma work that should not be ignored.

Several studies have documented that STS/CF/VT is a serious and common problem among rape counselors/therapists and rape victim advocates. Schauben and Frazier's (1995) study of 220 female counselors found that as the percentage of therapists' caseloads devoted to treating sexual assault victims increases, counselors report more post-traumatic stress symptoms. Similarly, Brady et al. (1999) conducted a national survey of 1,000 female psychotherapists and found that therapists with higher levels of exposure to sexual abuse material reported significantly more trauma symptoms (e.g., difficulty concentrating, disturbed sleep, irritability, stress), but no significant disruption in cognitive schemas. Consistent with these findings, Astin (1997), a sexual assault therapist, noted:

"When the main focus of my work shifted to working with rape victims . . . I found myself experiencing nightmares of being raped. Or I would turn a dark corner in my home and imagine a rapist coming toward me just like had for my client (p. 102-103) . . . I [realized I] was just as vulnerable as anyone else. That realization made me more susceptible to symptoms of vicarious traumatization. It also has brought me closer to the struggles of my clients. For that I am grateful (p. 102-103; 108)." Tyra (1979), Eberth (1989), and Wasco (1999) have found that volunteer rape crisis counselors/rape victim advocates also reported behavioral, somatic, and psychological reactions to their work. Even providing medical care to rape survivors can produce secondary stress as Hartman (1995) documented that nurses who work with victims of violent crimes, including rape, experienced health complaints.

Although mental health providers are trained to assist with multiple forms of psychological trauma, this literature suggests that working with victims of sexual violence may present additional challenges. By its very nature, the roles of trauma therapist and rape victim advocate require empathic exploration of painful material. Counselors must personally endure repeated exposure to distress and use their own feelings of sorrow as tools for therapy and intervention. As such, it is impossible to escape that kind of work without personal consequences. Figley and others argue that self-care, not psychotherapy, is the solution for practitioners (see Munroe et al., 1995 ; Pickett et al., 1994). With opportunities to vent and process their feelings with others, trauma therapists and advocates can buffer themselves from the ill effects of their work. Saakvitne and Pearlman's approach to addressing vicarious traumatization emphasizes three key factors. First, practitioners must develop their sense of awareness, which is "[b]eing attuned to one's needs, limits, emotions, and resources. Heed all levels of awareness and sources of information, cognitive, intuitive, and somatic. Practice mindfulness and acceptance" (p. 76). Second, service providers must work toward balance: "[m]aintaining balance among activities, especially work, play, and rest. Inner balance allows attention to all aspects of oneself" (p. 76). Finally, awareness and balance can foster connection: "[c]onnections to oneself, to others, and to something larger. Communication is part of the connection and breaks the silence of unacknowledged pain. These connections offset isolation and increase validation and hope" (p. 76). These three components should be addressed within three fundamental domains of practitioners' lives: professional, organizational, and personal. Activities that heighten awareness, provide structure for respite, and develop a psychological sense of community may be effective VT preventive strategies for trauma therapists and advocates.

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