To the Graduate Council:

I am submitting herewith a dissertation written by Madelon Jean Parks entitled "Long-Term Effects of Rape on the Victim." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Psychology.

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LONG-TERM EFFECTS OF RAPE ON THE VICTIM

A Dissertation

Presented for the

Doctor of Philosophy

Degree

The University of Tennessee, Knoxville

Madelon Jean Parks

August 1984

DEDICATION

This work is dedicated to the memory of my sister, Elizabeth (Betsy) Parks Rosenberg, who suffered the ultimate victimization, murder, on May 6, 1975. May there come a day when murder and rape are things of the past.

ACKNOWLEDGMENTS

Recognition and appreciation go first to the brave women who contributed their time, memories, and current experiences so that this study could be accomplished. I hope the final report confirms the faith they displayed in me.

My thanks go to my committee members. Charlie Cohen not only guided this research project but shaped my way of thinking about people. Howard Pollio supplied his enthusiasm for my research and his faith that talking with people is the best way to learn about them. Bob Wahler contributed his dedication to research and his guidance which helped sustain my progress during a period of Charlie's illness. Priscilla White offered her support and her pragmatism when things seemed hopelessly complex. Anne McIntyre provided a standard of excellence and helpful hints regarding mundane but critical details.

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ABSTRACT

In order to learn about the long-term effects of rape on victims, 10 women who had been raped 3 or more years ago were interviewed concerning the changes they had perceived in themselves since the rape, particularly concerning their relationships with men and the course of those changes over time. From the themes presented by the victims, a two-dimensional category system was derived which elucidated the nature of the changes they perceived. The similarities between the victims' statements and David Shapiro's description of the paranoid style were discussed.

The victims took the Leary Interpersonal Check List, rating various categories of males and themselves in relation to those males. Victims and an undergraduate comparison group held common views of males as dominant, powerful, and aggressive. The victims differed from the undergraduates in seeing themselves as less affiliative in relation to men and more conscious of their self-interests.

The victims also took the SCL-90-R, a psychological symptom check list. The predominant dimension was Depression, in terms of both current experience and those symptoms which they attributed to the rape.

A Prevalence Survey was distributed at three mental health facilities to determine what proportion of the female clinical outpatient population has experienced forced sexual contact in the past. Figures for forced sexual contact in general ranged from 34% to 43%. Figures for

rape and sexual assault ranged from 16% to 30%, and figures for incest ranged from 10% to 19%. At one facility, 11% reported both rape and incest.

Clinical implications of the findings and suggestions for further research were discussed.

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CHAPTER I

INTRODUCTION

There is much evidence to indicate that rape, sexual contact with another by force or coercion, has existed since prehistoric times and certainly since the codification of ancient Babylonian and Mosaic law (Brownmiller, 1975). The perception of rape as a social problem, distinct from instances of theft or defilement of property, has developed gradually and the impact of the earlier conceptions of rape is still felt today.

In terms of the coverage it has received in scientific and scholarly circles, the topic of rape is a relative newcomer. Much of the early interest centered on statistics regarding the incidence, the circumstances, and the characteristics of rape incidents (Amir, 1971). One of the important unanswered (and possibly unanswerable) questions about rape is: What is the incidence? The Uniform Crime Reports for 1980, compiled by the United States Department of Justice (1981), reported that "an estimated 71 of every 100,000 females in the country were reported rape victims" (p. 15). This figure reflected a 6% increase over 1979 and a 38% increase over 1976 (p. 15).

Figures concerning rapes reported to law enforcement agencies are generally considered to be representative of only a fraction of the number of rapes actually committed. Estimates of the ratio between reported and unreported rapes range from a conservative 1:2.1 (Curtis, 1976) to a probably exaggerated 1:10 (Griffin, 1971). Most

victims who go to a hospital emergency room also report their victimization to the police, if only because of laws requiring hospitals to contact police when they treat a victim of a violent crime. What about the numbers of victims who do not make a report to an "official" agency? Rape crisis centers receive calls from many victims who do not plan to call the police. For example, in 1980, the Knoxville Rape Crisis Center received about twice as many calls reporting recent rapes as did the Knoxville Police Department (L. G. Blackburn, personal communication, 1981). Katz and Mazur (1979) reported in a pre-Preface section of their book that in a limited survey of an unspecified female psychiatric sample as well as in a sample of females who had attempted suicide, approximately one-quarter of the females reported a "history of rape" (p. ix). Given this figure and Abarbanel's (1976) calculation that, at the present rate, "chances are better than 1 in 15 that a woman will be raped during her life" (p. 478), it seems crucial that mental health professionals be acquainted with the issues a rape victim is likely to face.

The experience of rape from the victim's perspective was largely ignored in the literature until the mid 1970s. Since that time, there has been a burgeoning of articles, both theoretical and empirical. The majority of the effort and attention of researchers has been focused on rape victims' reactions to rape within the first year and a fairly complete picture of the variety of responses has emerged (Burgess & Holmstrom, 1974b; Kilpatrick, Veronen, & Resick, 1979; Sutherland & Scherl, 1970). Less well documented have been the long-term effects

of rape on the victims, despite the efforts of Burgess and Holmstrom (1979a, 1979c). Other investigators have hinted at or even described possible long-term effects without identifying their data base (Halleck, 1962; Calhoun, Selby, & King, 1976; Notman & Nadelson, 1976; Warner, 1980).

Some researchers studying the early reaction to rape, especially Burgess and Holmstrom (1974b, 1979b), listened closely to the victims and presented their findings in such a way that the reader was able to feel he or she could truly understand and appreciate the victims' experiences. However, studies purporting to address long-term effects have tended to involve considerable abstracting on the part of the investigators (Bart, 1975; Burgess & Holmstrom, 1979a, 1979c) or to be more "objective" in their reliance on instruments measuring a specific type of response, often, the sexual response (Becker, Skinner, Abel, & Treacy, 1982). Other than individual case studies (Safran, 1983), no studies have focused on an in-depth look at the victims' perceptions of the long-term effects and how the victims make sense of their experiences.

Von Eckartsberg (1978) criticized the "anonymous group-average" approach to research, writing further that, "Within this context, the full meaning and context of the 'event encounter' that we perceive in our own life, as a meaningful adventure, never gets examined" (p. 189). Although rape victims might not consider their rape experience and its sequelae as an "adventure," it is clear the long-term repercussions and the victims' understanding of them have not

been examined fully. The primary goal of this research project, then, is to examine carefully, being as faithful as possible to their personal realities, rape victims' descriptions of their rape experiences and the changes in their lives that they perceive as related to the rape, focusing on the questions:

1. How do rape victims perceive the impact the rape has had on their lives? Especially on their relationships? And more specifically on their relationships with men?
2. What is their perception of how the impact has changed with time?

Areas of secondary interest which will be addressed in the study are:

1. factors rape victims identify as being helpful or unhelpful in coping, especially over time;
2. similarities and differences among subjects' long-term responses to rape;
3. patterns, if any, of psychological symptomatology reported by victims;
4. victims' perceptions of men and of themselves in relation to men, particularly on the dimensions of dominance and affiliativeness;
5. the prevalence of the experience of forced sexual contact in the female clinical (mental health service consumers) population.

CHAPTER II

LITERATURE REVIEW

Definitions of Rape

Definitions of rape vary tremendously. Even the legal definition of rape is not consistent from state to state. Individuals may know in their own minds what acts they would or would not consider rape, but might have difficulty articulating a logically consistent definition. Researchers and authors have frequently written about "rape victims" without giving an operational definition of rape or delineating the criteria for inclusion or exclusion from the study. Holmstrom and Burgess (1979) were a rare exception to this rule. When a conceptualization of rape is discussed, the focus is typically on the appropriateness of emphasizing the sexual component versus the aggressive component, which may include elements of power, anger, and violence (Becker, Abel, & Skinner, 1979; Burgess & Holmstrom, 1979c).

The broadest definitions of rape include any sexual contact with an unwilling person. Some authors chose to narrow the definition by excluding male victims or female offenders, by excluding any but vaginal penetration, or by excluding forced sexual contacts between spouses. Two elements, however, are common to all definitions of rape: coercion and sexuality. Because research in the area of victim reactions to rape has not progressed far enough to tell if there are significant differences in victim reactions to the different types of

sexual assault, it is difficult to assess the impact of the definitional confusion.

In order to provide a context for the present study of long-term effects of rape, the existing literature on both short- and long-term effects will be reviewed, first for content and then for design and methodological issues. The area of interest, and therefore review, will be limited to the reactions of adult victims of rape and will focus on emotional, psychological, and interpersonal reactions.

Short-Term Effects

As noted above, the topic of rape is a relative newcomer to scientific and scholarly investigation. The early 1970s was the period during which the rape victim's plight began to receive considerable attention in professional and scientific publications. Prior to that time, only a few articles had been written on the subject. Halleck's (1962) article was one of the first to focus primarily on victims' emotional needs. Halleck, directing his comments to family physicians, discussed the victim's having to deal with severe anxieties, somatic symptoms, depression, anger, and self-blame. He clearly believed that, if these issues were not resolved, there was a possibility the victim would develop "serious psychiatric problems in later life" (p. 273).

Sutherland and Scherl (1970) and Fox (formerly Sutherland) and Scherl (1972) were perhaps the first to identify the sample from which they drew their descriptions of patterns of psychological response in

rape victims. Drawing on their work with 13 victims over the course of a year, they identified a three-stage pattern. The first phase, labeled "acute reaction" (1970, p. 504), occurs immediately following the assault and may last for a few weeks. The victim may experience shock, disbelief, and dismay. She may be agitated and incoherent or she may appear quite stable. The victim may experience gross anxiety as she faces medical, legal, and other practical decisions, such as whom to tell, what action to take to insure her future safety, and so on.

Phase two, "outward adjustment" (Sutherland & Scherl, 1970, p. 507), is a time when anxiety lessens and the victim returns to her usual routine. The authors believed this phase represents a period of pseudo-adjustment when feelings and thoughts about the rape are handled through denial or suppression. The victim typically prefers not to discuss the rape, feeling she is ready to put it behind her. The third phase, "integration and resolution" (1970, p. 508), typically is ushered in by the appearance of depression and a desire to talk. Issues which had previously been handled superficially reemerge. Major tasks of this period include integrating a new view of oneself and resolving one's feelings about the assailant. Anger at the self and the assailant is common during this period.

Ann Wolbert Burgess and Lynda Lytle Holmstrom have published more in the area of rape victim reactions than any other person or persons. The majority of their books and articles have grown out of an ongoing study conducted with 146 rape victims who were admitted

to the Boston City Hospital emergency room over the course of a year. In their various publications, Burgess and Holmstrom have discussed issues such as the victims' counseling requests (1974a), victims' coping behavior before, during, and after the assault (1976), and the responses of medical, law enforcement, and legal agencies (under Holmstrom & Burgess, 1978). Of more relevance to this study are their findings on victims' emotional reactions (1974b), coping strategies related to recovery over time (4-6 years) (1979a), long-term sexual disruption (1979c), and relationship issues with a husband or boyfriend (under Holmstrom & Burgess, 1979).

Burgess and Holmstrom are probably best known for their description of rape victim responses during the first year postrape. They worked with a subsample of 92 adult victims and labeled the pattern of symptoms they observed the "rape trauma syndrome" (1974b). Like Sutherland and Scherl, they identified stages of recovery, but limited their formulation to two stages. The first is an acute phase of disorganization which typically lasts for the first several weeks postrape. The initial reaction may be shock and disbelief, which then gives way to fear, anger, and anxiety. These emotions may be evidenced through crying, restlessness, and tenseness (the expressed style) or they may be masked by an outwardly calm and composed demeanor (the controlled style). Also, during this first phase, victims may fear physical violence and death, feel humiliated and embarrassed, desire revenge, or blame themselves for the rape (pp. 982-983).

Somatic reactions during the first phase have been noted to include physical trauma from injury, muscle strain, skeletal muscle tension manifested in tension headaches, the startle reaction (becoming edgy or jumpy with little provocation), sleep disturbances, gastro-intestinal irritability, and genitourinary disturbances (Burgess & Holmstrom, 1974b, p. 982).

The second phase, a long-term process of reorganization, frequently includes a sharp increase in activities such as changing residences and phone numbers, visiting family members, and traveling. Nightmares and phobias are frequently reported. The phobias are often related to the circumstances of the rape and result in fear of being indoors or outdoors, of being alone or being in a crowd, and of resuming sexual relations with a partner (Burgess & Holmstrom, 1974b, pp. 983-984).

From their conversations with 16 victims and their spouses or live-in partners, Holmstrom and Burgess (1979) identified several issues which frequently emerge in the first three months postrape. The males must deal with their own reactions in terms of who has been victimized (self, other, or both), in terms of a possible desire to get revenge on the rapist, and in terms of wishing to undo the event, what the authors called the "if only" reaction (1979, p. 322).

Partners of rape victims are also faced with discussing the rape itself, helping the victim deal with phobias she may develop, and resuming sexual relations. These relationship issues may be more or less problematic for any given couple. Factors which affect the degree

of difficulty a couple experiences include the placement of blame (on the assailant, the victim, or the male partner), the conceptualization of rape as primarily sexual or as primarily violent, and the quality of the couple's previous relationship (Holmstrom & Burgess, 1979).

The Philadelphia Sexual Assault Victim Study (PSAVS) reported by McCahill, Meyer, and Fischman (1979) rivals Burgess and Holmstrom's early works in terms of sample size and scope of the investigation. The PSAVS subjects were also drawn from females who reported rape at a large urban hospital. Interviews were conducted at four time intervals: within 5 days postrape, then at 3, 7, and 11 months postrape. Of the initial sample of 709 subjects, 213 were available for the last follow-up interview. Social workers conducted home interviews which focused on the rape incident, the victims' experiences with medical and criminal justice systems, as well as the victims' social relationships and their adjustment in behavioral, social, and psychological areas. The researchers sifted through masses of data and selected 13 dependent variables for analysis. These variables and the percentages of victims affected are summarized in Table A-1, Appendix A.

All the variables listed in Table A-1, Appendix A, have relevance for this study, but a few deserve special mention. In relation to the development of increased negative feelings toward known and/or unknown men, it was found that "a rape victim who is previously acquainted with her attacker, even if he is no more than a relative stranger to her, is significantly more likely to experience increased

negative feelings toward known men than is a victim who is raped by a total stranger" (McCahill et al., 1979, p. 67). Conversely, increased negative feelings toward unknown men were "most common among victims who were not previously acquainted with their attacker" (p. 32).

McCahill et al. (1979) found that a victim's family members affect her postrape adjustment in many ways. For example, "a married woman is nearly twice as likely to experience worsened relations [not limited to sexual relations] with her husband than is an unmarried woman with her boyfriend (45% versus 23%)" (p. 48). Similarly, "a married rape victim is more than twice as likely to experience worsened relations with other family members [that is, not including her husband] than is an unmarried victim (34% versus 15%)" (p. 48). Additionally, a victim who lives with her mother is less likely than a married woman to have severe increases in her insecurities about her sexual attractiveness or to have eating or sleeping disturbances. A woman who lives with her father is less likely than other victims, at 1 year postrape, to experience a negative reaction toward known men. Thus one can see that a victim's family of origin may at times offer a different kind of support and aid in the adjustment process than does the husband who is likely to be dealing with intense feelings of his own.

There are only a handful of empirical studies on rape victims' reactions in the first year other than those already described. Kilpatrick et al. (1979) are among the even smaller number of researchers in the area who have used established, "objective"

measures of mood states and of psychological distress and who have incorporated a control group. They found that rape victims had significantly elevated scores on a variety of scales measuring anxiety, tension, and depression over the first month postrape. By 3 months, the differences between the two groups (victims and nonvictims) had diminished markedly and by 6 months, the groups differed on only 7 of 28 measures of distress. All 7 were measures of fear and anxiety.

Feldman-Summers, Gordon, and Meagher (1979) studied the impact of rape on sexual satisfaction, using 15 rape victims and a nonvictim control group. The time elapsed since the rape for the victims ranged from 2 months to 7 years, with a median of 12 months. Only 2 subjects had been raped more than 2 years prior to the study. The authors found that the victims' current sexual activity was similar in frequency to but lower in satisfaction than the control group's current sexual activity. There had been some recovery for victims in satisfaction from 1 week postrape, but satisfaction at 2 months postrape was not as high as it had been before the rape. Satisfaction with autoerotic and primary affectional activities (holding hands, hugging, and so forth) did not decrease after the rape.

Holmes (1979) included, in her interviews with 61 victims, questions about how the rape had affected their feelings toward men. Over half reported their feelings were "not as good" as before the rape in the following five areas: communication-talking, trust, affectional-nonsexual, comfort, and sexual attraction-interest. An increased sense of fear and apprehension was reported by 32.8%, and

31.1% reported heightened feelings of distrust manifested by skepticism, negativism, and by a tendency to withdraw from others. When asked how well they were doing in general, compared to before the rape, the victims were almost evenly divided between reporting better, the same, and worse. All of the victims Holmes interviewed had been raped 3 years or less before the interview. Holmes' data clearly show that most rape victims perceive negative changes in their relationships with men, at least during the first 3 years postrape.

Medea and Thompson (1974) developed a questionnaire which focused on the characteristics of rape situations and the victims' reactions. They published the questionnaire in underground papers and distributed copies at several rape conferences, reaching a predominantly white, middle class sample of 60 victims. Neither the range nor the means of the time since the assault were specified. The researchers developed categories to organize the ways in which the victims reported their lives had been affected (Table 1).

A questionnaire published in Viva magazine produced 1,070 responses from rape and attempted rape victims, the largest sample known to this author. About a third of the rapes had occurred within the past year, about a half had happened within the past 3 years, and 10% had taken place over 10 years before the study. Bart (1975) reported the following findings.

> Almost half suffered a loss of trust in male-female relationships. About a third were affected sexually, had nightmares, and felt hostility toward men. About a quarter said they felt a loss of self-respect and a similar number received psychiatric care. Sixteen percent had suicidal feelings, 16 percent felt a loss of independence and 14 percent had physical injuries. (Bart, 1975, p. 41)

Table 1

Life Affected by Rape: Victims' Perceptions

Life affected	Percent
sexually	28
independence	27
fear of men	42
hostility toward men	17
self-respect	18
trust (in male-female relationship)	23
physical injuries	10
suicidal feelings	7
nightmares	5

Note. Excerpted from Against Rape by Andra Medea and Kathleen Thompson. Copyright © 1974 by Andra Medea and Kathleen Thompson. Reprinted by permission of Farrar, Straus and Giroux, Inc., p. 143.

Saturansky (1977) did a clinical study of 9 rape victims with a control group of 5 women who had suffered traumatic accidents. Looking for personality factors which might affect a woman's likelihood of being raped and using extensive interview data of the victims' prerape development, she found "no pattern of personality dynamics or life experience . . . to be consistent for the rape victims as a whole" (p. 4704-B). She found no differences between groups in Machover Figure Drawings, but did find that victims of rape "told significantly more [TAT] stories with themes of suicide, men being negatively experienced and/or aggressing against women, and romance or love stories" (p. 4704-B). Saturansky interpreted this difference as a reflection of the victims' efforts to cope with anger and fearfulness toward men, but given the design of the study, it is impossible to

know if this difference was present before the rape or developed afterwards. Successful litigation and unsuccessful litigation seemed connected with successful adjustment and disruption of previous adjustment, respectively.

The remaining studies of short-term rape victim reactions are relatively weak methodologically or add little additional information, so they will be mentioned only briefly. McCombie (1976) did a descriptive study of victims seen in the well-respected Beth Israel Hospital Rape Crisis Intervention Program. Of primary relevance to this study are the victims' responses to the question of what difficulties they expected in the future as a result of the assault. The most frequently mentioned concerns were their own adjustment and self-image, general distrust of others and specific distrust of men, others' reactions to the victims, and sexual adjustment.

In addition to the above empirical (more or less) studies of the short-term effects of rape on the victims, there have been several theoretical or descriptive articles written. Notman and Nadelson (1976) integrated empirical findings and psychodynamic theory in their discussion of a four-phase reaction pattern and of such issues as anger, guilt and shame, unconscious fantasies, and life stage considerations. Forman (1980) described five phases of victim response and emphasized corresponding psychotherapeutic considerations. White and Rollins (1980), using Reubin Hill's theoretical formulation of family crisis as an organizing framework, discussed the impact of rape on the family unit.

Even the better empirical studies reviewed above have significant methodological limitations which must be taken into consideration when interpreting the findings. In many of the studies, the subject pools consisted of groups of rape victims who had gone to a hospital emergency room or had called a rape crisis center. In most cases, research efforts and crisis intervention counseling programs were intertwined (Becker et al., 1979; Burgess & Holmstrom, 1974a, 1974b, 1976, 1979a, 1979b, 1979c; Feldman-Summers et al., 1979; Fox & Scherl, 1972; Holmes, 1979; Holmstrom & Burgess, 1979; Kilpatrick, et al., 1979; McCombie, 1976; Sutherland & Scherl, 1970). Studies built on this design have at least two serious drawbacks. One is that the sample is inherently biased because all the subjects chose to report their victimization to helping agencies. As already indicated, there are many victims who never initiate a report and it is difficult, if not impossible, to know how victims who report are different from those who do not.

A second drawback of the most common design in rape victim research concerns the dual functions of gathering data and providing crisis intervention counseling. The researcher/interviewer must decide which function has highest priority at any given instant and one would expect that the quality of both functions is thereby compromised. A related issue is that, without a control group of victims who report the rape but who do not receive crisis intervention counseling, one gathers data, not on the natural course of recovery from rape, but on the assisted recovery process. This author is not aware of any

nonassisted victim control groups; there would be ethical difficulties with denying treatment for the sake of research.

Even nonvictim control groups are a rarity in the study of victim reactions to rape. This author is aware of only three studies which included such control groups: Feldman-Summers et al. (1979), Kilpatrick et al. (1979), and Saturansky (1977). Because of the lack of control groups, it is questionable whether nonvictims might not also experience a rise in similar psychological and interpersonal difficulties at certain periods. For example, a preponderance of victims across many of the studies fall in the age range of late teens to early 20's, a time when many nonvictims seek mental health assistance for the first time. Another complicating factor is the question of whether the cluster of symptoms which have been labeled "rape trauma syndrome" (Burgess & Holmstrom, 1974b) is specific to the rape experience, whether it is characteristic of victimization in general, or characteristic of crisis events in general.

Long-Term Effects

Implicit in many of the discussions of the effects of rape on the victim is the idea that rape is a crisis and that the tenets of crisis theory and crisis intervention apply. In addressing the question of whether victim responses to rape are adequately and accurately dealt with in the rape-as-crisis conceptualization, Holmes (1979) carefully reviewed the literature dealing with rape as a crisis. She found that in many cases, the authors took for granted the link between crisis

theory and reactions to rape (Calhoun et al., 1976; Fox & Scherl, 1972; McCombie, 1976; Silverman, 1978; Sutherland & Scherl, 1970). Only Williams and Williams (1973) and Burgess and Holmstrom (1979b) have made explicit the theoretical link between the experience of rape and crisis. Although Burgess and Holmstrom have mentioned rape as crisis in a number of their articles, their most recent and perhaps clearest discussion is in Chapter 12, "Crisis Theory and Crisis Requests" in Rape: Crisis and Recovery (1979b). They discussed the interaction between rape as an external, situational crisis and the victim's developmental stage (à la Erickson) in the life cycle.

Since Holmes' (1979) review, another theoretical article has been published in which Bassuk (1980) discussed rape as a crisis. However, she also clearly described special issues with which rape victims must deal, thus delineating how she believes rape is similar to and different from other crises. The three issues she identified as specific to a rape victim are (1) "feelings of vulnerability and powerlessness that threaten her basic sense of safety in the world," (2) "loss of integrity of bodily boundaries," and (3) confrontation of "the power relations between men and women in our society" (pp. 126-127).

As Holmes (1979) pointed out, clear empirical support for describing responses to rape as crisis behavior is nonexistent beyond the general descriptive studies already mentioned, such as Burgess and Holmstrom (1974b) and Sutherland and Scherl (1970). Holmes' (1979) dissertation research was designed to test some of the theoretical tenets of crisis theory as demonstrated in the responses of rape

victims. The concept of primary interest for present purposes is the "crisis theory concept that crises are, by definition, time-limited" (p. 77) and that a resolution of some sort will be reached within about 2 months. From the conceptual framework, Holmes formulated the following hypothesis: "recent victims will evidence a significantly higher degree of crisis response than other victims" (p. 76).

Using Halpern's (1973) Crisis Scale to operationalize crisis behavior, Holmes (1979) did not find empirical support for her hypothesis concerning recovery from rape over time. There was little variance in mean crisis scores across the groups defined by time-since-assault: under 2 months, 2-6 months, 7-18 months, over 18 months. The last group had the lowest score, as predicted, but the trend was not strong enough to be statistically significant and the downward turn in crisis scores did not occur until the 18 month interval.

In her discussion of her results, Holmes (1979) pointed out that the data do not permit one to determine if the notion of time-limited crisis behavior is invalid in general, or just not applicable to responses to rape. At any rate, the conceptualization of rape-as-crisis has been seriously questioned.

Holmes' (1979) research raises the question of how long <u>does</u> it take to recover from a rape, if the crisis behaviors are not significantly lessened by 18 months? A related issue is the question of what, if any, are the long-term effects of rape?

Burgess and Holmstrom have done the only true "long-term" studies of victim reactions that this author has been able to locate (1979a, 1979c). Of their original sample of 92 adult victims of forcible rape, they were able to contact 81 for a 4-6 year follow-up. Victims were asked whether they felt "back to normal, that is, the way you felt prior to the rape? and, Has the rape interfered in your life and, if so, in what areas?" (1979a, p. 1278). Of the 81 victims, 30 felt it had taken them months to recover, 30 felt it took years, and 21 felt they had not yet recovered (1979a). The authors did not describe the reasons offered by the latter group for not feeling recovered. Neither did they justify their definition of "back to normal" nor their use of this concept as a dependent variable. Victims who used conscious defense mechanisms of explanation (finding a "reason" for the rape), minimization, suppression, and dramatization were more likely to feel recovered at the time of the follow-up. Increased action, such as changing residence, traveling, or studying rape, was also associated with speedier recovery. Nine victims reported making suicidal attempts and 14 relied on drugs or alcohol as a coping tactic. (Data are not available on how many of these women had used these strategies before the rape.) Of the 51 victims who were engaged in some type of partnership relationship at the time of the rape, 59% experienced disruption of the relationship, 14% experienced semidisruption, and 27% experienced no disruption. Partnership stability was associated with faster recovery as was positive self-assessment, but such associations do "not tell the direction of cause and effect" (1979a, p. 1279).

In another article growing out of their follow-up contacts, Burgess and Holmstrom (1979c) explored the impact of rape on the victims' sexual lives and presented a gloomier picture than did Feldman-Summers et al. (1979). Burgess and Holmstrom found that the victim's prior level of sexual activity does not appear to affect the length of recovery, but the more sexual symptoms a victim developed, the longer her recovery period was likely to be. Almost every victim reported experiencing some sexual difficulty, or at least a change in the frequency of activity. Of the victims who had been sexually active at the time of the rape, 38% reported they had given up sex for at least 6 months and 33% "reported a delay in resuming sex and a decrease in usual frequency" (pp. 651-652). Sexual difficulties included development of an aversion to or loss of interest in sex, flashbacks to the rape during sexual activity, vaginismus, and lack of orgasmic response. Approximately half of the sexually active victims had concerns about their partners' reactions, fearing the males might think the rape was their (the victim's) fault, that they wanted it, or that they were unclean or undesirable.

Burgess and Holmstrom (1979b) discussed other findings from their follow-up research in their book, Rape: Crisis and Recovery. That victims view their rape as a "major life event" was demonstrated by the rankings made on a scale from 1 to 10, 1 meaning the rape had little impact on their life and 10 meaning the rape had a major impact. Forty percent of the victims "ranked the rape as the most upsetting event in their lives, giving the rape a ranking of 10" (p. 408).

"Almost 30% of the victims ranked the rape as a highly stressful situation," meaning they gave the rape a rank of 8 or 9 (p. 409). Only 7% gave a ranking of 1-4 to the rape.

Continuing to draw from the same data, Burgess and Holmstrom (1979b) went on to identify factors "that were observed to aid in recovery from rape" (p. 421).

> These factors include: the presence of a family grief stress at least 2 years prior to the rape; evidence of a positive self-esteem; use of conscious defense mechanisms of explanation, minimization, suppression, and dramatization; and action-oriented behavior such as moving, changing residence, or reading on the subject of rape. (Burgess & Holmstrom, 1979b, p. 421)

Factors they identified as delaying recovery from rape were:

> prior victimization; presence of chronic life stressors of economic stress, lack of social support, and existing biopsychosocial problems; negative self-esteem; decreased action following the rape; maladaptive responses to stress of substance abuse and/or suicidal behavior; blitz rape occurring in home territory or confidence rape occurring despite protective company; and subsequent victimization. (Burgess & Holmstrom, 1979b, p. 434)

For some reason which was not articulated, Burgess and Holmstrom were willing to make inferences regarding causal relationships in their book (1979b) while explicitly avoiding such conclusions in their article (1979a).

Burgess and Holmstrom (1979b) categorized the victims' responses to the question of whether the rape had interfered with their lives into the following "Victim Themes on Follow-Up." Thirty-seven percent of the victims identified their decreased trust, especially in men, as an issue. Approximately 25% identified an increased need for safety as their most important concern and a similar number identified decreased

feelings of self-confidence as an issue. Unfortunately, it was not made clear what percentage of women felt each of these concerns continues to be problematic for them.

In their final chapter, Burgess and Holmstrom (1979b) discussed "unresolved sexual trauma," which they defined as a rape or assault "which remains unsettled at an emotional level" (p. 449). They presented a case study of a woman who had been raped 6 years previously and had developed symptoms 2 years previously, after a district attorney had contacted her in relation to the case. The symptoms the victim presented were, "'I am nervous and irritable for no reason; have mood swings; get depressed; and don't like or want sex'" (p. 452).

Although Burgess and Holmstrom's study, which they reported in their 1979 publications, is a longitudinal one, and all the victims had been raped at least 4 years prior to the follow-up contact, it is impossible to discern which effects continue to be salient for the victims (except in the case study just described) and therefore, which symptoms should be considered "long-term," or present 3 or more years after the rape.

Two questionnaires cited above are often mentioned as studies which reveal long-term effects of rape on the victim, but must be interpreted cautiously in this regard. Bart's (1975) study included women who had been raped 3 or more years prior to their response to the questionnaire, but because it also included a predominance of more recent rape victims and because no distinction was made between

short- and long-term findings, the results cannot be taken as clearly reflecting long-term results. Similarly, Medea and Thompson's (1974) questionnaire appears to address long-term effects, but since they did not report the time elapsed since the rape for their respondents, this conclusion is unjustified.

Authors of two other studies presented their works as dealing with the long-term effects of rape. Becker et al. (1982) addressed the presence of sexual dysfunction in rape and incest victims. Of the rape victims (N = 22), 63.6% reported fear of sex, 59.1% reported arousal dysfunction, and 63.6% reported desire dysfunction (p. 70). Because less than half of their subjects were victimized more than 3 years before the study and because some were victimized as recently as 2 months before the study, it would be improper to interpret this data as representing long-term effects, especially because no breakdown by time since assault was reported.

Miller, Williams, and Bernstein (1982) assessed the "long-term impact of rape on the marital relationship of the victim and her partner" (p. 51). However, the time since the rape "ranged from less than 1 month to 35 years (M = 2.37 years, SD = 6.20)" (p. 52), meaning there is a heavy weighting of short-term effects and the results cannot be taken to reflect only long-term effects. However, the problem areas identified were suggestive: "differences in commitment and emotional support; sexual concerns, fears, dissatisfactions, and dysfunctions; and poor communication patterns" (p. 53). The authors did write that "the degree of relationship maladjustment was

not related to length of time since the rape" (pp. 55-56), with the demarcation for length of time being less than 1 year versus more than 1 year prior to the study.

In addition to the empirical studies described above, there have been several authors who have addressed long-term effects with frustratingly little documentation of the basis for their statements. Halleck (1962), as mentioned above, alluded to the possibility of victims developing "serious psychiatric problems in later life" (p. 273), if early symptoms are not treated. Warner (1980), who wrote an article titled, "Aftercare: A Lifetime Follow-Up," listed a variety of symptoms frequently mentioned in short-term studies, but offered no evidence concerning which, if any, could be expected to persist or reemerge over a given period of time. Calhoun et al. (1976) reviewed research on short-term effects and reached the following conclusions without citing evidence to support them.

> If a good resolution is not accomplished, many long-term problems can occur. Anxiety in situations reminiscent of the rape incident or even phobias can result. Disruption of sexual functioning is not uncommon, nor is disruption of interpersonal relationships with men. (Calhoun et al., 1976, p. 125)

Notman and Nadelson (1976) presented a similar summary of long-term effects without citing their data base.

> Some of the issues that reemerge in some women at a later time are (1) mistrust of men, with consequent avoidance or hesitation; (2) a variety of sexual disturbances; (3) phobic reactions to situations that are reminiscent of the rape; and (4) anxiety and depression, often precipitated by seemingly unrelated events that in some small details bring back the original trauma. (Notman & Nadelson, 1976, p. 412)

The dearth of knowledge concerning the long-term psychological and interpersonal effects of rape is apparent in that Katz and Mazur (1979), in their extensive review (340 pages) of many aspects of the victim's experience, could only muster a page and half on the long-term psychological effects (pp. 227, 229). This summary was derived only from clinical and theoretical articles because the authors could not find empirical studies of long-term effects, even though their definition of "long-term" was relatively liberal, more than 1 year after the rape.

Given the problems with the empirical studies and theoretical articles cited above, one may find that case studies seem to provide a more satisfying sense of understanding a victim's experience. Safran (1983) reviewed with a rape victim the 3 years since she was assaulted in her own home. The short-term reactions were consistent with patterns previously described. The problems currently bothersome to the victim were (1) difficulties with concentration related to a constant listening for a repeated intrusion, (2) wondering if she would ever feel safe again (she can sit on her own patio only 15 minutes before worrying there might be someone in the bushes), (3) a recurrent bad dream and awakening and mistaking her husband for the rapist, and (4) concerns about what the event will mean to her children. Although these long-term effects could be categorized into such groups of symptoms as suggested by Calhoun et al. (1976) and Notman and Nadelson (1976), there is a richness in the case study which is not present in the articles reviewed above.

A critical issue which warrants discussion yet which fits neatly with neither content nor methodological discussions is the question of the victim's "responsibility" in the rape situation. Halleck (1962) addressed the "problems of the woman who is forcibly molested or raped and who has not been sexually provocative preceding the offense" (p. 274), and qualified his discussion with the following comments.

> A major factor which tends to obscure this problem is the question as to whether rape actually did occur. In many instances, in which it is known that force was used in obtaining sexual intercourse, this may have been brought on by the provocativeness of the victim. The problem here is different from that of the unwilling victim. (Halleck, 1962, p. 273)

Halleck goes on to imply that a woman who "has been overtly seductive before an assault" (p. 274) may have a personality problem which contributes to her behavior.

Perhaps the most controversial notion of victims' responsibility expressed in the literature is Amir's (1971) conception of "victim-precipitated" forcible rape wherein the rapist's interpretation of the victim's behavior constitutes victim-precipitation.

> Theoretically, victim precipitation of rape means that in a particular situation the behavior of the victim is interpreted by the offender either as a direct invitation for sexual relations or as a sign that she will be available for sexual contact if he will persist in demanding it. (Amir, 1971, p. 260)

Although these two examples are admittedly from an early period in the professional discussion of rape, the notion of blaming the victim persists for many people, including some representatives of the medical, law enforcement, and judicial systems, some friends and family

members of rape victims, and some victims themselves. Of the 7 recent rape victims interviewed, Libow and Doty (1979) found that 2 indicated another person (police, friend) had suggested the victim carried some blame. Of the 7, 4 indicated they felt they were personally responsible to some degree and typically cited some type of poor judgment regarding circumstances in which they had put themselves (hitchhiking, going to a bar, etc.). Libow and Doty (1979) pointed out that the victims' attributing responsibility to themselves in terms of judgments they might have made differently may be related to the possibility of controlling things differently in the future and thereby avoiding harm. Even though it clearly could be stated that no error in judgment on a woman's part justifies a subsequent rape, she may still have to deal with how her actions may have made the attack possible. How the victim deals with this issue may be important to how she copes with the rape over time.

Implications of Past Research for the Present Study

Given the current status of the literature on victims of rape as described above, it becomes clear that, particularly in the area of long-term effects, as Holmes (1979) wrote, "one might suggest (not altogether facetiously) that the one thing we do know about rape and its aftermath is that we 'know' very little" (p. 1).

It would appear legitimate then, to begin again, in essence, to look at rape victims' experience over time in a way that imposes as few assumptions and expectations as possible. Giorgi (1970) and Colaizzi

(1978), among others, have decried the traditional approach to psychological research in which the methodology and goals have been modeled after the natural sciences. As has been demonstrated above, this approach leaves one unsatisfied if one wishes to understand the experience of being a rape victim and living with the rape as a part of one's history. Taking "experience" as one's topic or subject has been well articulated and justified as a legitimate, meaningful, scientific inquiry (Colaizzi, 1978; Giorgi, 1970; Valle & King, 1978).

Colaizzi succinctly summarized the task at hand.

> The return to the things themselves, the meaningful study of psychological phenomena, at the same time requires us as psychologists to endeavor to descriptively identify what each phenomenon is. Identification of phenomena must, then, become the crucial first step in psychological research, and must become the new hallmark of psychological methodology. Only then does phenomenological psychology accomplish the following three-fold program: the phenomenological return to the things themselves; the investigation of phenomena in a meaningful way; and the relinquishing of the grip maintained by the technological attitude. (Colaizzi, 1978, pp. 56-57)

Following Giorgi, Colaizzi (1978) stressed the importance of identifying one's objectives and one's presuppositions regarding the topic, for these objectives and presuppositions, or one's "approach" to the research, will largely determine one's method. The primary objective of the present study was to gain an in-depth understanding of rape victims' perceptions of the experience of being a rape victim. The investigator presupposed that understanding changes in interpersonal relationships, especially relationships with men, would be critical to understanding victims' experiences of rape over time. She also presupposed that the effects victims experienced might change over

the course of several years. Accordingly, interview questions were developed to tap victims' perceptions of changes, if any, in their relationships and their perceptions of how the effects, if any, had varied over time. Other questions and instruments were selected to provide a context for the victims' statements or to obtain data in different forms which would allow comparison between objective measures and the subjects' conversational statements.

CHAPTER III

METHODS AND PROCEDURES

Subjects

Different groups of subjects were involved in two distinct phases of the study, the Prevalence Survey and the interview process.

Prevalence Survey Subjects

The target population for the Prevalence Survey (Appendix B) was adult (18 years old or older) female outpatients involved in group or individual therapy at two community mental health centers and one university psychological training clinic. The sample consisted of such patients who responded to the survey, which was distributed over the course of a week at each of the three facilities. Each woman who met the age and program criteria (patients in day treatment programs or receiving medication only were excluded) was given a survey form when she arrived for her appointment. Therapists were asked to identify any of their patients they felt to be inappropriate for the survey (because the patient was mentally retarded, psychotic, or in acute crisis), so that those patients would not be given a survey form. Patients at the facility for their first appointment were, at the therapist's discretion, asked to participate in the survey after the intake was completed.

At the mental health center serving an East Tennessee city of a moderate size, 67 Prevalence Surveys were returned. The average age

of the respondents was 36 years. Thirty-five surveys were returned at the mental health center serving a rural East Tennessee population. The average age of those respondents was 32.4 years. The average age of the 12 respondents at the training clinic was 31.5 years. All respondents in all settings identified their race as white, except 3 who identified themselves as black (2 at the city mental health center and 1 at the rural mental health center) and 2 at the rural facility who did not specify a race.

In-Depth Subjects

Adult (age 18 or older) women were eligible for the in-depth portion of the study, which involved an interview and pencil and paper exercises, if they had been raped 3 or more years ago, when they were 16 years of age or older, and if they had not experienced incest, sexual abuse, or sexual coercion before age 16. For the purpose of subject selection, rape was operationally defined as the forced sexual penetration of any body opening of a female by a male. Spousal rape, rape of a woman by her spouse, was not excluded by this definition.

A total of 10 volunteers served as subjects for the interview and other procedures. Three volunteered after reading the Information Sheet for Volunteers (Appendix C) which was attached to the Prevalence Survey when it was distributed at the mental health facilities. These volunteers, who constituted the clinical subsample, contacted the investigator in person at the time they completed the survey. Appeals to the general public yielded the remaining 7 subjects. Three of these

volunteers responded to notices (Appendix D) posted in public places, such as grocery stores and libraries. A notice (Appendix E) published in a university newspaper for 1 week yielded 2 volunteers and announcements at a rape crisis center yielded 2 more. The 7 volunteers from the general public contacted the investigator by calling the number provided and leaving their names and numbers. The investigator then returned the call. In all cases, the investigator briefly screened each volunteer, in person or over the phone, to confirm that she met the criteria for the in-depth portion of the study. Volunteers were also given more information about the study and were encouraged to ask questions. If a volunteer met the criteria and wanted to participate, an appointment was scheduled.

All the subjects were white women. Their ages at the interview and at the rape and the lengths of time since the rape are summarized in Table 2.

Table 2

Ages of Subjects at the Interview and the Rape and Time Interval Since Rape

	Mean	Standard deviation	Median	Range
Age at interview	29.8	5.7889	29.0	19-42
Age at target rape	21.1	3.4785	21.5	16-26
Years since target rape	8.9	4.5080	8.0	3-17

The term "target rape" refers to the incident which a subject identified as the primary focus of the interview. Two subjects identified rape incidents (one vaginal, one oral) prior to their target rapes. One subject described a subsequent rape incident and another subject described a "voluntary but involuntary" incident in which she gave in to a boyfriend's pressure to have intercourse. Still another victim described an ongoing situation in which a family member makes advances and fondles her when no other people are present. One subject perceives as rape those incidences in which men have ignored her preference not to escalate their sexual encounter.

The marital status of the subjects at the time of the rape and the time of the interview are summarized in Table 3.

Table 3

Marital Status of Subjects at the Time of the Rape and of the Interview

	Number of subjects	
Marital status	At the target rape	At the interview
Never married	7	3
Married	0	2
Remarried	0	1
Divorced	2	4
Separated	1	0

The two divorces and one separation were very recent at the times of the respective rapes. Additionally, one of the single women had recently broken up with her boyfriend at the time of her rape. One of the subjects had been beaten by her husband prior to the

rape. Three of the subjects who married after their rapes had husbands that beat them. All four of these women have divorced the men who beat them. Four of the women were virgins at the time of the target rape. A fifth subject had been a virgin when she was raped 4 years before the target rape and a sixth subject was a virgin when she was raped (forced to perform fellatio) 3 years before the target rape.

The annual family incomes of the 10 subjects ranged from $1,440 to $50,000, with a mean of $14,926, standard deviation of $15,772.05 and median of $8,250. Occupations represented included homemaker, nurse, college student, clerical worker, factory supervisor, and administrator. One subject attended high school but did not graduate. Four obtained some education or vocational training beyond high school. Five earned baccalaureates and 3 of those have also done some graduate work.

A summary of the circumstances the subjects described concerning their target rapes is presented in Table 4.

Comparison Group

Ten white single female undergraduate students (average age = 18.6 years, standard deviation = .7) were recruited from psychology classes to take the Interpersonal Check List (ICL) to provide a basis of comparison for the in-depth subjects' scores on that measure. The undergraduate group also served as the pilot study sample which was used to test the feasibility of the ICL instructions which were developed for the present study.

Table 4

Characteristics of Target Rapes

Subject number	Relationship of rapist(s) to victim	Number of rapists involved	Circumstances of initial contact on occasion of rape	Location where attack was initiated	Type of penetration forced	Extent of injuries reported
1	acquaintance	1	introduced to rapist at a bar by friends	rapist's home	vaginal penetration fellatio	broken bone abdominal injuries
2	acquaintance	1	rapist broke into victim's home	victim's home	vaginal penetration cunnilingus	bruises and scratches
3	stranger	1	rapist broke into victim's home	victim's home	vaginal penetration	bruises torn fornix hyphema
4	friend	1	group activity	rapist's car	vaginal penetration	sore muscles
5	acquaintance	1	first date	rapist's car	vaginal penetration	bruises and scratches
6	stranger	1	rapist broke into victim's home	victim's home	vaginal penetration	none
7	strangers	3	victim abducted from parking lot	rapists' car	vaginal penetration fellatio	dislocated joint prolapsed uterus
8	acquaintance strangers	1 5	first date	rapist's home	vaginal penetration fellatio anal penetration	vaginal bleeding bruises
9	acquaintance	1	first date	rapist's car	vaginal penetration	none
10	friend	1	victim had requested a ride from rapist	rapist's car	vaginal penetration	none

Instruments

Prevalence Survey

The Prevalence Survey (Appendix B) was developed by the investigator as a means to learn what proportion of adult women who are obtaining mental health services report one or more instances of forced sexual contact in their past. The survey questions did not differentiate between various kinds of sexual contact, such as full intercourse versus fondling. For a woman to answer the first and most important question affirmatively, she would have to identify in her own mind an event which she perceived both as sexual and as having been forced upon her. Additional questions concerned the prevalence of forced nonsexual events (among those who did not report forced sexual contact), circumstances of the forced event, the event's perceived effect on relationships, and aspects of the event's relationship to therapy.

Subject Data Sheet/Informed Consent

Survey respondents who, after reading the attached Information Sheet (Appendix C), were interested in volunteering for the in-depth portion of the study, were asked to provide the information requested on the Subject Data Sheet and to sign the Informed Consent form (Appendix F) which described the management of the data obtained up to that point.

Alternate Questionnaire/Alternate Subject Data Sheet

Subjects who were recruited from the general population, as opposed to the clinical population, completed, at the time of the interview, the Alternate Questionnaire (Appendix G) and the Alternate Subject Data Sheet (Appendix H) which did not contain the questions referring to therapy. Additional demographic data were also requested on the Alternate Subject Data Sheet.

Leary Interpersonal Check List

The Leary Interpersonal Check List (ICL) is a list of 128 adjective phrases that can be used to measure how a subject perceives himself or herself as well as how the subject perceives other people he or she is asked to describe. Leary (1957) incorporated the ICL, which was designed by R. Suczek and R. LaForge, into his system of interpersonal diagnosis. Scores on two dimensions may be derived. The "Dominance" score represents the subject's relative placement of self or other on a dimension of Dominance versus Submission in relationships with others. The "Love" score represents placement on the dimension of Love versus Hate. A summary octant score may then be derived from the Dominance and Love scores. The octant score reflects the subject's placement on a circular scheme for which the Dominance versus Submission dimension forms the vertical axis and the Love versus Hate dimension forms the horizontal axis. The circle is divided into eight segments. Each octant (numbered 1-8) represents a specific mode of interacting with others (see Appendix Q).

Leary (1957) emphasized that any of the eight modes of interacting could be either adaptive or maladaptive, depending on the intensity and rigidity with which a person adopted a particular style. Ideally, an individual would be able to exhibit all eight styles of behavior, varying the style as needed for a particular situation. The following descriptions of the octant styles are derived from Leary's (1957) Chapters 15-22.

Octant 1 represents a continuum from a managerial to an autocratic style. Having power is seen as a way of dealing with anxiety. The octant 1 person strives for control and success.

The continuum of octant 2 includes competitiveness and narcissism. The octant 2 person is self-confident and feels superior to others. Independence from others is a critical part of avoiding anxiety.

Aggressive and sadistic are labels which describe octant 3 people. Such individuals maintain a hostile, critical attitude toward others and may become physically destructive as well.

Octant 4 includes rebellious and distrustful people. They feel deprived and often act bitter and resentful.

Self-effacing and masochistic behaviors are characteristic of octant 5. Such people present themselves as weak and inferior.

Octant 6 individuals are docile and dependent. They rely heavily on others and are more affiliative than octant 5 individuals who are similarly passive.

Cooperative and overconventional individuals would be included in octant 7. Such individuals are sociable and very likely to conform to the expectations of others.

The responsible or hypernormal mode is included in octant 8. Such individuals like to appear reasonable, mature, and competent. They are similar to octant 1 and 2 people in their dominance, but are the most affiliative of these three groups.

Videotape

To provide a standard stimulus for the subjects to rate with the ICL, the investigator produced a videotape. Two graduate students, one male and one female, were the actors. They were engaged in conversation and were seated in arm chairs which were arranged at an angle of about 120°. A brief segment, of about 2 minutes duration, was presented to the subjects who were then to rate each actor, using the ICL. The videotape segment was presented without sound to allow for maximum projection on the subject's part.

SCL-90-R

The SCL-90-R is a 90-item self-report inventory designed to measure symptomatic psychological distress. A subject is asked to respond to each item, indicating how much discomfort it had caused him or her during the specified time period. The response is made in terms of a 5-point scale ranging from "not at all" to "extremely." The inventory takes 15 to 20 minutes to complete. The SCL-90-R yields scores on nine primary symptom dimensions and three global indices of

distress. The primary symptom dimension scores incorporate both the number of symptoms checked and the intensity reported. The three global indices reflect (1) the total number of symptoms reported (Positive Symptom Total), (2) the intensity of distress, adjusted for the number of symptoms endorsed (Positive Symptom Distress Index), and (3) the number of symptoms and intensity combined (Global Severity Index). Several sets of norms have been published. The two relevant for present purposes are Norm A--Outpatient Females and Norm B--Nonpatient Females (Derogatis, 1977).

A review of each dimension description and the individual items reveals that the majority of items tap symptoms that have been reported by rape victims during the first year postrape, many of which have already been mentioned above. The Somatization dimension is perhaps the least applicable in terms of the specific item make-up, but some of the items (headaches, nausea or upset stomach, soreness of muscles) have been reported by victims (Burgess & Holmstrom, 1974b). The Obsessive-Compulsive dimension taps the recurrent thoughts victims often have of the rape as well as the general cognitive inefficiency many victims experience (Burgess & Holmstrom, 1979b; Sutherland & Scherl, 1970). The dimension of Interpersonal Sensitivity is related to decreased social activities and general discomfort in the presence of others (McCahill et al., 1979) and to feelings of inferiority or worthlessness (Medea & Thompson, 1974).

All the symptoms on the Depression dimension have been reported by rape victims (Burgess & Holmstrom, 1979b; Katz & Mazur, 1979;

Sutherland & Scherl, 1970). Various items on the Anxiety and Phobic Anxiety scales are repeatedly reported by victims and are among the earliest and most intense psychiatric symptoms to develop, although the phobias may also be associated with later stages of adjustment (Burgess & Holmstrom, 1974b).

The Hostility dimension taps irritableness, anger, and desire for revenge which some victims experience (Burgess & Holmstrom, 1979b; Holmes, 1979; Medea & Thompson, 1974). A somewhat related dimension is Paranoid Ideation which taps the loss of trust and increase in skepticism or suspiciousness many victims experience (Holmes, 1979; McCahill et al., 1979; Medea & Thompson, 1974). The Psychoticism dimension would most likely be most relevant to those victims who experience a "compound reaction" when the rape trauma syndrome exacerbates past or current psychiatric or social difficulties (Burgess & Holmstrom, 1974b, p. 985). A group of "additional items" on the SCL-90-R measures miscellaneous symptoms such as appetite and sleep disturbances, guilt, and thoughts of death and dying, all of which have been reported by rape victims (Katz & Mazur, 1979).

That the SCL-90-R is sensitive to the symptomotology experienced by recent rape victims, as well as being sensitive to their recovery, has been demonstrated by Kilpatrick et al. (1979). Using the SCL-90-R and several other measures, the researchers tested 46 victims and 35 nonvictims at four time intervals: 6 to 10 days, 1 month, 3 months, and 6 months postrape. At the first two assessments, rape "victims scored significantly higher than nonvictims on eight of the

nine symptom dimensions of the SCL-90-R, and on all three global indices of distress" (p. 662). Hostility was the only dimension on which the groups did not differ significantly. At 3 months, the victims' distress was apparently easing, with significant differences found between groups only on Interpersonal Sensitivity, Anxiety, Phobic Anxiety, Paranoid Ideation, Psychoticism, and the Global Severity Index. At 6 months, victims scored significantly higher than the others only on the Anxiety and Phobic Anxiety scales.

Interview

A semistructured interview (Appendix I) was developed for this study by the investigator. Questions early in the interview were designed to gather information concerning the rape itself to provide a context for information gathered with the later, more open-ended questions. The early questions focused on factors identified in the literature as related to victims' short-term responses to rape. Later questions were designed to tap the victim's perception of the impact the rape had on her life. Of particular interest to the interviewer were the impact of the rape on interpersonal relationships and the course of the changes over time, i.e., whether the victim still feels the effect(s) of the rape or whether she feels she has recovered.

Data Collection

Prevalence Survey

At each of the three mental health facilities, the Prevalence Survey was distributed over the course of 5 consecutive business

days. The survey was handed to each eligible woman as she checked in with the receptionist. Although the survey contained instructions, the receptionist introduced it with a brief comment to the effect that the center was conducting a survey and participation would be appreciated, if the subject was willing. The survey and the procedure of returning it to a box at the reception desk were designed to protect the subjects' anonymity, and patients had the option to return their form blank to the box.

In-Depth Study

The interviewer met individually with each of the 10 subjects. The three interviews with the subjects from the clinical population were conducted at the mental health center where those subjects received therapy. The 7 subjects from the general population were interviewed at the university psychological training clinic.

Before beginning the procedures, each subject read and signed the Informed Consent form. Because the clinical volunteers had completed the Prevalence Survey and Subject Data Sheet previously, and because they were already in therapy, their Informed Consent (Appendix J) included slightly different details than did the Alternate Informed Consent (Appendix K), which the remaining subjects signed. The nonclinical subjects then completed the Alternate Questionnaire and Alternate Subject Data Sheet. From that point, the procedures were identical for both portions of the sample.

Instructions for the ICL were presented orally by the investigator. The subjects were asked to rate the person or group of people described at the top of each answer sheet, which included:

Male in the videotape

Female in the videotape

General description of men (over age 16) you know, other than your current or latest boyfriend or spouse

Yourself in relation to the men you know with the same qualifications as one the previous page

Your current or latest boyfriend or spouse, if you have one

Yourself in relation to the person you described on the previous page

General description of men (over 16) who are strangers to you

Yourself in relation to men (over 16) who are strangers to you

Male involved in the coercive event you will be discussing

Yourself in relation to the male involved in the coercive event

Yourself in general

After watching the videotape, the subjects were asked to work through the 11 answer sheets. The order of the four pairs of answer sheets, on which the subjects rated a male or group of males and then themselves in relation to the male or group, were systematically varied across subjects, but the ratings of the video actors and the self in general maintained the first and last positions, respectively.

The subjects then read and completed the SCL-90-R independently. The reference time period was specified by the investigator as

the past 7 days, including the day of the interview. Once the subjects had completed the SCL-90-R, they were asked to go over the inventory again, circling the number of every item which described a symptom they had ever had which they attributed to the rape.

The semistructured interview was audiotaped with the subjects' knowledge. The interviews lasted about 60 to 90 minutes. The order of questions varied somewhat depending on the direction the subjects took in their discussions. The investigator asked follow-up questions when she felt further elaboration was needed. The investigator concluded the interviews with a brief description of the study and her research goals, and subjects had the opportunity to make further comments or to ask questions.

Comparison Group

The ICL was administered to the 10 undergraduate women as a group. First they heard an oral introduction given by the investigator, and then they completed the Informed Consent form (Appendix L). The instructions given for completion of the ICL were the same as those given to the rape victims, except that the comparison group did not rate a male involved in a coercive event or themselves in relation to such a male. Again, the order of the pairs of answer sheets were systematically varied across subjects, except for the video actors and the self in general ratings.

Data Analysis

Prevalence Survey

The Prevalence Survey data was analyzed by determining the percentages of women who reported experiencing forced sexual contact and the characteristics of those incidents, such as relationship of the subject to the offender, age of the subject at the incident, and so on.

Interpersonal Check List

Mean T-scores for both the Dominance and Love dimensions were obtained for the victims' ratings of the various categories of males and ratings of themselves in a variety of conditions. Those means which were significantly different from the test mean were identified. To help determine if the victims' response pattern was unique to their group, their means were compared to the means obtained from the undergraduate comparison group. Four two-way analyses of variance were used. The first compared the groups' ratings of males (videotape male, known males, strangers, and current or past boyfriend or spouse) on the Dominance dimension. The second compared the ratings of the males on the Love dimension. The third analysis of variance compared the two groups' Dominance ratings of themselves (in relation to known males, to strangers, and to current or past boyfriend or spouse, and themselves in general). The fourth compared the groups' Love ratings on themselves. In those cases where an F value revealed a significant main effect, a post hoc test, the Least Significant Difference Test, was used to identify the locus of the significant differences.

The victims' ratings of the male(s) involved in the rape and their ratings of themselves in relation to these males were addressed individually, as the comparison group had no comparable rating. The point-biserial coefficient was used to determine the extent of the relationship, if any, between ratings of strangers and knowledge or lack of knowledge of one's attacker.

Octant summary scores were derived for the victims' and undergraduates' ratings of males, except the actor, and of themselves in all conditions. Fisher's exact probability test was used to test for significant differences between the two groups' distributions of octant scores on the dichotomies of affiliative versus oppositional, dominant versus submissive, and socially desirable versus socially undesirable octants.

SCL-90-R

Mean T-scores for each of the nine symptom dimensions and for the three global indices were obtained and those significantly different from the test mean were noted. Those items which more than half of the victims identified as a symptom they had experienced and attributed to the rape were reported in tabular form along with measures of the women's current distress level for those items.

Interview Data

The primary purpose of the analysis of the interviews was to see what rape victims had to say about the long-term impact of the rape on their lives, especially their interpersonal relationships, specifically

with men, and how the effect(s) had or had not changed over the years. It was hoped that the victims' statements on these issues would suggest a category system which would in turn suggest new ways of understanding their experiences. This system could then provide a structure for examining the individual subject's pattern of response.

The interview tapes were transcribed in their entirety into typewritten protocols. All protocols were read and then significant statements were extracted, an early step suggested by Colaizzi (1978). Because the purpose here was somewhat different from Colaizzi's, repetitions of statements, both within and among protocols, were recorded rather than dismissed.

Two major issues which had to be addressed were the criteria for a statement being chosen as "significant" and the extent of the protocol to be included in each excerpt. Statements were selected if they referred to a change or condition which the victim attributed to the rape and which she was either experiencing now or had experienced sometime after 3 years after the rape. Some of the statements clearly specified the nature of the change or condition while others included rather vague references to "it" or to "effects."

Several lengths of excerpts were considered, from single sentences to entire pages of the protocols. The goal in excerpting was to fairly represent the nature and complexity of the victim's experience. Thus, the conversational equivalent of a paragraph was chosen as the unit of meaning. At times, an excerpt spanned an interviewer's

question for clarification, or left out unrelated material. An effort was made to preserve the wording of the speaker as carefully as possible, but with deletions of repetitious phrases or verbal mannerisms such as, "you know." Excerpts ranged in length from one to about a dozen sentences. The number of statements excerpted from a protocol ranged from 4 to 16, and the total number of statements was 95.

Once the significant statements had been identified, they were typed onto index cards to facilitate handling. The investigator read through the cards several times, grouping them in several different ways, searching for the most coherent thematic structure. Once a seemingly satisfactory system had been identified, it was refined and elaborated through discussions with others and through collaborative efforts to sort the significant statements into categories. The resulting system contained two dimensions. The first consisted of three categories; the second had four. Each significant statement received a score on each dimension.

To determine whether the category system could be communicated to others who could then reliably score the significant statements, two independent raters, graduate students in clinical psychology, were asked to score the items. In training sessions, the raters were familiarized with the category system, and they practiced using the system by scoring actual significant statements. The raters also provided feedback to the investigator on the comprehensibility of the category system and the decision map developed by the investigator to aid in scoring. Twenty-five statements were chosen for the practice

by the investigator and represented, in approximately proportional numbers, all the subjects and all the categories, based on preliminary ratings by the investigator. When agreement between the two independent raters reached approximately 80% in the practice sessions, the raters were given the remaining 70 significant statements to score independently. The investigator also scored the remaining statements.

The decision map (Appendix M) was designed to help raters make scoring decisions. It represented in concise, graphic form the sequential assessments required of raters and guided their decision-making process. Scores were assigned independently for each dimension. That is, the score on the first dimension was not dependent on the score for the second dimension or vice versa.

The two dimensions of the category system differed in that each statement could potentially be scored in one, two, or all three categories of the first dimension while only one category from the second dimension could be assigned. Consequently, different reliability statistics were necessary to summarize the results for the dimensions. However, for each dimension, three parallel sets of reliability figures were derived, one for each pair of scorers: Investigator x Rater 1, Investigator x Rater 2, and Rater 1 x Rater 2.

The summary statistics for the first dimension were percentages of agreement, partial agreement, and disagreement concerning all the statement ratings. The reliability of scoring within each category was then assessed using percentage agreement because concurrence on not assigning a category was of as much interest as concurrence on

assigning the category. Phi (ϕ), the product-moment correlation for two sets of dichotomous data, was chosen to measure agreement for each category and χ^2 for a two-by-two table was used to test for statistical significance of agreement. Both ϕ and χ^2 take into account the number of agreements that would be expected by chance.

For the second dimension, the summary statistic chosen was the symmetric lambda (L_s), which indicates the degree of relationship between two nominal variables. The reliability of scoring within each category was then assessed, using the effective percentage agreement for occurrences (occurrence agreement), because agreement on non-occurrence was not of particular interest and occurrence agreement is a more conservative measure than percentage agreement. Again ϕ and χ^2 were used as measures of correlation and significance.

Each significant statement was then given a final scoring based on the agreement of at least two of the three scorers. All statements were scored by all scorers, either in practice sessions or in independent ratings.

Each subject's response pattern was then examined, based on the ratings her statements received. A summary statement was written by the investigator regarding each subject's style of response to the rape and the nature of the repercussions she had described. The entire protocol was reviewed and the summary statement evaluated for accurateness and completeness, as a way of evaluating the usefulness of the category system.

The protocols were then examined for issues the victims had discussed which did not pertain to the areas covered by the categories

but which warranted attention and discussion. Identifiable patterns of victim responses were discussed in regard to their possible relation to other variables.

CHAPTER IV

RESULTS

Prevalence Survey

At the urban mental health center, 34% of the 67 respondents reported having experienced at least one incident of forced sexual contact. At the rural mental health center, 43% of the 37 respondents reported at least one incident of forced sexual contact. The rate of response from the psychological training clinic was not sufficiently high to warrant citing a percentage. Across all three settings, 36 of the respondents who reported forced sexual contact completed their questionnaires in such a way that further analysis can be made of the additional data they provided.

Thirteen respondents (19%) from the urban and 10 (27%) from the rural mental health center reported at least one incident of nonsexual coercion. Across all three settings, 21 completed their surveys in a manner which allows for further analysis.

Of the 36 who reported forced sexual contact, 21 (58.3%) reported only 1 incident of forced sexual contact or 1 series of incidents with the same offender. Nine respondents (25.0%) reported 2 incidents or series (each with a different offender). The remaining 6 respondents (16.7%) reported 3 incidents or series of incidents. Thus, a total of 57 incidents or series of incidents of forced sexual contact was reported by the 36 respondents. In all but one case, the offenders were male. Of the 57 incidents or series, 20 (or 35%) could be

classified as incest. That is, they occurred when the victim was 18 years old or younger and the offender was related to the victim. The remaining 65% of the incidents would be classified as rape or some other form of sexual assault. Seventeen (47%) of the 36 subjects experienced incest as defined above. Twenty-five (69%) experienced rape or other sexual assault. Six (17%) experienced both. The characteristics of those 57 incidents are summarized in Table 5.

Of the 67 total respondents at the urban mental health center, 7 (10%) reported incest and 11 (16%) reported rape or another form of sexual assault. Five (7%) did not provide sufficient information to accurately classify the kind of sexual coercion they experienced.

Of the 37 total respondents at the rural mental health center, 7 (19%) reported incest, 11 (30%) reported rape or sexual assault, 4 (11%) reported both, and 2 (5%) did not provide enough information to accurately classify the kind of sexual coersion they experienced.

The Survey did not include a question regarding the extent of the sexual contact, so it is impossible to tell which of the 57 incidents involved sexual intercourse and which did not. However, the critical factor is that the woman perceived the incident as sexual and as forced. Conversations with some of the respondents suggested they were more conservative in their criteria for forced sexual contact than are most researchers in the field which suggests that the above figures may reflect an underestimation of the prevalence of incest, rape, and sexual assault in the clinical population.

Half (18) of the respondents who reported forced sexual contact felt their relationships had changed a lot as a result. Fourteen felt

Table 5

Characteristics of Forced Sexual Contacts Reported on Prevalence Survey

	Number	Percent
Age of female at time of incident		
Age range		
12 years or younger	19	33.3
13-16	12	21.1
17-20	10	17.5
21-29	13	22.8
30 or older	3	5.3
	57	100.0
Nature of contact with offender: One-time incident vs. repeated incidents		
Category		
One-time event	32	56.1
Repeated event	19	33.3
No data	6	10.5
	57	99.9
Relationship of offender to female		
Relationship		
Family member	26	45.6
Friend or acquaintance	23	40.4
Total stranger	5	8.8
Acquaintance/stranger (multiple offenders)	1	1.8
No data	2	3.5
	57	100.1
Interaction of nature of contact (one-time vs. repeated) and relationship of offender to female		
One-time event		
Family member	9	15.8
Friend or acquaintance	16	28.1
Total stranger	5	8.8
Acquaintance/stranger (multiple offenders)	1	1.8
Repeated event		
Family member	14	24.6
Friend or acquaintance	5	8.8
Total stranger	0	0.0
Unable to classify	7	12.3
	57	100.2

there had been some changes and 4 reported no change. Among the women who reported nonsexual coercion, the distribution of responses across the three categories of changes in relationships was not significantly different from the distribution of responses of the sexually coerced.

Most (63%) of the respondents who reported sexual coercion felt that experience was part of the reason they were coming for counseling as opposed to it being either the main reason (9%) or not connected (28%) to counseling. There was not a significant difference in the distributions of the sexual versus the nonsexual groups on this question.

Sixty-eight percent of those respondents who reported forced sexual contact and 57% of those who reported nonsexual coercion had discussed it with their therapists. The difference in percentages is not significant.

Interpersonal Check List

The mean Dominance and Love T-scores are presented in Table 6. For the victim sample, 3 of 11 Dominance means were significantly different (at the .05 level) from the test mean of 50; additionally, 5 of the Dominance means and 3 of 11 Love means were significantly different from the test mean at the $p < .02$ level. Because the victims were asked to rate a set of groups and individuals unique to this study, the import of this pattern was unclear. To help determine if the pattern was specific to rape victims, the victims' scores were

Table 6

ICL: Mean Dominance and Love Scores for Victims and Undergraduates

Person or group rated	Victims		Undergraduates	
	Dominance means[a]	Love means[b]	Dominance means[a]	Love means[b]
Male in videotape	45.5	49.7	51.8	49.7
Female in videotape	60.7**	46.4	61.8**	45.2
Current or past boyfriend or spouse	57.5*	52.1	62.8**	43.9
Self in relation to current or past boyfriend or spouse	60.5**	49.1	58.0*	53.4
Other known males	64.6**	45.8	62.4**	44.9
Self in relation to known males	57.9*	46.3	58.7*	54.2
Strangers (males)	62.5**	35.9**	61.2**	36.9**
Self in relation to strangers	56.4	38.4**	57.0	48.5
Male(s) involved in rape	61.2**	36.9**	---	---
Self in relation to rapist(s)	45.3	52.7	---	---
Self in general	58.1*	45.0	47.6	51.5

Note. Undergraduates were not asked to rate male(s) involved in a coercive event or themselves in relation to such a male.

[a]The higher the score, the more dominant and the less submissive is the rating.

[b]The lower the score, the more hostile and the less affiliative is the rating.

*Significantly different from test norm, $p < .05$.

**Significantly different from test norm, $p < .02$.

contrasted with those of the comparison group in 4 two-way analyses of variance. The two groups' ratings of males (videotape male, known males, strangers, and current or past boyfriend or spouse) were compared first on the Dominance dimension and then on the Love dimension. Similarly, the two groups' ratings on themselves (in relation to known males, to strangers, and to current or past boyfriend or spouse, and themselves in general) were compared on the Dominance and Love dimensions. The results of these analyses of variance are presented in Table 7.

Three of the eight main effects were found to contribute significantly ($p < .02$) to the variation in scores, but none of the interactions was significant ($p \leq .05$). In the ratings of males on the Dominance dimension, the victim and undergraduate groups did not differ significantly from each other. When they were considered as one group, the women did rate the various males differentially. A post hoc test, the Least Significant Difference Test (LSD), revealed that the overall mean Dominance score for the male in the videotape was significantly lower than the other three ratings of males, none of which were significantly different from each other. The overall means are presented in Table 8.

The means included in Table 8 are all significantly ($p < .05$) greater than the test mean of 50, except for the rating of the male in the videotape. These results suggest that women in general perceive males in their environment as relatively dominant and that rape victims are not significantly more likely to do so. The perception of males as dominant did not appear to affect the women's ratings of the unknown

Table 7

Analysis of Variance Summaries for Victim vs. Comparison Group by Persons Rated

Source	df	Mean square	F
Ratings of Males--Dominance			
Between groups	1	82.02	0.8503
Between treatments (males)	3	906.41	9.3967*
Interaction	3	96.51	1.0005
Error	72	96.46	
Ratings of Males--Love			
Between groups	1	82.02	1.1108
Between treatments (males)	3	700.65	9.4886*
Interaction	3	87.74	1.1882
Error	72	73.84	
Ratings of Self--Dominance			
Between groups	1	168.20	0.7092
Between treatments (selves)	3	159.08	0.6708
Interaction	3	139.77	0.5893
Error	72	237.16	
Ratings of Self--Love			
Between groups	1	833.05	7.2295*
Between treatments (selves)	3	310.45	2.6942
Interaction	3	69.58	0.6038
Error	72	115.23	

*$p < .02$.

Table 8

Overall Means for Dominance Ratings of Males

Male in videotape	Current or past boyfriend or spouse	Strangers	Known males
48.65_a	60.17_b	61.85_b	63.50_b

Note. Means with different subscripts differ significantly at $p < .02$.

male on the videotape. The reason(s) for this is not clear, especially given the subjects' high Dominance rating of the female actor.

As on the Dominance dimension, the victim and undergraduate groups did not differ significantly from each other on their ratings of males on the Love dimension; however, the combined group did differentiate between the males. The post hoc LSD test revealed that the overall mean Love score for strangers was significantly lower than the other three ratings of males, none of which were significantly different from each other. The overall means are presented in Table 9.

Table 9

Overall Means for Love Ratings of Males

Strangers	Known males	Current or past boyfriend or spouse	Male in videotape
36.40_a	45.35_b	48.00_b	49.7_b

Note. Means with different subscripts differ significantly at $p < .02$.

Of the means in Table 9, only the one referring to strangers is significantly ($p < .05$) below the test mean of 50. It is also the only mean significantly ($p < .02$) different from the others. This pattern suggests that both victims and nonvictims perceive men who are unknown to them as particularly aggressive and exploitive relative to the other men in their environment.

In the women's ratings of themselves on the Dominance dimension, there were no significant differences either between the victim and undergraduate groups or among the combined group's ratings of themselves in the different contexts.

There was a significant ($p < .02$) difference between the victim and undergraduate groups on their ratings of themselves on the Love dimension. The rape victims perceived themselves as consistently more aggressive and less affiliative than did the undergraduate women, except in relation to their boyfriends or spouses, as determined by the LSD test. The mean Love scores for each group are presented in Table 10.

The means of the victims' Dominance and Love ratings of the males involved in the rape were significantly ($p < .02$) different from the test means and closely paralleled their ratings of strangers, even though 7 of the 10 target rapes involved friends or acquaintances. Because 1 of the target rapes involved both an acquaintance and strangers, 4 of the rapes involved total strangers. There does not appear to be a relationship between perceptions of strangers and being raped by strangers versus nonstrangers. The point-biserial

Table 10

Love Score Means of Self-Ratings by Victims and Undergraduates

Rating	Means	
	Victims	Undergraduates
Self in relation to strangers (males)	38.4_a	48.5_b
Self in general	45.0_c	51.5_d
Self in relation to known males	46.3_e	54.2_f
Self in relation to current or past boyfriend or spouse	51.1_g	53.4_g

Note. For each row, means with different subscripts differ significantly at $p < .02$.

coefficient for rape by strangers versus nonstrangers and Dominance scores of strangers is .396. The point-biserial coefficient for rape by strangers versus nonstrangers and Love scores of strangers is -.281.

The frequencies of the summary octant scores for the victims' and undergraduates' ratings of themselves in general are presented below.

	Octants							
Group	1	2	3	4	5	6	7	8
Victims	1	4	1	2	0	0	0	2
Undergraduates	3	2	1	0	1	0	0	3

Using the Fisher exact probability test for significance for two-by-two contingency tables, there was no significant difference found between

the distributions of the victims and the undergraduates in the numbers of those whose summary points fell in the affiliative octants (1, 6, 7, and 8) versus the oppositional octants (2, 3, 4, and 5). Similarly, there was no significant difference between the groups in the numbers of summary points which fell in the dominant octants (1, 2, 3, and 8) versus the submissive octants (4, 5, 6, and 7) or in the numbers which fell in socially desirable octants (1, 2, 7, and 8) versus the socially undesirable octants (3, 4, 5, and 6).

The frequencies of the summary octant scores for the victims' ratings of the males are presented below.

	Octants							
Group	1	2	3	4	5	6	7	8
Current or past boyfriend or spouse	5	1	1	0	0	1	1	1
Strangers	1	7	2	0	0	0	0	0
Known males	4	4	1	0	0	0	0	1
Rapist(s)	1	4	5	0	0	0	0	0

Fisher's test was used to compare the six permutations of pairs of males on each of the three dichotomies, affiliative versus oppositional, dominant versus submissive, and socially desirable versus socially undesirable. Of the 18 comparisons, 2 showed significant differences at the .005 level. Both concerned the affiliative versus oppositional dimension. Both rapists and strangers were judged to be significantly more oppositional than the current or past boyfriend or spouse. Men in all the above categories were rated in the dominant octants by all

the victims, except for two who rated their current or past boyfriend or spouse as submissive. The predominance of the males was rated in the socially desirable octants, except for the rapists, of which half were rated as desirable and half as undesirable. This pattern was not significantly different from the other categories of males.

The frequencies of the summary octant scores of the undergraduates' ratings of the males are presented below.

Group	Octants							
	1	2	3	4	5	6	7	8
Current or past boyfriend or spouse	4	5	1	0	0	0	0	0
Strangers	0	6	4	0	0	0	0	0
Known males	3	5	2	0	0	0	0	0

Fisher's test was used to compare the victims' and the undergraduates' octant summary points on the three categories of males on each of the three dichotomies and no significant differences were found. Also, there were no significant differences among the undergraduates' ratings of the above categories of males in terms of the three dichotomies.

The pattern of findings indicates that the rape victims and undergraduate females tend to view men similarly, primarily as dominant and socially desirable. The patterns on the affiliative versus oppositional dichotomy are less clear. The only significant differences were between the victims' affiliative rating of the current or past

boyfriend or spouse and the oppositional ratings of both strangers and the rapists. Contrary to what might be expected, there was a trend for the undergraduates to be more likely than the victims to rate known men, strangers, and the current or past boyfriend or spouse as oppositional. The two-way analysis of variance and LSD test on the victims' and undergraduates' Love scores for the males distinguished the strangers as being significantly less affiliative than all the other males rated, except rapists. This pattern was not consistently sustained after the conversion to octant scores.

The analysis of variance for the victims' and undergraduates' ratings of themselves on the Love dimension suggested the victims see themselves as less affiliative than do the undergradutes, except when relating to their current or past boyfriend or spouse. After conversion to octant scores, however, there were no significant differences between the victims' and the undergraduates' ratings of themselves in any of the conditions on any of the three dichotomies. There was a trend for victims to see themselves as more oppositional but there was not a significant difference.

SCL-90-R

The victims' raw scores on the SCL-90-R were converted to T-scores. Two sets of norms were used. The norms for female psychiatric outpatients were used for the 3 subjects recruited from the mental health center. The norms for female nonpatients were used for the 7 subjects recruited from the general population. The mean

T-scores for each subgroup on the nine symptom dimensions and the three global indices are presented in Table 11. One of the nine symptom dimension means, Depression, was significantly greater ($p < .05$) than the test norm of 50. The Positive Symptom Distress Index (PSDI), one of the global indices, was significantly greater ($p < .02$) than the test mean. The PSDI is an intensity measure, corrected for the number of symptoms the subject endorsed.

Table 12 provides a listing of the SCL-90-R items which more than half of the victims identified as a symptom they had experienced and attributed to the rape. The table also includes the number of victims who identified each item as attributable to the rape, the number currently bothered by each symptom, and a measure of intensity for those currently bothered by the symptom.

Two of the nine symptom dimensions were heavily represented in Table 12. Eight of 13 Depression items and four of nine Interpersonal Sensitivity items were identified. Other dimensions represented were Anxiety (three items), Paranoia (two items), Psychoticism (two items), and Obsessive-Compulsive and Hostility (one item each).

No effort was made to determine if the women felt the current manifestations of symptoms were related to the rape. Nevertheless, the concurrence of the significance of the Depression mean and the preponderence (62%) of Depression items identified suggests that depression, as measured by the SCL-90-R, is a problematic area for rape victims. The Interpersonal Sensitivity dimension was the only other symptom dimension which contained a high proportion (44%) of

Table 11

SCL-90-R: Mean Dimension and Global Scores for Victims

	Female nonpatients[a]	Female psychiatric outpatients[b]
Symptom dimensions		
Somatization	47.29	53.67
Obsessive-Compulsive	55.29	51.67
Interpersonal Sensitivity	57.71	56.00
Depression	61.57*	59.00
Anxiety	56.71	52.00
Hostility	57.57	55.67
Phobic Anxiety	56.00	48.33
Paranoid Ideation	50.29	52.33
Psychoticism	52.29	50.00
Global indices of distress		
Global Severity Index	58.71	54.33
Positive Symptom Distress Index	63.43**	53.00
Positive Symptom Total	54.86	54.67

[a] $n = 7$. [b] $n = 3$.

*Significantly different from test norm, $p < .05$.

**Significantly different from test norm, $p < .02$.

Table 12

SCL-90-R Items Identified by More Than Half of the Victims As Attributable to the Rape

Item	Number of victims who attributed symptom to the rape	Number of victims currently experiencing the symptom	Intensity measure[a]
Loss of sexual interest or pleasure	10	8	2.38
Crying easily	6	3	2.00
Feelings of being caught or trapped	8	6	2.50
Blaming yourself for things	6	4	2.75
Feeling blue	6	5	2.60
Worrying too much about things	7	6	3.17
Feeling hopeless about the future	8	6	2.17
Feelings of worthlessness	7	2	2.00
Feeling shy or uneasy with the opposite sex	10	6	2.33
Feeling others do not understand you or are unsympathetic	6	3	2.00
Feeling inferior to others	6	5	2.00
Feeling very self-conscious with others	6	5	2.40
Nervousness or shakiness inside	7	5	1.60
Suddenly scared for no reason	7	3	2.33
Feeling fearful	9	5	2.20
Trouble falling asleep	6	4	2.00
Sleep that is restless or disturbed	7	5	2.20
Feelings of guilt	7	7	2.57
Feeling that most people can not be trusted	8	4	2.00
Feeling that people will take advantage of you if you let them	6	4	2.00
Having thoughts about sex that bother you a lot	6	2	3.00
Never feeling close to another person	6	4	2.75
Repeated unpleasant thoughts that won't leave your mind	7	5	1.60
Having urges to beat, injure or harm someone	6	3	3.00

Note. The items in column 1 are from the SCL-90-R. Copyright 1975 by Leonard R. Derogatis. Adapted by permission.

[a]This score reflects the average intensity score for those subjects who report some current level of distress. Possible scores range from 1 to 4, or "a little bit" to "extremely," respectively.

items identified by subjects as related to the rape. In both the Depression and Interpersonal Sensitivity dimensions, the average intensity scores for those women still experiencing the identified symptoms were at the moderate level (2.0) or higher.

Interview

Category System

The category system which evolved from the significant statements produced by the rape victims consists of two dimensions, each of which has several categories. The first dimension, nature of the change, is presented in Table 13. This dimension reflects the victims' perceptions of the changes they attributed to the rape. The three categories pertain to different points on a continuum from other-focus to self-focus. The first two categories, A and B, are both interpersonal in nature, but in category A, the primary emphasis and focus is on the Other in the relationship. The content is related to the increased awareness of or sensitivity to the aggressive and exploitive potential of the Other. This category represents changes having to do with new awareness of the potential harm others, primary males, are capable of causing. The associated affects are tension, anxiety, and anger. Several victims became more sensitive to the issues of power, dominance, and control in relationships and are easily angered by what they perceive as men's attempts to control them in any way, including sexually. Many victims experience anxiety and tension when they are

Table 13

Nature of Change Attributed to Rape (Dimension I)

A. Heightened awareness of or sensitivity to the aggressive and exploitive potential of the other, primarily male

Associated affect: tension, anxiety, anger
--more sentitive, reactive to others
--description of angry, tense interactions
--issues of power, dominance, and control figural in interactions, including sexual ones
--description of hostile or indifferent responses on victim's part, hostility likely to be seen as justified by victim
--victim may move against or away from the other

B. Heightened awareness of one's own vulnerability in relation to the other, primarily male

Associated affect: fear
--more distrustful
--more defensive, closed off, less open to others
--fears of abandonment, insecurities in relationships, need for reassurance
--amorphous or specific fears, which may limit activities
--anticipation that bad things happen to one
--sexual difficulties related to impaired trust
--avoidance of other in interest of self-protection

C. Self-focus, self-reflection or commentary
--unresolved emotions
--different perspective on life
--negative self-concept, view of self as bad, worse, unhappier
--feelings about discussing the rape
--frequency of thoughts about the rape and intensity of associated feelings
--sexual difficulties related to internal issues rather than to issues of control or distrust

in the presence of men. Some victims reported responding to their anger or anxiety by angrily confronting the men or by withdrawing from the interaction.

The second category, B, is juxtaposed with the first, but the emphasis is on the Self and the content is related to heightened awareness of one's own vulnerability in relation to the Other. This category represents changes having to do with a changed perception of the Self in relation to others, a perception of the Self as more vulnerable. The associated affect is usually fear, either amorphous or specific. Relationship problems arise in the areas of the victim feeling insecure, fearing abandonment, needing reassurance from the other person, and having great difficulty in trusting and accepting the love of another. The victim may avoid relationships in an effort to protect herself and she may feel she is more closed off emotionally and less likely to get close to another person.

The third category, C, involves changes or effects that are primarily Intrapersonal in nature, such as changed perceptions of the self, changed perspectives on life, and unresolved emotions and memories related to the rape. Some victims felt they were "bad" people because they had been raped. Most still experienced some uneasiness when discussing their rapes. Sexual difficulties were included here if the victim described them as internally determined rather than interpersonally determined.

The distinctions between categories A and B and between B and C are important and thus warrant a summary description. Both

categories A and B involve reference to the interpersonal world. The emphasis in category A is on the Other in the relationship and the emphasis in category B is on the Self in the relationship. Both categories B and C focus on the victim's sense of herself. The emphasis in category B is on the Self which is involved in interpersonal relationships. The emphasis in category C is on the Intrapersonal or internal world of the victim. Because several of the statements were quite complex in their content, raters had the option of assigning two or even all three categories if it was deemed necessary to capture the breadth of a statement.

The second set of categories used to code the significant statements pertains to the subsequent course of the change (see Table 14). This dimension represents the victim's experience of the change or effect over time. The first two categories involve the perception of some transition or relief over time, such as a transition from guilt to anger or a sense of relief in less frequent thoughts of the rape or less intense interpersonal problems. The distinction between the first and second categories is based on what, if any, factor the victim identified as mediating the transition or recovery. If the passage of time or no other specific mediator was mentioned by the victim, the first category was assigned. Here, there was a sense of the rape fading from figure to ground, with no apparent effort involved. If a specific process or mediator, other than the passage of time, was identified as having facilitated the transition or recovery, the second category was applicable. Examples of mediating factors the victims mentioned are

Table 14

Subsequent Course of Change Attributed to Rape (Dimension II)

1. Time or unspecified mediator important in victim's sense of recovery, relief, improvement or transition in a problem or affect related to the rape
   --decreased frequency of problem occurrence
   --decreased intensity of affect associated with rape or problems due to rape
   Sense of rape fading from figure to ground

2. Specified process important in victim's sense of recovery, relief, improvement or transition in a problem or affect related to the rape
   --decreased frequency of problem occurrence
   --decreased intensity of affect associated with rape or problems due to rape
   --reference to working through, working on, or working out a problem
   --experiences with others, especially specific relationships, including therapy relationships, seen as helpful
   --increased action or initiative on victim's part seen as helpful
   Sense of rape remaining a figural event to be addressed, yet some relief is obtained from doing so

3. Explicit statement that problem persists without any sense of relief or recovery
   --"I still . . .," "never recover," etc.

4. Implication that problem persists without any sense of relief or recovery
   --present tense used in describing problem, with no reference to improvement

Notes.

Expression of a positive feeling about a change due to the rape does not necessarily imply improvement.

To be included in category 1 or 2, total recovery need not be present.

If victim states she feels partially or mostly recovered and then elaborates, base sorting on the nature of the elaboration rather than on the introductory statement.

If the problem is described in past tense with no reference to current experience, assume some improvement is implied.

relationships with patient, caring lovers or spouses, relationships with counselors, and the victims' own efforts to work through their problems caused by the rape via introspection and reflection or via dialogue with others. There was a sense that the rape had remained a figural event to be addressed, yet some relief was obtained from doing do.

The third and fourth categories reflect no sense of transition or relief from the changes or effects brought about by the rape. The third category involves explicit statements that the problem persists and implies a comparison to the past or future. Such statements included phrases such as, "I still . . .," and "you never recover from . . . ." The fourth category includes statements which imply the problem persists through the use of present tense but which involve no explicit statement such as "still." An example of a category 4 statement is, "I'm much less tolerant of things men do and say . . . ."

Reliability Check

The scorings of the 70 statements which the investigator and the two raters made independently formed the basis for the evaluation of the reliability of the category system. Reliability statistics were obtained by comparing the scorings by the investigator to those by each rater and those by the raters to each other.

The summary statistics for Dimension I are presented in Table 15. "Agreement" refers to those statements on which the two scorers in question were in complete agreement as to which Dimension I categories

Table 15

Summary Rater Agreement Levels for Dimension I

Rating pair	Percent		
	Agreement	Partial agreement	Disagreement
Investigator x Rater 1	78.6	14.3	7.1
Investigator x Rater 2	70.0	15.7	14.3
Rater 1 x Rater 2	68.6	14.3	17.1

to assign, and inversely, which not to assign. "Partial agreement" refers to those statements to which more than one category had been assigned and the two scorers agreed on the assignment of one category, but not the other(s). "Disagreement" refers to those statements for which there was no concurrence in the scoring. Figure N-1 in Appendix N provides a summary of the patterns of agreement between the raters for the categories of Dimension I.

The overall agreement levels for the investigator were 78.6% with Rater 1 and 70.0% with Rater 2. Rater 1 and Rater 2 agreed completely 68.6% of the time. Partial agreement levels were very consistent across all pairs, ranging from 14.3% to 15.7%, but disagreements ranged from 7.1% to 17.1%.

When the patterns of agreement for the individual categories were examined, using two-by-two occurrence-nonoccurrence tables, moderate to high correlations, ranging from .43 to .86, were found (see Table 16). In general, the lowest levels of agreement were associated

Table 16

Rater Agreement Levels by Category for Dimension I

Category	Percentage agreement	ϕ	χ^2
Category A			
Investigator x Rater 1	88.6	.72	32.8458*
Investigator x Rater 2	78.6	.43	10.6016*
Rater 1 x Rater 2	78.6	.43	10.6016*
Category B			
Investigator x Rater 1	88.6	.73	33.8880*
Investigator x Rater 2	87.1	.69	30.4342*
Rater 1 x Rater 2	84.3	.61	23.0606*
Category C			
Investigator x Rater 1	93.9	.86	48.0640*
Investigator x Rater 2	88.6	.79	40.5826*
Rater 1 x Rater 2	87.1	.75	36.8059*

*$p < .01$, nondirectional test.

with category A and the highest levels were associated with category C. All the values of χ^2 were significant at the .01 level, indicating each pair of raters was agreeing more than would be expected on the basis of chance. The demonstrated reliability levels were judged to be sufficient to permit further analysis of the Dimension I data.

The summary reliability statistics for Dimension II are presented in Table 17. Because only one category could be assigned to each statement, the agreement and disagreement percentages refer to complete agreements and disagreements. Agreement was over 80% for

Table 17

Summary Rater Agreement Levels for Dimension II

Rating pair	Percentage agreement	Percentage disagreement	Symmetric lambda
Investigator x Rater 1	81.4	18.6	.72
Investigator x Rater 2	82.9	17.1	.75
Rater 1 x Rater 2	84.3	15.7	.76

all three pairs of raters and the symmetric lambda ranged from .72 to .76, reflecting high correlations. Figure O-1 in Appendix O provides a summary of the patterns of agreement between the raters for the categories of Dimension II.

When agreement on the individual categories was examined using two-by-two occurrence-nonoccurrence tables, moderate to high correlations were found, ranging from .66 to .86 (see Table 18). Because only one category could be assigned to each statement for Dimension II (as opposed to one, two, or three for Dimension I), occurrence agreement rather than percentage agreement was used. Again, all the χ^2 values were significant at the .01 level, and the reliability levels were judged sufficient to warrant further analysis.

Of the original 95 statements, 25 used in practice sessions and 70 used for reliability rating, only 1 was ultimately excluded from the category system. It was excluded, not on the basis of the type of problem described, but on the hypothetical nature of the victim's statement. She stated, "I'm not saying this is true, . . . but now I may think . . . ." Of the remaining 94 statements, 93 were given a

Table 18

Rater Agreement Levels by Category for Dimension II

Category	Occurrence agreement (%)	ϕ	χ^2
Category 1			
Investigator x Rater 1	80.8	.76	37.7588*
Investigator x Rater 2	80.0	.84	45.2475*
Rater 1 x Rater 2	71.4	.68	29.3916*
Category 2			
Investigator x Rater 1	61.1	.73	33.2297*
Investigator x Rater 2	77.8	.85	45.8113*
Rater 1 x Rater 2	78.6	.86	46.4397*
Category 3			
Investigator x Rater 1	57.1	.68	27.4946*
Investigator x Rater 2	64.3	.74	33.2205*
Rater 1 x Rater 2	61.5	.72	30.9598*
Category 4			
Investigator x Rater 1	68.0	.75	35.4103*
Investigator x Rater 2	60.0	.66	27.1356*
Rater 1 x Rater 2	76.9	.81	42.0645*

*$p < .01$, nondirectional test.

final rating based on the agreement of at least two of the three scorers. Discussion and resolution by consensus was used to arrive at a final score for the 94th item.

The frequencies of the various statement scores are presented in Table 19. Table 20 summarizes the totals by category. These tables reveal that the highest frequencies were to be found in categories C (self-focus) and 1 (time or unspecified factor as mediator of improvement) and the largest group of scores was C-1. Many of the statements in this group had to do with the subjects' feelings about talking about the rape and the frequency with which they thought of the rape. Almost unanimously, they think of the rape less often now than they did in the first few years, and they are more comfortable discussing it now. This group (C-1) also included statements concerning new perspectives on life, such as the following one.

> I changed in what I'd put up with and what I put my time into because, when something like that happens to you, you kinda realize that ga, you're gonna die! You know you're gonna die some day, somehow, and you'd better make what you do now intense and good, and better do what you want to do now instead of just settling for less. . . . The intensity is not quite as strong as it was right after that [the rape] happened, but it continues to a certain extent now.

Statements from category C also included such statements as those of two victims who believed after the rape that they were "bad" people for having engaged in sexual relations, one victim's reference to exacerbated claustrophobia, and one's reference to a prolonged depressed appetite.

Categories A and B occurred in approximately equal proportions across the subjects as a whole. These statements, concerning

Table 19

Frequencies of Statement Scores by Subject

Statement score	Subject number										Totals by score
	1	2	3	4	5	6	7	8	9	10	
A1		3								1	4
A2					1		3			1	5
A3									1		1
A4		2	2	2				1		2	9
B1		1			1		1				3
B2		1			3						4
B3	1	1					2	2			6
B4		1		2	1	1		4			9
C1	4	1	5	3	6	2	2	1		1	25
C2		1			1	2	2	1			7
C3		1				2		1	3	1	8
C4		1			1	1		2		1	6
AB2				1			1				2
AB4						1	1				2
AC4						1					1
BC1					1						1
BC2					1						1
Totals by subject	5	13	7	8	16	10	12	12	4	7	

Note. Only scores which occurred at least once were included. Thus, no statements were scored AB1, AB3, AC1, etc.

Table 20

Statement Score Totals by Category

Category	Frequency	Percent
Dimension I		
A	19	20.2
B	22	23.4
C	46	48.9
AB	4	4.3
AC	1	1.1
BC	2	2.1
		100.0
A--total	24	25.5
B--total	28	29.8
C--total	49	52.1
		107.4[a]
Dimension II		
1	33	35.1
2	19	20.2
3	15	16.0
4	27	28.7
		100.0

[a]The total percentage is greater than 100 because several statements were scored in more than one category.

heightened awareness of aggressive and exploitive potentials of others and awareness of one's own vulnerability in relation to others, respectively, were more likely than C (Intrapersonal) statements to be classified in category 3 or 4, indicating that the interpersonal problems were more likely to be seen by the victims as persisting unabated.

Within Dimension II, the distinction between categories 1 and 2 (transition or relief noted) and 3 and 4 (relief not noted) proved to be an important one in assessing individuals' perceptions of their current status. The distinction between categories 1 (time or unspecified mediator) and 2 (specified mediator of improvement) also proved to be important in assessing the individuals' views of their recovery process, i.e., whether they just got better or whether they actively worked to resolve their feelings, perhaps independently, perhaps in a relationship. Relationships with kind, supportive, patient males were generally seen to be more substantially helpful than were relationships with counselors or therapists.

The distinction between categories 3 and 4, explicit versus implicit statements that a problem persists, respectively, did not seem to add any information which proved useful in making distinctions among statements or among subjects.

Subjects' Individual Response Patterns

The investigator wrote a summary description for each subject based on the final ratings her significant statements received. These summary statements are presented in Appendix P. Each protocol was

then reviewed in an effort to judge the accurateness and completeness of the summary descriptions of long-term effects. Eight of the 10 summaries were judged to be adequate representations of the types of problems and the degree of recovery the victims described. The summary for Subject 1 was not felt to represent the extent to which the victim felt "shy and paranoid around men." This subject had attributed many of these feelings to her experiences with her abusive ex-husband and therefore, several of her statements which clearly referred to him were not included in those rated. The summary for Subject 3 was found to be consistent with the content of the protocol but not with her affect. She cried several times during the interview and was at a loss as to explain why. She stated she did not feel depressed in general or distressed by the rape. The possibility of significant denial on this subject's part was clinically apparent.

Because all but two of the summary statements were judged to be adequate representations of their respective protocols, in terms of the varying aspects of long-term effects that the subjects' emphasized, the category system would seem to be a useful tool for organizing data derived from interviews on the long-term effects of rape on the victim. The most serious drawback of the system is one common to most efforts to organize data, that is, that some of the richness of the original protocols and some subtle differences between people are lost as one looks for commonalities. Some of these differences and the richness of the interviews are revealed in the following section.

Other Issues Discussed by Victims

In the course of the interviews, in attempting to establish a context in which to understand the long-term effects, and in pursuing topics raised by the victims, numerous issues came up which were not directly related to long-term effects or their change over time. Thus, those issues were not incorporated into the category system, but they warrant discussion nevertheless.

The victims' descriptions of the short-term effects were very similar to those which have been reported in the literature: fear, withdrawal from friends and family, and decreased appetite. Embarrassment and humiliation are themes that have been discussed in the literature. The women in this sample did not use those words per se, but three remembered fearing that others would be able to tell what had happened "from the way I acted," that "they're going to see it," or "I just felt like it showed all over." Two of the three women spontaneously acknowledged that their sense of reality contradicted these feelings yet their sense of conspicuity was strong in the early days.

Two victims recalled that their experience had made their friends aware of rape as a possibility for them and that those friends considered taking precautions themselves. One victim, who has told only one of her current friends about the rape, indicated she would be more inclined to tell her friends if they were not already aware of the possibility of rape.

Some early reactions involved potentially self-destructive behavior. One victim, who had been raped on a first date, reported that

she had gone to bed immediately with the next three men she dated. She recalled feeling "really worthless" and thinking, "that's what they expected . . . . If they made any sexual advances toward me, then I was going to have to go through with it." Another woman, who was brutally gang-raped, felt "real down" on herself and began drinking heavily, a pattern that lasted several years. She went into prostitution for a couple of months, thinking, "Well, what the hell? You know, they've used me all they can, let me get paid for it." She also had a lesbian "encounter" which was related to her ambivalence and confusion about her feelings about men. This victim had had suicidal ideation prior to the rape, but the rape exacerbated those feelings and she made several suicidal gestures after the rape. Another woman who had not been suicidal before the rape made two attempts in the month after the rape.

Several of the victims mentioned other experiences or factors in addition to the rape which they believed affected their relationships or perspectives on life. One stated,

> I didn't notice it back then, but now I'm more shy or paranoid around men. But I don't think it was just the rape. I think it was how my life has gone. You know, divorce and all that'll make you feel funny around men.

The "all that" included physical abuse and repeated desertions by her husband. Another woman, who had been brutally beaten by her husband after one rape and before the target rape, described her current distrust of men and her confusion and ambivalence about relationships with them. She stated, "I have trouble deciding if that [the rape] is

what's made the big impact or my marriage. But I think it's more the rapes, the rape, than the marriage."

A victim whose father had died when she was in her early teens felt confused about "which feelings are coming from because I don't have a father or if it's because of rape?" She described the primary residual effect of the rape as being temporary anxiousness when she finds herself alone with a male for the first time. Yet, "most of [her] best friends have been guys and that seems like it would be completely opposite if you've been raped." The woman described herself as having been a spoiled "Daddy's girl," "just the apple of his eye," and said, "I guess from that I just like having attention from guys that I can trust or I know well."

One victim, who felt the rape had made her permanently less open, fresh, and innocent, acknowledged that some change in that direction occurs as one grows older, but felt the rape had had a profound effect on her in that way. Another felt that the insecurities she had developed "just in general from growing up and [her] relationship with [her] family" had been exacerbated by the rape and that, as a result, she has "more insecurities about relationships with men than any other aspect of [her] life." She felt that, as a consequence, for many years she unconsciously selected men with whom there would be little chance of developing a good relationship.

Although books and articles about child victims often include references to parents (Burgess & Holmstrom, 1979b), rarely are parents mentioned in studies of adult rape victims. Yet most of the

victims interviewed for the present study expressed strong feelings concerning their parents and the rape. Five of the women have never told either parent about the rape. One was from a religious family and felt very guilty about having sex before marriage, even though she had not wanted to. Another saw her parents as conservative and judgmental and feared that they would blame her for the rape and criticize her for having been drinking and smoking pot at the time. She had not been sharing her feelings with her parents before the rape, but shared even less with them afterwards and is "just now getting beyond that with them," more than a decade later.

Of the five who did tell one or both parents, one did so by explaining on a tape that she had been raped 2 years previously and sending the tape to her family through the mail. She has not discussed the rape with her family since then. Another told her parents immediately after the rape. They traveled to her city and helped her make decisions about moving and so forth. The subject felt her parents were more traumatized by the rape than she was. She feels that as a result they are more protective of her and more tolerant of her living with her current boyfriend. One victim told her mother, who became angry about the favors the victim asked as a result. This mother blamed the rape on the victim's lifestyle. Another victim told her mother, who pressed the victim to charge the assailant with rape in addition to assault. Other than this episode, the victim appreciated her mother's support. However, the mother was sufficiently upset by the incident that she went for counseling herself. Still another victim

told her mother, with whom she was living at the time. The mother pushed the victim to report the crime, and although the victim resisted strongly at the time, in retrospect, she's glad she did report it, as convictions resulted. The victim and her mother have continued, however, to have conflict over the rape. The mother clipped newspaper accounts of the rape and sent them to relatives when the victim wanted to keep things as quiet as possible. The mother pushed the victim to talk about the details of the rape when the victim wanted to withdraw and not to talk about it. The mother still brings up the rape and attributes the victim's transient depressions to the rape. This irritates the daughter and she now keeps her contact with her mother to a minimum.

In addition to interactions with their parents, several of the victims cited things they felt had been helpful or unhelpful in the early days following the rape. One who had been attacked while sleeping at home was afraid to be alone, either at home or in going about her activities. One who had been abducted from a parking lot was afraid to leave her home alone. Both enlisted friends to keep them company and initially felt their friends were helpful in this way; however, both later realized that they had to stop relying on their friends. The first victim accomplished this by "forcing" herself to do things alone and the second, by moving to another city.

Of the five who reported their rapes to the police, only one felt the police and hospital staff had been actively helpful and supportive. Another noted her surprise that the police she dealt with had not

"insinuated that [she] led them [the rapists] on," as she had anticipated they would from the movies she had seen and the stories she had heard. Two, however, reported difficult experiences with police. One reported being asked, "What happened? Did you like it? Why did you go with him?" as she lay in the back seat of the cruiser, crying in pain from her injuries. Another was made to wait several hours before being allowed to swear out a warrant and then was accused of being a prostitute by the woman who handled the paperwork.

Two victims who were enrolled in universities shortly after the rape found the academic work to be helpful in their early adjustment. One saw it as a way to focus her heightened energy and the other found it a reassuring source of self-satisfaction regarding her ability to function well. Two others found reading alone in their rooms to be "a real good escape."

Although most victims found their friends' attentiveness and comments to be helpful, one commented, "There were people who would say, 'If there's anything I can do to help you, let me know,' which is not very helpful. What that does is once again make you more aware that something has happened." Comments such as, "You should have known better than to . . ." were also not perceived as very helpful.

Three victims clearly stated that a relationship with a gentle, caring, patient man had facilitated their recovery, specifically in the sexual arena. For one of the victims, the relationship was the one in which she was involved at the time of the rape and for a year afterwards. The other two victims were describing their current relationships with men they had not known at the time of the rape. Four

subjects described themselves as happily involved in satisfactory relationships with males at the present time. In general, such relationships were seen as more substantially helpful than relationships with counselors or therapists.

Only two of the victims had never been involved in any sort of counseling or therapy. One of these had talked to her female friends from time to time about the rape and felt it helped her to hear their supportive comments.

The experiences and reactions of the eight who have been involved in counseling or therapy varied widely. The three subjects who were recruited from the mental health center were of course in therapy at the time of the interview and each of them was in her second episode of treatment. One had been in treatment at the time of the rape. Both of her entries into treatment were prompted by specific relationship difficulties, but she has felt some urgency to discuss her rape. A second victim did not see either entry into therapy as directly related to her rape. A third victim saw her rape as the main reason she entered therapy the first time but as unrelated to this episode of treatment. None of the victims has discussed her rape in depth with any of her therapists, despite her persistent strong feelings about the rape. All three members of the clinical subsample had experienced two rapes. Only one of the remaining seven victims reported more than one rape, and she has never sought professional counseling.

Of the remaining five subjects who have had some sort of counseling since the rape, one went into counseling immediately after

the rape, presumably to deal with the rape but focused primarily on a former relationship, the breakup of which had caused her much distress. A second victim saw her family physician regularly so he could monitor her physical recovery from the rape-related injuries. He would invite her into his office after the examination and counsel her to end her withdrawal and self-pity. At the time, she resented his advice which seemed insensitive to her, but in retrospect, she feels his talks with her helped her to move on to other things in her life. A third victim was referred for therapy when she developed pneumonia a few months after her rape. She discussed the rape with her therapist but did not see it as necessarily the primary stressor as she was also attempting to adjust to graduate school. She stated that, in retrospect, she feels the therapist's "nondirective" approach was helpful and she implied she addressed in therapy some personality issues of which she might not have been aware otherwise. A fourth victim went for two or three sessions of counseling for issues she felt were not related to the rape. She was so frustrated by the therapist's nondirective approach that she did not go back.

The fifth victim has seen several counselors over the decade since she was raped. She has some specific ideas about which interventions were helpful and which were not. Her first contact with a counselor was within a week after she was raped on a first date. She took the therapist's statement, "We get a lot of cases with girls coming to college for the first time and something like this happens," as confirmation that the event was related to her own inexperience and age and

was therefore her fault. She did not go back to that counselor. She also described a therapist whom she perceived as having "a lot more anger toward men than I do." When she was describing a feeling, she found the therapist's response, "Well, what do you expect from a man?!" to be singularly unhelpful. The response she found most helpful regarding her concerns about the rape came from a therapist who empathetically

> encouraged me to feel those feelings, to place myself back in that situation and experience it and talk about how I was feeling, but then to move away from that and say, "O.K., how am I feeling now about it and what can I do about it now?"

The victim felt that both aspects, acknowledging feelings she had not acknowledged before and talking about what to do now, were necessary components in satisfactorily addressing her reactions to the rape.

One idiosyncratic response deserves special mention. Typically rape is viewed by victims and observers as a potentially life-shattering experience; however, one of the victims interviewed for the present study felt her experience of rape actually helped her get over a devastating breakup with a former boyfriend. Nine months after the breakup, she was still "wrapped up in it" and "still really in a kinda crisis with that." In reference to the rape, she said, "But you know how things like that will shake you up and they'll make you make decisions and get over yourself and move on."

The three victims who are in helping professions in which they deal with patients or clients all said they felt their own experiences with rape have made them feel more sensitive to those in need. Two

mentioned they are especially sensitive to victims of rape or sexual abuse.

Concerns about their future safety seemed to take illogical forms for a couple of victims and one set of parents. One victim was abducted from a parking lot and raped. Although initially after the rape she did not mind being left at home alone, now she becomes very nervous and fearful when home alone. She locks all the doors and windows and draws the shades, even in the daytime. If her husband is at home, however, she feels quite comfortable leaving the doors and windows open until late at night, as if his being there eliminated any danger. Similarly, the parents of a victim who was raped by a man who broke into her home while she slept are perceived by the victim as more tolerant of her living with a man. She imagines they are less upset than they would have been otherwise because they feel she needs to live with a man and "it won't happen again if she does."

Relationships Between Variables and Recovery

With a small sample and having no global measure of degree of disturbance due to the rape or of degree of recovery, it is difficult to address such questions as whether women who were virgins when they were raped have more difficult adjustments or whether having agreed to the initial contact with the man who later raped resulted in more guilt for the victim than a sudden attack. Nevertheless, given the extent of the subjects' discussions, a few observations can be made. As a group, the four women who were virgins at the time of the target

rape tended to be less symptomatic now than those who had had sexual relations previously. Even so, two of them have had significant struggles with feelings of guilt and feelings that they were "bad" people. The two women who had been raped prior to the target rapes and who had been virgins at the earlier rape are among the most severely disturbed currently. Length of time since the rape did not appear to be related to current levels of distress. These generalizations apply to both the interview data and the SCL-90-R scores.

As noted in the literature review, the question of a victim's "responsibility" for her own rape is a difficult one. Only 2 of the 10 victims clearly felt that the incident had been their "fault." For the first, this idea formed a part of a circular thought pattern. She felt, "If I hadn't done all those things [drinking, smoking, necking], it wouldn't have happened. . . . I felt like it was something bad that had happened, but it happened because I was bad." Later she stated, "I [felt like I] was a terrible person because something terrible had happened to me. I felt real guilty." The second woman felt like she was at fault because, "I just felt like I let myself get into it. . . . I just blamed myself a lot for what happened, felt like I shoulda known better than to get in that situation." Both had been raped while on a first date. The first continued to have problems for years concerning her feelings that she was a bad person and undeserving or "unworthy" of having a good, loving relationship with a man. The second woman continues to worry about her "guilt" in not having foreseen the rape.

Two victims rejected blame per se but felt guilty intensely. Both had entered willingly into the initial contact with the male. One was

overwhelmed with guilt because she had had sex before marriage, even if unwillingly. The other's guilt was associated with the rapist's being a friend's estranged husband and with her confusion about whether she had done anything to lead him on. She was quite angry at herself for having "let this happen," even though she had struggled to escape.

Two other women who had willingly entered into the initial contact with the man rejected the notion that they were at fault or to blame, but did make comments about themselves such as, "I knew better than to go out and get into trouble. . . . It was real dumb," "I was just too trusting, I guess," and "Well, I was pretty naive before." Nevertheless, neither discussed particular feelings of guilt.

The remaining four victims were attacked by surprise, three in their beds at home and one in a parking lot. None discussed fault or feelings of guilt at all, except one who stated, "I think a number of people worry about whether it's their fault, but I never had that. In my own mind I knew it wasn't." Clearly, feelings of guilt and questions about one's own responsibility were related to rapes where the victim has had at least some prior interaction with the rapist and willingly entered into social contact on the occasion which ended in rape.

Reasons Given for Participating in the Research

The reasons the subjects gave for volunteering for the research clustered in four areas, although some subjects mentioned more than

one reason. Two felt it might help themselves to talk about it. Two were interested in helping the investigator complete her research, one because she had done research herself and had friends doing research and the other because her sister was a student and might need people to help her one day. Three mentioned a curiosity about long-term effects of rape and wanted to contribute their own experiences to the research. Four mentioned their hope that the results of the research would be used to help other victims of rape. Although they did not give this as a motivating reason for participating, two subjects saw the interview as a "test" or opportunity to see how they handled discussing their rapes.

CHAPTER V

DISCUSSION

The subject sample and procedures used to gather and analyze the data for the in-depth portion of the study will be discussed first. Next will come a review of the findings placed in the context of previous research findings, along with possible interpretations and a suggested organizing framework. Clinical implications will then be explored, followed by suggestions for future research.

Sample and Procedures

Sample

The group of 10 women who volunteered to participate in the present study were certainly not homogeneous. They were as disparate as a divorced mother on welfare and a childless woman with a family income of $50,000 who is pursuing a graduate degree in her chosen profession. Colaizzi (1978) suggested as sufficient criteria for phenomenological research that subjects have experience with the topic in question and that they be articulate. Each subject stated she met the first criteria, that is, that she had been raped. No effort was made by the investigator to confirm the women's reports of having been raped. No monetary or material reward was offered which might motivate a woman to fabricate a story of rape. The subjects varied in their articulateness, but all were able to describe aspects of their experiences in such a way as to convey meaning to others.

The inclusion of the clinical subsample was deemed important in the present exploratory study for two reasons. First, in looking for women who might have experienced long-term detrimental emotional effects from rape, it was expected that mental health centers would be fertile ground as the patients there have been identified by themselves or someone else as having emotional problems. Second, as one of the primary purposes of the study was to determine what kinds of problems rape victims might present to a clinician, it was deemed crucial to talk with some actual patients. The possibility that the patients had psychological problems which predated the rape or were unrelated to the rape certainly may confound the findings. In fact, all three volunteers of the clinical subsample described preexisting problems. Two of them clearly stated they felt the rape had exacerbated or perpetuated those problems and were able to discuss their perceptions of that process. A somewhat unexpected finding was that five of the seven subjects drawn from the general population had had at least minimal contact with a counselor or therapist.

That the sample was obtained by asking for volunteers inherently biases the sample, and it does so in ways that are difficult to positively identify. The common elements among these women were that they were willing to talk about their experiences of rape to a stranger and that they were willing to expend their own time and energy to do so, with no guarantee, or possibly even expectation, of personal benefit, either tangible or untangible. It is impossible to know in what ways these women differ from those rape victims who

were aware of the study and chose not to volunteer. One possibility is that those who volunteered were more likely than the others to perceive the rape as having serious long-lasting effects on them and to want others to be aware of potential effects of rape. Yet, two of the volunteers presented themselves as essentially totally recovered and whatever residual effects they described were minimized. Another possibility is that those who did not volunteer are more secretive about their experience and are more uncomfortable discussing it. Several of the volunteers made it clear, however, that they rarely mention their rape to friends and several still experience discomfort in discussing the rape. It may be that talking about the rape has a special meaning for those who volunteered. Several of the victims mentioned their hopes of helping others by talking. Two saw participating in the interviews as a way of "testing" how they were coping. If those who did not volunteer have different thoughts and feelings about talking about rape, the findings of the present study may not apply to them.

The problem of sampling bias is one common to all rape research, whether the group is identified by police records or recruited from emergency rooms or rape crisis centers. One reason the appeal was made to the general public and clinical population was the investigator's hope of recruiting subjects who had not reported their rapes to any of the above institutions from which rape victim samples are typically drawn. That half of the 10 subjects had never reported their rapes to legal or medical authorities or to a rape crisis center indicates that this goal was met.

The degree to which the findings from the present study may be generalized to other rape victims is limited because the sample was not random and the victims agreed to talk. This bias will exist, however, in all studies of rape victims in which pressures are not brought to bear to force reluctant victims to talk. A second, more tractable limitation to generalizing the findings is the small sample size, which was indicated given the interview nature of the study and the in-depth analysis of the resulting protocols.

Procedures

The administration and scoring of the SCL-90-R followed standard practice and warrants little attention here except that the subjects were asked to identify those items they had experienced and attributed to the rape. There were a number of items which more than half of the victims identified, indicating there is some commonality among their symptomatic experiences.

Because the use of the ICL for rating groups of people in general is relatively uncommon, the directions designed for the present study were tested first in a pilot study with undergraduate students to make sure that the directions were understandable. Because the directions for the ICL were unique, a comparison group was needed as the investigator could not presume that the test mean would be an appropriate basis for comparison. A portion of the pilot study sample was chosen randomly to serve as the comparison group. The comparison group was more homogeneous in age, marital status, and level of education than was the victim group. As such, it did not meet the ideal of a

group of matched control subjects, but did provide a valuable basis of comparison for the pattern of scores found among the victims.

The method of interview analysis used was one developed for this study by the investigator after reviewing a variety of possible procedures. The review of the literature and the investigator's own interests had led her to develop the interview questions to explore the long-term effects of rape, especially on the victim's relationships, and the evolution of those changes over time. These areas of interest also formed the criterion for the selection of significant statements from the protocols and shaped the nature of the two dimensions of the category system. Yet, within each dimension, the investigator was open to the emergence of whatever themes the subjects might present. The articulation of the categories within each dimension underwent several significant conceptual shifts in the process of searching for the most satisfactory system. Discussion with others, including attempts to explain the categories as initially conceived by the investigator and attempts to reach concensus on scoring of sample statements, played a critical role in refining the descriptions of the categories and the scoring criteria. The reliability statistics indicate adequate levels of agreement were found to allow further use of the category system with some degree of confidence.

Interpretation of Findings

Prevalence Survey

At the urban and rural mental health centers, 16% and 30%, respectively, of the respondents reported at least one incident of rape

or sexual assault (excluding incest) in their histories. The only figure for the proportion of rape victims in a clinical sample the investigator had found in the literature was approximately a quarter (Abarbanel, 1978). The figures from the present study suggest that, although proportions may vary among various clinics and populations, sufficient numbers of female patients have experienced rape or sexual assault for clinicians to be concerned with the identification and treatment of such women. When incest was included, the percentages of those who had experienced forced sexual contact rose to 34% and 43% for the urban and rural centers respectively, which signifies more emphatically the need to be able to address issues of sexual coercion.

That 89% of the victims felt that their relationships had changed at least some due to the sexual coercion and that 72% felt the sexual coercion was, if not the main reason, part of the reason they had come for therapy further confirms the need for clinicians to be willing and able to address the consequent issues. That 68% reported they had discussed their coercion with their therapist indicates that, in most cases, the issue comes up, but the accounts of the interview subjects indicate the issue is rarely addressed in depth in therapy. Only two of the eight interview subjects who had had contact with a counselor after their rape felt they had satisfactorily addressed the related issues, and one of those subjects had seen numerous counselors before she satisfactorily resolved the rape issues. Clearly there is much work to be done in training clinicians to identify and address sexual coercion and related issues.

Interpersonal Check List

The initial supposition was that rape victims would perceive men as more dominant, hostile, and aggressive than do women who have not been raped. The ICL was chosen as an instrument because it provides a measure of people's perceptions of themselves or others on the dimensions of dominance versus submission and affiliativeness versus hostility. That the victims as a group did not differ significantly from the undergraduate comparison group on their ratings of males on either the Dominance or the Love dimensions is an important finding. Together with the pattern of scores, it indicates that women, whether they have been raped or not, tend to view men as having dominant and disaffiliative qualities, that is, as managerial, competitive, and aggressive. Strangers and rapists are viewed as the least affiliative males. Men known to the women, especially men they have considered to be boyfriends or men to whom they have been married, tended to be viewed as more affiliative, but this distinction (for current or past boyfriends or spouses) was statistically significant only for the victims.

It is not readily apparent why the male in the videotape was rated relatively neutrally by the women in both groups. Even the consistent view of strangers as dominant and oppositional did not appear to color their perceptions of him. It may be that the characteristics of the taped interaction with a female who was perceived by the subjects as domineering precluded the male's being seen as dominant or oppositional. Another possibility is that because he was

on tape rather than actually present, he was not seen as potentially threatening. The possibility that the women did not attribute distinctive qualities to him because they did not know him does not seem consistent with their readily attributing qualities to "strangers," men that they do not know, or to the female on the videotape.

In terms of understanding the rape victims as different from the undergraduates on the aspects measured by the ICL, the most important difference would seem to be the victims' rating themselves as more disaffiliative on the Love versus Hate dimension. That is, even though the two groups of women have similar views of men, the rape victims describe themselves as less likely to be congenial to those men. This difference was not statistically significant when octant scores were used for the comparison; however, because the trend was consistent and was significant in the analysis of variance, some possible interpretations will be suggested.

The rape victims as a group were older than the undergraduates and none of the undergraduates was married. The victims have thus had more time and potentially more opportunities to become disillusioned in relationships with men, excluding for the moment consideration of the rape experiences. In fact, five of the victims reported at least one incident of being physically abused by men other than the rapists. Five of the victims have been divorced at least once. Perhaps such experiences would be sufficient to make women less affiliative. The interview data show that some women attributed some of their feelings about interacting with men to factors other than the

rapes (such as beatings, desertions, etc.), yet all stated explicitly that they believed the rape was associated with their feelings to a significant degree.

Perhaps the view of men the victims and undergraduates held in common reflects society's view of men in general, as powerful, assertive, aggressive people. The victims' disaffiliativeness may then reflect a self-protective gesture on their part. That is, their experiences with men apparently did not substantially alter their perceptions of men, but the victims may have changed their own behavior to reduce the possibility of being victimized again by a powerful, aggressive male. It is important to note that victims did not see themselves as more or less dominant than the undergraduates saw themselves. Thus, the victims apparently have not reacted by becoming more submissive in hopes of appeasing men nor more dominant as if to challenge men, but have become withdrawn, less likely to engage readily in congenial relationships, less likely to passively accept life as it is presented to them, and more likely to look out for their own needs. These changes derived from the ICL data closely parallel those described by the victims in the interviews.

SCL-90-R

The identification of depression as a prominent component of experience for the rape victims appears to be the major contribution of the SCL-90-R data. Depression was the only symptom dimension on which the nonclinical subsample's group mean was statistically higher than the test mean. The Depression dimension score was the highest

dimension score for the clinical subsample as well, although it was not statistically significant. Of the items more than half of the victims had experienced and attributed to the rape, fully a third were from the Depression dimension. Eight of the 13 Depression dimension items were identified. The victims also identified three other items which are not part of the Depression dimension but which frequently are considered symptoms of depression: trouble falling asleep, sleep that is restless or disturbed, and feelings of guilt.

The SCL-90-R was used by Kilpatrick et al. (1979) in their study of short-term effects of rape. They found that immediately (6 to 10 days) after the rape, on eight of the nine symptom dimensions of the SCL-90-R, the rape victims scored significantly higher than the control group members. At the 6 month assessment period, the only dimensions on which the victims had significantly higher scores were Anxiety and Phobic Anxiety. The victims in the present study did not score particularly high on either dimension. In fact, 4 of the 10 victims did not endorse any items on the Phobic Anxiety dimension. Perhaps it takes a significant period of time for the initial anxiety to fade. Later, a sense of depression may become the most prominent symptom.

From the data obtained in the present study, it is not possible to conclude that the victims attribute their current depressive symptoms to their rapes. It is clear, however, that they attributed those symptoms to the rape at some point in the past and that they are currently experiencing significant depressive symptoms.

The identification of four of the nine Interpersonal Sensitivity items on the SCL-90-R is consistent with the victims' Love scores on the ICL, but the identification of only two of the six items on the Paranoid Ideation dimension is somewhat surprising. Those two items do refer, however, to feelings that others can not be trusted and that they will exploit one if one allows it.

Interview

The existing literature on long-term effects of rape on victims suggests that depression, anxiety, phobias, sexual disruption, mistrust of men, and difficulties in heterosexual relationships are not unexpected. Each of these areas was mentioned by at least 1 of the 10 victims in the course of the interviews; however, none of the areas was cited by all the victims as a long-term problem. It is clear that there is wide variation among the victims both in the types of long-term problems they report and the intensity of the distress caused by these problems.

The primary contribution of the interview data is the elucidation it provides of the victims' mistrust of men and of their difficulties in heterosexual relationships. The identification of two related but distinguishable modes of relating to other people offers a more complete way of understanding victims' feelings about and behavior around men. That some women described only one or predominantly one stance while others expressed both suggests there are important individual differences among the victims in their interpersonal strategies. The two modes, (1) heightened awareness of the other's aggressive and

exploitive potential and (2) heightened awareness of one's own vulnerability will be discussed in the context of a theory of personality style.

Shapiro's Paranoid Style

In his book, Neurotic Styles, David Shapiro (1965) described various modes of human functioning by delineating characteristic styles of cognition and perception as well as subjective experiences and activity. He was primarily concerned with a person's mode or style of thinking and behaving rather than with the content of thought or the "what" of the behavior. Among the various styles he identified was the paranoid style. A comparison between his description of the paranoid style and rape victims' descriptions of their interpersonal relationships reveals many similarities. In suggesting that rape victims have adopted a paranoid style of functioning, it is important to emphasize that the behaviors and thought processes they describe are characteristic of the milder ranges of the style, rather than the psychotic loss of touch with reality that can take place in the more severe cases.

A key element of Shapiro's paranoid style is the suspicious mode of thinking and perceiving. The paranoid person is hyperalert for clues in the environment which will confirm preexisting notions of how things are. He or she is likely to ignore or dismiss as "'mere appearances'" (Shapiro, 1965, p. 57) facts which others would interpret as contradictory evidence. The paranoid person's attention is rigid and biased. Ambiguity and surprises are difficult to tolerate.

Shapiro believed that much of the paranoid's rigidity reflected an effort to compensate for the lack of an adequately developed sense of autonomy. A complete sense of autonomy involves being able to do as one wishes and feeling free to do so.

> While the normal person feels not only competent, but also free to exercise his will, and, in that sense as well, self-directing, in charge of his own life, and master of himself, the paranoid person is continuously occupied and concerned with the threat of being subjected to some external control or some external infringement of his will. (Shapiro, 1965, pp. 81-82)

This constant apprehensiveness is accompanied by an acute awareness of and sensitivity to external authority as well as resistance to authority. But internal impulses and desires can also be threats to security if they lead one to behave in such a way that one's will becomes vulnerable to subjugation by others. Thus, spontaneity and playfulness are almost nonexistent for the paranoid person and the range of affects is narrowly constricted. Tenderness may be perceived as weakness and therefore avoided. The potential loss of a sense of autonomy can be as threatening to the paranoid as potential physical harm.

The rape victims interviewed for the present study described thought processes and behaviors that are consistent with Shapiro's paranoid style. The hyperalertness to clues in the environment, clues that might signal a male's readiness to exercise his will at the expense of the female's, was described by several victims. Three stated clearly that they were more sensitive to sexual aggressiveness and antifemale attitudes. The ICL data indicates that the content of

victims' perceptions of men are not significantly different from other women's. Yet the ICL data and the victims' descriptions suggest that the victims become more acutely sensitive to those perceptions and tend to be constantly on the lookout for potential threats to their autonomy.

Two victims discussed their continued concerns in the sexual realm in terms of having great difficulty trusting a male's statements that he cares for them. They expect to be exploited sexually and the rigidity of this expectation precludes the relaxation necessary for personal and emotional intimacy. Efforts to take control of the sexual interaction and lack of arousal or sexual numbness may result. These problems seem to arise as much from the experience of having one's autonomy violated as from the experience of physical injury.

The lack of spontaneity and constriction of affect is present in other interpersonal arenas in addition to the sexual one. The following statement from one of the victims articulates this component clearly.

> I think the fear comes from the rape. I don't like to be in a room with people I don't know, men, because you don't know what they're going to do. I feel they're unpredictable and you don't know . . . how they're gonna turn on you. That's how I feel. I think they're gonna turn on me any time. And that's why I'm not very sociable to men or anything like that. If I see them and they look my way or something, I'll just give a half grin and drop my head because I don't want them looking at me. I don't think it's for shame or anything like that. I think it's just afraid of what--I know what they <u>can</u> do. . . . And that it can be done again. I just don't <u>want</u> to put myself in the place of it being able to be done.

Shapiro distinguished two types of manifestation of the paranoid style, "furtive, constricted, apprehensively suspicious individuals and

rigidly arrogant, more aggressively suspicious, megalomanic ones" (1965, p. 54). Although these are rather extreme descriptions for the victim population, nevertheless, the distinction is a useful one and closely parallels Dimension I categories B and A, respectively. Category B reflects the emphasis on one's own vulnerability and the associated fear and distrust while category A reflects the emphasis on the other's potential aggressiveness and exploitiveness and the associated tension, anger, and sometimes hostile lashing out. It should be noted that several victims expressed both modes in approximately equal proportions yet others emphasized one or the other. Thus this dichotomy would seem more useful in this context as a distinction between modes of response rather than among people.

That only two victims' ICL descriptions of themselves in general resulted in octant summary scores of 4, Leary's paranoid octant, is somewhat unexpected, given the consistency between the victims' interview statements and Shapiro's paranoid style. Upon examination, Leary's paranoid octant is found to involve a degree of passivity and submission which is not figural in Shapiro's description, a difference in conceptualization which may account for the relatively few scores falling in octant 4.

A similar discrepancy between expectations and data is noted in the lack of high scores on the Paranoid dimension of the SCL-90-R. High scores on this dimension depend on the endorsement of specific paranoid ideas. As Shapiro's description concerns a mode of thought rather than its content, the SCL-90-R would not necessarily adequately measure paranoia as Shapiro describes it.

Although depression was the predominant group of symptoms endorsed by the victims on the SCL-90-R, the women rarely mentioned depressive symptoms in the interviews. Thus one can only speculate about the sources of depression, especially since the victims were not asked if they associate their current symptoms with the rape. It would seem likely, however, that the depressive feelings may be related to a sense of loss of mobility and loss of possibilities for developing interpersonal relationships with men. This would be consistent with the increased limitations and social isolation inherent in adopting a paranoid stance.

Clinical Implications

The finding that the rape victims in the present study seemed to have derived more substantial help from relationships with caring, loving, patient men than from counselors or therapists is a thought-provoking finding for clinicians. Certainly the support provided by the patient males would not be begrudged the victims who were fortunate enough to receive it. Yet only one of the eight victims who had had contact with at least one counselor since the rape expressed enthusiastic satisfaction with the way she had been able to address her issues about her rape in therapy, and even she had had previous unsatisfactory attempts to deal with the rape in therapy. Three other victims stated that they felt their counseling had helped somewhat, but their statements were unenthusiastic. None of the three victims in the clinical subsample had directly addressed her rape with her therapist

in depth. Clearly, dealing with rape victims is an area in which clinicians need training and increased awareness.

The research findings provide the basis for several ideas for working therapeutically in the immediate aftermath of rape as well as in later periods of adjustment.

A crucial element to keep in mind is that a victim may not immediately construe an incident of forced sexual intercourse as rape, especially if she had had a prior relationship with the male or had agreed to be with him socially on the occasion which ended in rape. One woman who was raped by a date was quite shaken by the incident but did not classify it as rape in her own mind until about 5 years later. The key issue here would seem to be helping the woman sort out her ideas about responsibility, his versus hers, and her feelings about the violation of her autonomy with the goal of reducing the residual guilt that often accompanies rape by an acquaintance or friend.

The victims' evaluative perceptions about their early efforts, conscious or unconscious, at denial and suppression of the rape were mixed. One victim felt her failure to deal with her feelings in the early stages led to the perpetuation of serious relationship difficulties. Two victims felt that their being able to focus their energies on academic pursuits rather than dwelling on the rape was helpful. All three victims had made contact with counselors shortly after their rapes, but the first victim had not found the contact helpful, as she did not feel her feelings were understood. It would seem important

then, to allow the victim to set the pace at which she wants to confront the various issues related to the rape. Investment of energy in other activities, such as school, can be adaptive rather than merely an escape from dealing with the rape.

Several victims remembered receiving comments, which might normally sound supportive or helpful to others, which they found disturbing. For example, one counselor mentioned to a victim, who had been raped by a date, that similar incidents were not uncommon for young girls who were at college for the first time. Apparently the counselor's intended message was, "You're not alone," but the victim interpreted it as meaning the rape was due to her age and inexperience and was therefore her fault. Another victim found offers of help to be irritating because they reminded her "something" had happened when she was trying to forget it. Because it is extremely hard to predict a particular victim's response to interventions, it is critical to carefully monitor her response to one's comments so that misunderstandings such as in the first case described above can not only be cleared up but can lead to further valuable material, i.e., that the victim was inclined to blame herself.

For clinicians who are not working in a setting, such as a rape crisis center, where a client is automatically identified as a victim, the problems are somewhat different. Clients who are rape victims may not readily identify themselves as such, possibly because they believe they should not still be experiencing repercussions from their rapes. Given the figures of 16% and 30% reporting rape in their histories, it

would seem reasonable to include a question concerning history of sexual abuse or rape in the clinician's list of standard history questions. If the client reports such a history, an inquiry into any perceived residual effects would suggest to the client that not only are residual effects possible and common, but worthy of attention in the therapeutic relationship.

Although there were identifiable themes which were relevant for several of the rape victims interviewed for this study, perhaps the most important thing to remember is that each victim responded to her rape in a unique way. Each unique response was a function of the interaction of (1) the victim's personality, (2) her life circumstances at the time of the rape, and (3) the characteristics of the rape itself. The question arises whether the adaptations the victims have made are necessarily problems which need to be resolved. A related issue is the possibility that the paranoid stance adopted by some victims might actually reflect a more healthy awareness of the possibilities in this world. If this is the case, the victim might need to become reconciled to this world view rather than stripped of her "healthy paranoia" (C. P. Cohen, personal communication, 1984). Thus, the clinician should avoid making assumptions about what kinds of help the rape victim wants or needs. Because the victim is unlikely to be able to articulate how she would like to deal with the rape, a collaborative effort may be needed to identify the areas which are troublesome to the victim and the ways she would like things to be different. The clinician should also entertain the possibility that what the victim

needs most is to talk to someone who listens in an empathic, nonjudgmental manner.

The clinician should also consider the possibility that the victim has made a reasonable adjustment to the rape and that pressing the victim to discuss painful or negative feelings may be counterproductive. Figley (1983) distinguished between a "survivor" (p. 10) of a catastrophe and a victim. "A survivor is able to take advantage of the skills developed as a result of his or her catastrophic experiences: the skills of survival; the confidence of mastering the stress during and following the catastrophe" (Figley,, 1983, p. 10). The data from the present study show that clinicians should not assume a rape victim has residual problems; she may be a survivor.

Burgess and Holmstrom (1979b) described the combination of rape trauma and past or current physical, psychiatric or social difficulties as the "compounded reaction" (p. 388), and discussed a minority of their sample in this category without giving a figure. It is important to note that even when such difficulties have not been identified by helping agencies, preexisting views of oneself as bad or inferior, feelings of insecurity, suicidal ideation, or general hostility towards others may neatly fit with the dynamics of rape such that these ideas are further confirmed in the victim's mind and the problems are exacerbated or intensified. This process appeared to be relevant for 7 of the 10 victims of the present study, 3 of whom formed the clinical subsample. Whether this pattern is over-represented in this group of volunteers is unclear, yet the clinician should be aware of the

possibility that the rape, rather than being totally incongruous to the victim's previous experience and perception of herself, may be readily incorporated by the victim as confirmation of her worst fears.

Suggestions for Further Research

Although understanding what changes or effects victims attribute to a rape was the primary goal of this study, perhaps the most serious limitation of the study is that the design does not allow one to say conclusively that the problems identified by the rape victims were caused by the rape or that the problems are unique to rape as opposed to other types of trauma. To address the question of causality and uniqueness, it would seem that two control groups would be needed, one whose members had experienced nonsexual assault and one whose members reported neither sexual nor nonsexual assault. It would be important for the three groups to be similar in age and in their marital or heterosexual relationship histories. Certainly larger numbers of subjects would improve the generalizability of the findings. If the paranoid reaction is a response to having one's autonomy violated, it may be that even women who have not experienced assault per se may have developed a paranoid style in reaction to nonphysical coercive experiences.

The Prevalence Survey could be used to gather more specific data if a question were added which distinguished between intercourse and other types of forced sexual contact. The investigator may have been unnecessarily cautious in excluding psychotic patients from taking the

questionnaire. A pilot study to see how well psychotic women handled the inquiry into their sexual histories could provide guidance for the future.

The interview, as constructed by the investigator, may have unnecessarily limited the range of information gathered from the rape victims. An interview which began with an open-ended question such as, "Tell me about your experience of being a rape victim," might prove to be more effective in identifying issues that are of primary concern to victims as opposed to investigators. It was somewhat surprising that the victims did not discuss more bodily concerns and this might become the focus of follow-up questions whether or not victims spontaneously mentioned it. Another facet which might be addressed by an interview is whether the victims had considered the possibility of being raped as a hazard of living and a potential for them specifically prior to their rapes and what, if any, impact prior awareness of the possibility might have on the feelings experienced and on the recovery process.

Clearly the area of long-term effects of rape is one in which there is still much to learn. Asking victims to describe in their own words how they feel they have changed would seem to be a productive method of inquiry.

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APPENDIXES

APPENDIX A

ADJUSTMENT PROBLEMS

Table A-1

Summary of Adjustment Problems Immediately and 1 Year After the Rape

Adjustment problem	Immediately after the rape	1 Year after the rape
Increased fear of streets	65.9%	54.1%
Increased negative feelings toward unknown men	57.5	50.7
Decreased social activities	50.3	53.6
Change in sleeping patterns	49.9	43.0
Change in eating habits	47.3	43.0
Worsened sexual relations with partner[a]	46.6	39.1
Increased fear of being home alone	43.2	24.8
Worsened heterosexual relationships	40.2	26.2
Increased negative feelings toward known men	36.6	29.3
Increased nightmares	31.1	20.7
Worsened relations with husband or boyfriend[a]	26.9	26.0
Increased insecurities concerning sexual attractiveness	18.7	15.7
Worsened relations with family	17.0	15.2

[a]Only computed for appropriate age groupings.

Note. Reprinted by permission of the publisher, from The Aftermath of Rape by Thomas W. McCahill, Linda C. Meyer and Arthur M. Fishman (Lexington, MA: Lexington Books, D. C. Heath and Company, Copyright 1979, D. C. Heath and Company), p. 74.

APPENDIX B

PREVALENCE SURVEY

QUESTIONNAIRE

As part of a research project, the Center is using a questionnaire to learn about women who have been forced to do things against their will. The questions below have been designed to help us understand you and others who have similar experiences. Your answers to the questions won't be connected with your name in any way, unless you decide to help us with the rest of the study. Whether you do or don't answer the questions will not change the help we give you. Answering the questions on this and the next page will indicate you have decided to participate of your own free will. Furthermore, you may stop your participation at any time without penalty.

1. Your age:_____ your sex:_____ your race:_____

2. Has anyone ever forced you to have physical sexual contact against your will? (Check one of the blanks below and follow the instructions.)

   Yes_____ GO TO THE NEXT PAGE.

   No_____ GO TO QUESTION #3.

3. Have you ever been in a situation in which you were forced or felt threatened with harm (physical or emotional) if you didn't cooperate in some event that was NOT sexual?

   Yes_____ GO TO THE NEXT PAGE.

   No_____ STOP Thank you for your help. Please fold these pages and put them in the large box at the reception desk.

If you chose not to answer any of the questions, please fold these pages and put them in the large box at the reception desk.

4. Please answer these questions about the event(s) with each person you had in mind when you answered "Yes" on the first page:

	1st person	2nd person	3rd person
How old were you when it happened?	_____	_____	_____
Was it (check one): a 1-time event?	_____	_____	_____
repeated?			
Was the other person male or female?	M___F___	M___F___	M___F___
Was the other person (check one):			
a family member?	_____	_____	_____
a friend or acquaintance?	_____	_____	_____
a total stranger?	_____	_____	_____

5. Do you think the event(s) have changed how you get along with people? Check one:

_____Yes, my relationships have changed a lot as a result.

_____There have been some changes in my relationships.

_____No, the event has not changed my relationships.

6. Do you think the event(s) have something to do with the reason you're coming to see a counselor? Check one:

_____That's the main reason I'm coming for counseling.

_____That's part of the reason, but not the most important.

_____That is not connected with my coming for counseling.

7. If you have already started counseling, have any of the events come up in counseling for discussion?

Yes_____ If yes, did you bring it up? Yes_____ No_____
Did your counselor bring it up? Yes_____
No_____

No_____ If no, was it because you didn't want to bring it up? Yes_____ No_____
Because you're waiting for counselor to bring it up?
Yes_____ No_____
Because you don't feel it is important?
Yes_____ No_____

THANK YOU for your time and effort in answering these questions. Please read the next page to see if you would like to help with the rest of the study. If you decide not to, fold these pages and put them in the large box at the reception desk.

APPENDIX C

INFORMATION SHEET FOR VOLUNTEERS

The rest of the study concerns how people think and feel years later about having been forced to do something against their will. I would like to talk with women who have been in such situations but who did not experience sexual abuse or incest before they were 16 years old.

I would like to talk with two types of women:

1. Those who were raped, 4 or more years ago, when they were 16 or older. (Rape means forced sexual penetration of any body opening.)
2. Those who, 4 or more years ago, when they were 16 or older, were forced or felt threatened with harm (physical or emotional) if they didn't cooperate in some event that was NOT sexual.

If either #1 or #2 applies to you, you can help in the rest of the study. I would meet with you individually to talk about your thoughts and feelings about the event you have in mind. (Our voices would be taped, but your name will not be on the tape and the tape will be stored in a locked place.) I would also ask you to do some pencil and paper exercises. This should take not more than 3 hours of your time. As soon as our meeting is over, any link between your name and the information you give me will be destroyed. The list of participants will be kept confidential.

Talking about such experiences may be painful for you, but you can help me help others who have experiences similar to yours. If you would like, after the study is finished, I could let you and your counselor know what I learn from the study. Because I won't know which answers are yours at that point, I will not be able to give you feedback on your personal answers.

If you are interested in helping with this part of the study, I would like to talk with you briefly today so that we can schedule a time for our interview appointment. Please hold on to the questions you've already answered and ask the receptionist to introduce you to me so we can talk about your being in the rest of the study and I can answer any questions.

If you have decided not to help more, or if the descriptions above do not apply to you, thank you for your time and effort. Please fold your questionnaire and place it in the large box at the reception desk.

Jean Parks, Doctoral Student in Psychology
974-2161
UT Psychological Clinic, 227 Austin Peay Building
University of Tennessee, Knoxville, TN 37916

APPENDIX D

SAMPLE POSTED NOTICE

Help Wanted

How do women feel years later about being forced to do something against their will? To answer that question, I am interviewing women who have experienced rape or nonsexual assault. The study is part of my dissertation research in psychology. It is designed to help counselors better understand and work with such women.

If you were raped or physically assaulted (robbed, mugged, beaten or battered) 3 or more years ago when you were 16 years old or older, and if you did not experience sexual coercion before age 16, you may be eligible for the study.

For more information, call 974-2161 and leave your first name and phone number for "Jean" or write "Jean" at the UT Psychological Clinic, 227 Austin Peay, University of Tennessee, Knoxville, TN 37996.

APPENDIX E

SAMPLE NEWSPAPER ADVERTISEMENT

ATTENTION: RAPE and NONSEXUAL ASSAULT are the focus of my dissertation research. If you are female and were raped or physically assaulted (robbed, mugged, beaten or battered) 3 or more years ago when you were 16 years old or older, and if you did not experience sexual coercion before age 16, you may be eligible for the study. The identities of participants will not be revealed when the findings of the study are reported. For more information, call 974-2161 and leave your first name and number for "Jean" or write "Jean" at the UT Psychological Clinic, 227 Austin Peay, UTK, Knoxville, TN 37996.

APPENDIX F

SUBJECT DATA SHEET

Marital status: Never married___ Married___ Separated___

Divorced___ Widowed___ Remarried___

Employment status: Full time___ Part-time___ Unemployed___

Approximate yearly income (from all sources) $_____

Education: (check highest level) Any grade through the 8th___

Some high school___

High school graduate___

Some education after high school___

College graduate___

How much time has passed since the event you plan to discuss?___years___mos.

How many counselors have you had?___

How much time has passed since you started counseling this time?___months

---

(This lower part will be cut off and stored separately from your other data.)

INFORMED CONSENT

I have read the Information Sheet for Volunteers in the study of forced events. I am volunteering to participate. In signing this form, it is agreed I may withdraw at any time without penalty. I understand my signature and phone number or address will be stored in a locked place separate from the information I have given on the Questionnaire and on the Subject Data Sheet. Ms. Parks will protect my privacy if she has to contact me. If I am not chosen to participate, my Subject Data Sheet will be destroyed and my Questionnaire will be added, without identification, to the other questionnaires.

The investigator (Jean Parks, 974-2161, UT Psychological Clinic, Austin Peay Building, University of Tennessee, Knoxville, TN 37916) agrees to answer questions about the study and procedures. I will sign another consent form before actually beginning the interview session.

I have agreed to volunteer of my own free will.

Date_____ Signature_____

Name (please print)_____

How may the investigator reach you?

Phone #_____ OR Address_____

_____

(If necessary, note the time of day best for me to contact you:_____) _____

APPENDIX G

ALTERNATE QUESTIONNAIRE

1. Age:_____ Sex:_____ Race:_____

2. Has anyone ever forced you to have physical sexual contact against your will? (Check one of the blanks below and follow the instructions.)

   Yes_____ GO TO QUESTION #4.

   No_____ GO TO QUESTION #3.

3. Have you ever been physically assaulted in a nonsexual way?

   Yes_____ GO TO QUESTION #4.

   No_____ STOP. Discuss with the investigator your eligibility for the remainder of the study.

4. Please answer these questions about the event(s) with each person you had in mind when you answered "Yes" to the question above:

	1st person	2nd person	3rd person
How old were you when it happened?	_____	_____	_____
Was it (check one): a 1-time event? repeated?	_____	_____	_____
Was the other person male or female?	M___F___	M___F___	M___F___
Was the other person (check one): a family member?	_____	_____	_____
a friend or acquaintance?	_____	_____	_____
a total stranger?	_____	_____	_____

5. Do you think the event(s) has changed how you get along with people? Check one:

   ____Yes, my relationships have changed a lot as a result.

   ____There have been some changes in my relationships.

   ____No, the event has not changed my relationships.

APPENDIX H

ALTERNATE SUBJECT DATA SHEET

Marital status: Never married_____ Married_____ Separated_____

Divorced_____ Widowed_____ Remarried_____

Number of previous marriages_____

Employment status: Full-time_____ Part-time_____ Unemployed_____

Student status: Full-time_____ Part-time_____ Not enrolled___

Approximate yearly income (from all sources) $_____

Education (check highest level): Any grade through the 8th_____

Some high school _____

High school graduate _____

Some post-high school _____

College graduate _____

How much time has passed since the event you plan to discuss?

_____years_____months

How many children do you have?_____

APPENDIX I

INTERVIEW FORMAT

1. How did you find out about this study?

2. What led you to volunteer for this study?

3. Now that it has been a while, how do you feel about talking about the incident that we will be discussing?

4. What was the incident?

5. How long ago did it happen?

6. So you were about___years old?

7. Had this ever happened to you before? Has it happened since?

8. Were you married then, or dating steadily? If so, are you still involved with him? If not, how many people have you seriously dated since you broke up with him? Is that more or less than you dated during a similar period prior to the incident?

9. With whom were you living at the time?
   With whom did you live for the first 6 months after the incident?
   With whom do you live now?

10. Tell me about the circumstances: (The questions that follow are designed for the rape victims. The comparable questions for the control group will be determined by the nature of the event they report.)

    Where were you?
    What time of day was it?
    Did you know the man?
    If so, what was the relationship?
    About how old was he? Of what race?
    Was there more than one attacker?
    What kinds of things did he say to you?
    What did you do when you realized what he wanted?
    Did he have a weapon?
    Did he make any threats?
    Did he use any kind of physical force or violence?
    What type of sexual contact did he demand?
    What type of sexual contact actually occurred?
    Did you have injuries? If so, what kind?
    Did you report the incident to the law, or seek any kind of medical or emotional help from friends, family or agencies?

11. Did changes occur in your life after the incident? If so, what kind?

12. What was the immediate reaction of the important people in your life?

13. Did changes occur in your relationships with others?
    If so, how did they change with your spouse/partner?
    mother/father?
    children?
    friends: male? romantic?
    nonromantic?
    female?
    work associates?
    Do you feel the incident continues to affect your relationships with any of these people?

14. What kinds of relationships have you had in the past with men?

15. Tell me about your current primary relationships (or your last one if you are not currently involved).

16. How would you rate your current level of sexual satisfaction? (If lack of satisfaction is expressed, ask, What, if any, of your dissatisfaction do you attribute to the incident?)

17. What kind of relationship did you have with your father? Is it different now? In what way?

(If a subject mentions some difficulty with men, and it is not elaborated, ask her if, and how, she connects the difficulty to the assault or rape.)

18. Have others' feelings and attitudes changed toward you? If so, how?

19. Have your feelings and attitudes changed toward others? If so, how?

20. Did the type and frequency of your social contacts change? If so, how?

21. Did you notice a change in the amount of time you spent alone versus how much time you spent with others?

22. Have you ever been in counseling or therapy? If so, when and for how long? Did you perceive the incident as a reason for seeking therapy? Why or why not? Did you discuss the incident with your therapist? Why or why not? If you did, how did you feel about his or her response?

23. Have you been reluctant or eager to talk about the incident? Why? What kinds of responses do you expect to get from others? What kinds of responses have you gotten?

24. How has this incident been consistent with or different from the general pattern of your life?

25. Have you seen changes or phases in how you have dealt with the event over time?

26. Can you think of any positive changes in your life due to this event?

27. Are there any other changes in your life that you think are connected with the event?

28. When you think about the event, and your life as a whole, do you feel totally recovered, mostly recovered, partially recovered, or not recovered at all?

Note: The above questions provide the basic outline of the interview. The order of the questions may be varied to follow a natural flow the individual subject and interviewer may establish. If a subject introduces other areas of concern, the interviewer may pursue these with appropriate questions. Subjects will be free to refuse any question or topic area.

APPENDIX J

INFORMED CONSENT

The purpose of this study is to learn how women think and feel years later about experiencing a coercive event. A coercive event is one in which a person is forced to do something against their will. The investigator will talk with two groups of women, those who have experienced a coercive sexual event and those who have experienced a coercive event that was not sexual.* The investigator hopes that the information gathered will provide clues for helping people who have similar experiences.

Each subject will be asked to complete three pencil and paper exercises. The first provides personal data for statistical purposes. (This is the Subject Data Sheet you completed when you volunteered.) The second exercise concerns your view of yourself and of several groups and individuals, including a male and female you will see on videotape. The third exercise involves marking the problems you had when you started counseling and the ones you have now.

Each subject will also be asked to participate in a one-to-one interview that will last about 45 minutes. The interview will cover topics related to the coercive event you experienced and the effect it had on your life. The interview will be recorded on audio cassette tape for data collection purposes later. You may ask not to discuss a topic at any time. Discussing your experience may be helpful to you and may give you some ideas you would like to bring up with your counselor.

Strict confidentiality will be maintained throughout the study. Once you have completed the pencil and paper exercises and the interview, any connection between your name and your data will be destroyed. The names of the participants will be stored separately from the data in a locked place. Results from the study as a whole will be available to you and your counselor or for publication. The audio tapes will be kept in another locked place and will be available only to this investigator and to two independent raters, to whom you will remain anonymous. The audio tapes will be destroyed after the project is completed. Should this investigator be required to cooperate with legal authorities, there will be no direct connection between you and the information you will have provided to me.

I hope you will feel free to ask me questions about the study before you begin or at any time during the procedure. Remember, you may withdraw from the study at any time without penalty.

Jean Parks, Doctoral Student in Psychology
974-2161 or
UT Psychological Clinic, 227 Austin Peay
University of Tennessee, Knoxville, TN 37916

I have been informed of the nature of this study and I agree to participate of my own free will.

Date_____ Signature_____

*Interviews were not conducted with the second group due to the lack of volunteers.

APPENDIX K

ALTERNATE INFORMED CONSENT

The purpose of this study is to learn how women think and feel years later about experiencing a coercive event. A coercive event is one in which a person is forced to do something against his or her will. The investigator will talk with two groups of women, those who have experienced a coercive sexual event and those who have experienced an assault that was not sexual.* The investigator hopes that the information gathered will provide clues for helping people who have similar experiences.

Each subject will be asked to complete four pencil and paper exercises. The first provides personal data for statistical purposes. The second concerns the coercive event you have identified. The third exercise concerns your view of yourself and of several groups and individuals, including a male and female you will view on videotape. The fourth exercise involves marking the problems you have now and the ones you have had in the past.

Each subject will also be asked to participate in a one-to-one interview that will last about 45 minutes. The interview will cover topics related to the coercive event you experienced and the effect it had on your life. The interview will be recorded on audio cassette tape for data collection purposes later. You may ask not to discuss a topic at any time. While discussing your experiences may be painful to you, it may be helpful to yourself and others. If you wish, I will be happy to discuss a counseling referral; however, you would be responsible for the cost of any counseling you obtained.

Strict confidentiality will be maintained throughout the study. Once you have completed the pencil and paper exercises and the interview, any connection between your name and your data will be destroyed. Not even I will know who has supplied what information. The signed consent forms of participants will be stored in a locked file separate from the data. Portions of the tapes may be transcribed to facilitate data analysis. The written portions and the tapes will be stored in a locked cabinet and will be available only to this investigator and to two independent raters, to whom your identity will remain unknown. Results of the study will be reported in such a way that no individual participant could be identified.

I hope you will feel free to ask me questions about the study before you begin or at any time during the procedures. At your request, I will be happy to inform you of the results of the study once the research is completed. You may withdraw from the study at any time without penalty.

Jean Parks, Doctoral Student in Psychology
974-2161 or
UT Psychological Clinic, 227 Austin Peay
University of Tennessee, Knoxville, TN 37916

I have been informed of the nature of this study and I agree to participate of my own free will.

Date_____ Signature_____

*Interviews were not conducted with the second group due to the lack of volunteers.

APPENDIX L

INFORMED CONSENT FOR COMPARISON GROUP

Informed Consent

To contribute to the understanding of the use of personality tests in psychological research, you are being asked to complete a pencil and paper test, the Interpersonal Adjective Check List (IACL). It involves reading and checking adjectives that apply to yourself and to the individuals and groups you will be asked to describe, including characters on videotape. The tape, which was developed for this study, depicts University of Tennessee-Knoxville psychology graduate students engaged in casual conversations as they wait to see a professor. The IACL has been used frequently for treatment and research purposes and the risk to subjects has been found to be negligible. Your instructions will be slightly different from the conventional instructions and you will be viewing the brief videotapes. It is not expected that these additions to the procedures will create any risk for you. In the unlikely event that you should become upset for some reason during the testing, you are urged to notify the Experimenter and to talk about your feelings. You are free to withdraw from participation at any time without penalty.

The Experimenter (Jean Parks, K-204 3500 Sutherland Avenue, Knoxville, TN 37919, 974-2161 or 584-7652) will answer any questions about the test or procedures. If the answer might prejudice your responses, the question will be answered after you finish the test. You will not be able to get feedback on the results of your test. Your name will not be associated in any way with your answers.

I have heard the oral introduction and I have read the above statements. I agree to participate in the study.

Date_____ Signature_____

APPENDIX M

DECISION MAP FOR SCORING SIGNIFICANT STATEMENTS

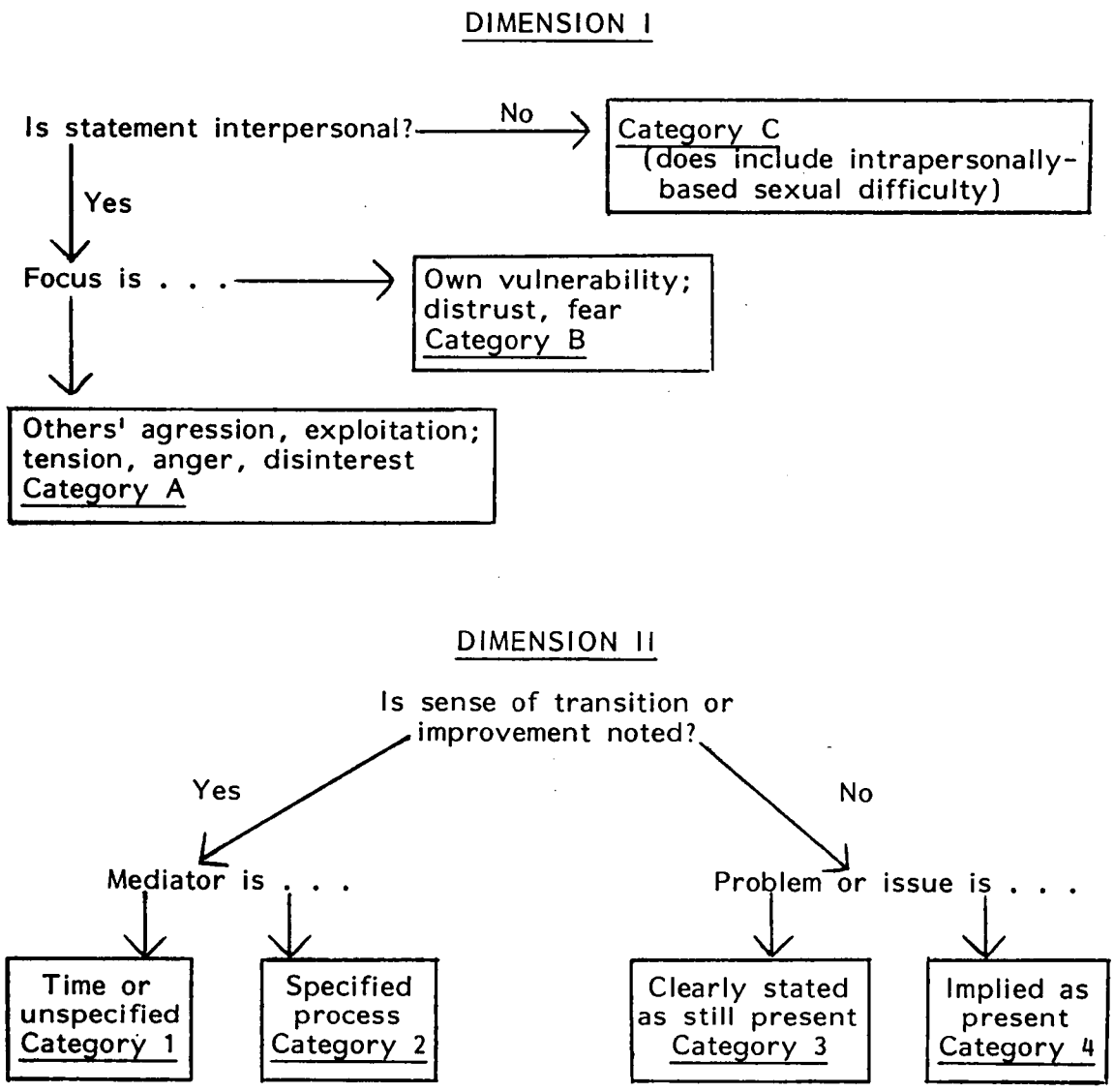

Figure M-1. Decision map for scoring significant statements.

APPENDIX N

COMPARATIVE RATINGS BY CATEGORY--DIMENSION I

Investigator

Rater 1 \ Investigator	A	B	C	AB	AC	BC	ABC
A	12	2	1	1	1		
B		12		2			
C	2		29			2	
AB				2			
AC							
BC		1	2				
ABC			1				

Investigator

Rater 2 \ Investigator	A	B	C	AB	AC	BC	ABC
A	7	2					
B	3	8		4			
C	3	2	33		1	1	
AB		1		1			
AC	1					1	
BC		2					
ABC							

Rater 1

Rater 2 \ Rater 1	A	B	C	AB	AC	BC	ABC
A	7	1	1				
B	4	9		2			
C	4	2	31			2	1
AB	1	1					
AC	1		1				
BC		1				1	
ABC							

Figure N-1. Comparative ratings by category--Dimension I.

APPENDIX O

COMPARATIVE RATINGS BY CATEGORY--DIMENSION II

Investigator

Rater 1	1	2	3	4
1	21	3	1	
2		11		
3	1		8	1
4		4	3	17

Investigator

Rater 2	1	2	3	4
1	20	1	1	1
2		14		
3			9	2
4	2	3	2	15

Rater 2

Rater 2	1	2	3	4
1	20		2	1
2	2	11		1
3	1		8	2
4	2			20

Figure O-1. Comparative ratings by category--Dimension II.

APPENDIX P

INDIVIDUAL RESPONSE PATTERNS

Subject #1

This subject was primarily self-focused. She feels she's improved over the course of time and did not describe any process which she felt mediated her improvement. She does have some persistent distrust and awareness of her own vulnerability which she attributes to the rape.

Subject #2

The residual effects this subject described were evenly spread over all three categories, from increased awareness of others' potential to harm one to self-focused issues, and included increased distrust and awareness of her own vulnerability. She felt time had helped some, particularly in the decrease in her initially heightened reactivity to others. She is aware of some aspects of working through the effects, yet is also aware of persistent problems in all areas (from other-focused to self-focused).

Subject #3

This subject was primarily self-focused and feels the passage of time has brought considerable relief. However, the sensitivity to others' potential for aggressiveness and exploitiveness which she did express persists with no sign of abating.

Subject #4

This subject described the full range of effects from all three categories. Those which were self-focused have gotten better with time. She has a sense of having worked through some of her heightened awareness of the potential of harm from others and her distrust, but in general, those issues continue to persist for her.

Subject #5

This subject's concerns were primarily self-focused, although she was also acutely aware of her sense of vulnerability and distrust. An overwhelming proportion of her statements reflected some sense of recovery. About half included a reference to a specific process she felt had mediated her progress while the other half referred to no mediator other than time.

Subject #6

The sixth subject was primary self-focused. She noted improvements in some of these areas due to time or to a specified process yet other areas continued to be troublesome. Although she made few statements concerning her perception of the dangerousness of others or concerning her own vulnerability, these issues were consistently viewed as persistent, having shown no improvement over time.

Subject #7

The full range of effects were presented by this subject in approximately equal proportions. She cited improvement in all areas, some with the passage of time, but primarily through specified processes. Those few problems she feels persist had to do with feelings of distrust and vulnerability.

Subject #8

This subject's primary concerns were in the areas of her own distrust and vulnerability in relation to others and of self-focused issues. She feels the effects in both areas persist and she noted only minimal improvement on some of her noninterpersonal issues.

Subject #9

This subject was primarily self-focused and she explicitly stated that the effects persist. She voiced minimal acknowledgment of increased sensitivity to the potential harmfulness of others.

Subject #10

This subject's attention was evenly divided between her awareness of potential harm by others and her self-focus. She described some improvement and some persistent effects in both areas.

APPENDIX Q

LEARY CLASSIFICATION OF INTERPERSONAL BEHAVIOR

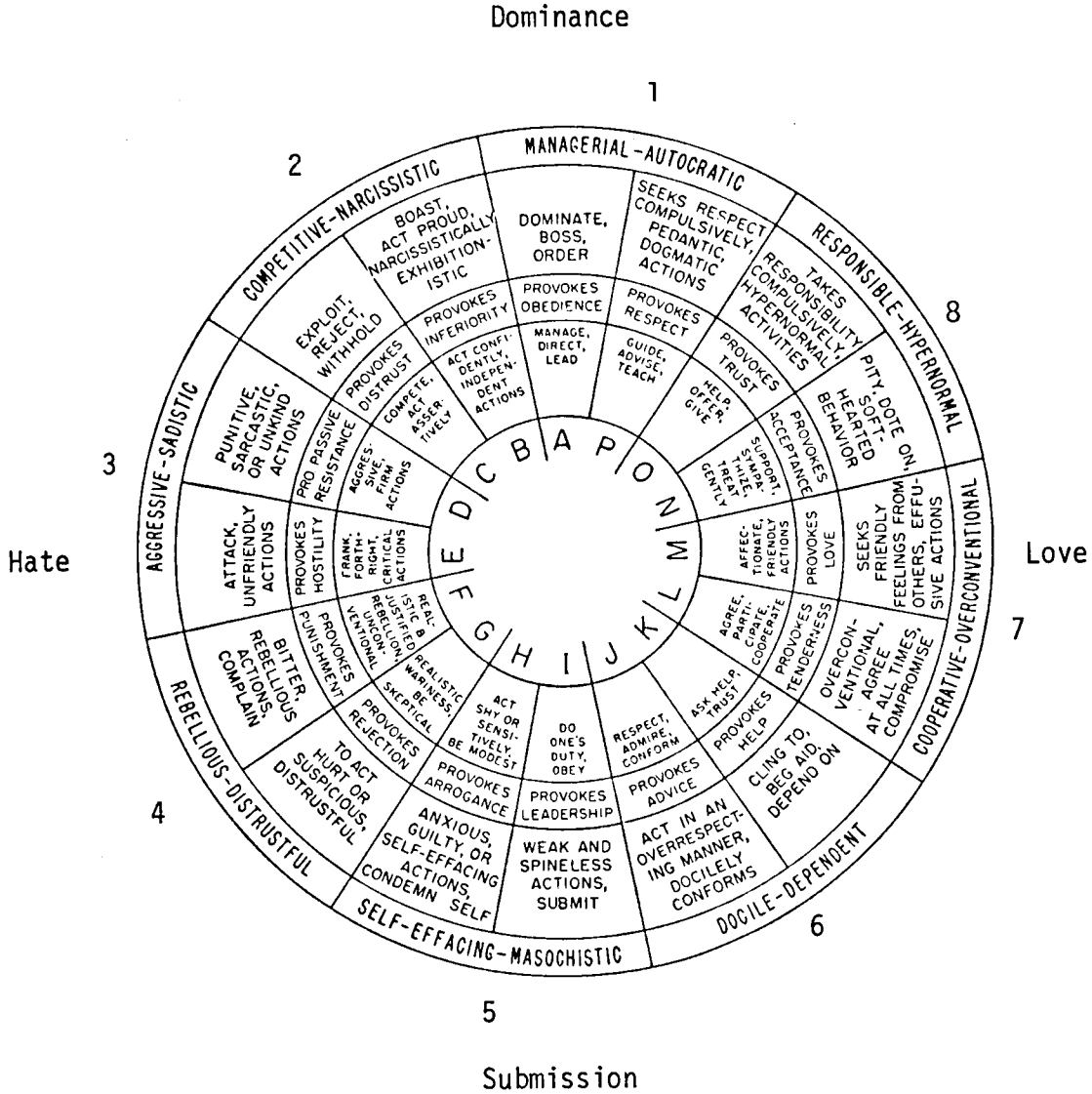

Figure Q-1. Leary Classification of Interpersonal Behavior.

Source: From Interpersonal Diagnosis of Personality (p. 65) by T. Leary, 1957, New York: Ronald Press. Copyright 1957 by T. Leary. Adapted by permission.

VITA

Madelon Jean Parks was born on January 9, 1955, to Ross L. and Elizabeth M. Parks in Asheville, North Carolina. She attended public schools in Buncombe County, North Carolina, and in Pensacola, Florida, and was graduated from Decatur High School, Decatur, Alabama, in 1973. In 1977 she received her Bachelor of Arts degree in psychology from Davidson College, Davidson, North Carolina. She worked as a houseparent for a year at Barium Springs Home for Children, a home for adolescents with behavior problems. She entered the doctoral program in clinical psychology at the University of Tennessee, Knoxville, in the fall of 1978 and was granted her Ph.D. in August 1984. She completed the predoctoral clinical internship sponsored by the University of Texas Health Science Center at San Antonio.