Office Counseling of Rape Victims

Jo Matheny, MD, and Philip J. Michels, PhD
Columbia, South Carolina

DR. JO MATHENY *(Senior Resident, Department of Family Medicine)*: Today we are meeting to discuss the family physician's role regarding rape victims, with an emphasis on intervention. Dr. Michels will begin with the case.

DR. PHILIP J. MICHELS *(Clinical Psychologist, Division of Behavioral Medicine, Department of Family Medicine)*: I have been seeing a 30-year-old woman for individual psychotherapy on a weekly basis for over 2 years. The patient has never been married and has been living alone, working as a cashier.

Near the end of the first year of treatment, the patient reluctantly confided (in writing) that she had been raped in her apartment by a young customer who had followed her home after work. The patient reported that she was petrified to inform her family because of their often unpredictable responses. Instead she went to the police. The patient went on to say that the detective with whom she discussed the case seemed to take a prurient interest in the details of the event and implied that the patient herself was culpable. To what extent the patient's emotional status had colored her conclusion is difficult to assess.

In any event, the trauma of the rape and the perception that the policeman was unsympathetic to her complaint were instrumental in the patient's very poor adjustment. She describes continued fear, mistrust, and helplessness when trying to relate to men. As an example, until recently she has remained guarded and protective during our office visits.

Despite holding down a job, she has become generally confused and, at best, ambivalent regarding her interactions with others, especially men. She is predictably unassertive and has a reluctance to get involved. Such submissiveness, which symbolizes a perceived loss of control resulting from the rape, is driven by her combination of fear and helplessness.

While previous personality factors have contributed to her dysfunctional lifestyle, the disclosure and subsequent discussion of the rape have opened new opportunities to mend her misperceptions of others. The supportiveness of psychotherapy, the reliving of memories, and the diffusion of feelings connected with details of the event have had a considerable therapeutic effect.

DR. MATHENY: Dr. Michels, is it common for patients to conceal information about being raped?

DR. MICHELS: Reluctance to report rape is common. Many rapes are not immediately reported to the police or the emergency room because of fears of retribution by the assailant, public humiliation, or shame to one's family, and many victims do not follow up with therapy.[1] The victim may later see a physician for venereal disease, pregnancy, or symptoms associated with poor adjustment. Actually, the rate of follow-up visits improved from 8% to 86% when victims were offered follow-up in a family practice clinic.[2]

DR. MATHENY: What was this patient's immediate response to the rape, and how might it compare with a victim's typical reaction?

DR. MICHELS: Her recalled response included curiosity, shock, confusion, fear, anger (including physical resistance), and supplication. Because of the wide variation of responses to rape, there may be no typical reaction. Burgess and Holmstrom[3], however, have described a "rape trauma syndrome." The initial phase of overwhelming shock occurs during pressure to make legal decisions, deciding whom to tell, and whether to use antipregnancy medication. The victim may feel guilty about the rape and wonder repeatedly whether it could have been prevented in some way. Our patient's reaction is an excellent example of this response. There can be global anxiety, or specific fears regarding being alone, being out of doors, or relating to groups of people characterized by race, sex, and so on. Feelings of anger are variable. Anger may be transformed into self-blame, which is supported by cultures that expect compliance and passivity in women. Identification with the aggressor resulting from a need for safety may make it more difficult to express one's anger.[4,5]

Burgess and Holmstrom[6] describe an "expressive style" with outward anxiety, fear, labile affect, or hysteria, and a "controlled style" with suppressed emotions and withdrawn behavior. This latter behavior fits that described of our patient.

DR. MATHENY: Essentially, the woman's sense of au-

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From the University of South Carolina-Richland Memorial Hospital Family Practice Residency Program, Columbia, South Carolina. Requests for reprints should be addressed to Dr. Philip J. Michels, Family Practice Center, Five Richland Medical Park, Columbia, SC 29203.

tonomy has been violated, which induces a profound feeling of general helplessness, loss of control over one's environment, and a loss of faith in others. Psychosomatic complaints and vegetative symptoms may also be seen deriving from an unrelenting fear concerning the unpredictable hostility of one's world.[7] Dr. Michels, please continue the phases of adjustment.

DR. MICHELS: Yes, Sutherland and Scherl[8] describe a second phase, outward adjustment, when the victim uses defense mechanisms such as denial, suppression, or rationalization. The victim suppresses her feelings in an effort to return to usual activities under the misguided assumption that she can "forget about it." The patient we are discussing appeared to have depression, and then acted out her guilt over the event in brief, superficial encounters with other belligerent men. Such pathological reenactments of earlier trauma have been shown in a variety of conditions and situations in relationships.

The final phase of coping involves the reintegration of self-concept dealing with feelings toward the assailant and dealing with generalized fears and anxieties.[3,8] Recurring memories of the event or nightmares may be quite disturbing. There may be depression. The victim will often feel a need to talk during this phase. Some women enter a period of action in which they take precautions such as moving to a new location, taking a new job, or strengthening the security of their home.

DR. JAMES EBERSOLE *(Director and Chairman, Department of Family Medicine)*: This process actually takes place over years, with a succession of crises and adaptations. Surprisingly, the ego concept may be strengthened over time.[9] In fact, in one study almost one half of the victims reflected an overall personality maturation attributed to rape. Significant residual effects remained in others, however. After 12 to 18 months, those patients reported a pervasive suspiciousness of others (76%), sexual difficulties (51%), fear of being alone (49%), depression (41%), fatigue (39%), sleep disturbances (24%), and lack of concentration (24%).[10] The family physician often sees the victim for complaints such as these at a time remote from the actual rape.

DR. MATHENY: One valid clue suggesting a history of rape is a generalized disturbance in all relationships with men, as is clearly the situation with our patient. As many as 25% of women in one sample avoided any further sexual relationships.[11] Even after 4 to 6 years, only 74% of rape victims reported feeling "recovered" from the side effects of rape.[12] Dr. Ebersole, can you tell us what factors affect psychological recovery after rape?

DR. EBERSOLE: Poor prognostic signs include a background of repeated victimization in the past, minimal psychosocial support, negative self-esteem, and a history of maladaptive responses such as alcohol, drug abuse, or suicide attempts. Chronic life stressors such as poverty or illness also play a part. Outcome can be affected negatively by the circumstances of the incident such as interracial rape, multiple assailants, location of the attack (eg, in a supposedly protective environment), and other sexual demands of the rapist.[3] Regarding our patient, lack of social support, negative self-esteem, and the policeman's perceived response to her complaint impeded improvement and encouraged the noncommunication about her trauma.

DR. MATHENY: Dr. Michels, how significant was the policeman's reaction to the patient's story?

DR. MICHELS: By her appraisal, his conduct was very significant. The patient's view of a safe and civilized environment was jeopardized by the incident and the protector's alleged counteraggressive lack of empathy. She reported that his failure to believe her intensified her feelings of fear and helplessness.

DR. MATHENY: Dr. Ebersole, what factors aid in recovery?

DR. EBERSOLE: Factors aiding recovery include strong family support, positive self-esteem, effective communication skills, adaptive defense mechanisms such as sublimation, cognitive control (eg, "I don't dwell on it"), and such positive actions as moving to another area, or writing about rape.[3]

DR. MATHENY: Generally, how can physician counseling aid in recovery?

DR. MICHELS: The patient's disclosure about the event can be the beginning of positive social support. To encourage such disclosure, the family physician should provide a caring and empathic relationship with the patient. Open-ended questions about the patient's personal life offer added opportunity.

The crisis model is probably discussed most in rape therapy. A supportive style is beneficial in the early stages. The victim shouldn't be forced to deal with her feelings until she expresses readiness to do so. Anticipatory guidance will warn of the stresses and feelings likely to occur in each phase.

A discussion of the patient's behavior and coping mechanisms during the attack is helpful. With our patient it is essential that she be freed from feeling guilty about her victimization and that she recognize that her rationalizations and suppressions have not been helpful. Rather, encouraging a problem-solving approach where a patient is in charge enhances self-esteem and self-confidence.

It is helpful to explore the victim's present life circumstances and how the rape is affecting present relationships, job performance, generalized fears, moral and spiritual attitudes, and possible physical complaints. Focusing on reality while alleviating unrealistic or irrational concerns is the goal. Emphasizing available choices allows the patient to reestablish control over her life.

In a later phase of reaction to the rape, physical symptoms may occur, or feelings of isolation or depression may be verbalized. Treatment goals are aimed at some symptomatic relief (eg, relief of insomnia) through careful use of medication and sound counseling intervention. Use of medication can falsely legitimize the physical nature of the complaint and make the patient either dependent on medication or less willing to deal with her problems through psychological means.[4]

Sometimes an event such as involvement in court serves

as a reminder of the rape, temporarily precipitating personality decompensation. The physician should deal with the current issue first, placing it in perspective with past events.

DR. MATHENY: What should the physician do if the patient chooses to discontinue counseling midway in her rehabilitation?

DR. MICHELS: Following initial readjustment, victims will often choose to discontinue counseling. In acquiescing to the patient's choice, the physician should also reassure the patient that a counselor will be available, if needed, in the future. Patients should also be informed that these problems may recur, and that recurrence is normal. Two days following the disclosure of rape information by my patient, she contacted me stating that she felt "funny." When attempts were made to specify her condition, she remained vague. Clearly her call was motivated by a need for reassurance that I was available.

DR. MATHENY: There is naturally much patient anger. How would the family physician cope with that?

DR. COLLIN BAKER *(Professor, Department of Family Medicine)*: It is most important that the person recognize it. Anger may be masked in many forms, such as anxiety, hopelessness, or guilt, as is evident in this case. Guilt may be exacerbated further by the assailant, society, her family, or by a court hearing. The patient needs to direct the anger away from herself. She can be shown the dysfunctional aspects of suppressing anger, following discussion of the feelings involved. Discussion may be quite effective in diffusing these feelings.[4]

DR. EBERSOLE: Another counseling consideration involves the loss model, which emphasizes the patient's loss of security, identity, control, and perhaps even important relationships with family and friends. This approach can explore the options in a problem by addressing specific questions, such as, "What will it take for you to feel safe?" The consequences of her actions can be tested: "If you had fought harder, what would have happened?" Concepts of sexuality can be explored: "Are all men really the same?" or "What does it mean to give up all relationships?"

DR. MICHELS: I am using this approach currently with our patient.

DR. BAKER: Behavioral therapy can be used for specific phobias. For example, systematic desensitization with relaxation can be used to treat fear related to going out alone.[13] The relaxation response, which is thought to be incompatible with fear, is practiced in the physician's office or when alone. The scenes can be verbalized on an audio tape recorder or visualized in the patient's imagination. In either case, the state of relaxation is induced first.

Eight to ten stressful events are listed by the patient in order of stressfulness. Examples of mild fear-arousing situations might be "putting on one's coat" or "being alone at night." A more stressful event might be "walking alone down the street." Then the patient imagines performing each act from the least to the most fear-arousing environment. When fear is aroused, the patient stops picturing the scene and returns for several minutes to a state of relaxation. Then she begins with an earlier, less disturbing picture on her list and again works up to the more disturbing scenes. She then stops to relax each time fear is produced. These exercises are practiced daily in this way until the patient can go through the entire list without fear.

Hypnosis by those experienced in its use can be used for reduction of anxiety and to induce relaxation.[14]

DR. MATHENY: Group therapy is quite valuable in treating rape victims, especially those with obsessive-compulsive tendencies, depression, anxiety, hostility, and somatic complaints. Group therapy has also been used together with thought stopping. A victim is instructed to say "stop" to herself each time she becomes aware of the presence of a disruptive thought.[15,16]

Has family therapy been shown to be helpful with rape victims?

DR. BAKER: Family members or significant others can be included, depending on the patient's preferences. Supportive families should be aware of the stages of adjustment for the victim, and they may need individual therapy to better handle their own feelings. Each member's attitude positively or negatively influences the victim's self-perception and can vitally affect her recovery.

DR. EBERSOLE: A husband or father often feels both rage and helplessness following the attack on a woman whom he was expected to protect. He may then become overprotective, or he may express anger at her for allowing this assault to happen. Both expressions are related to the protector's guilt. Moreover, a husband may avoid sex entirely or may urge it too soon, thinking "the first thing you do when you fall off a bike is to get back on it." The wife may interpret the avoidance as rejection or his advances as repeated rape.

Complex sexual difficulties may arise from the husband's own rape fantasies or from beliefs about his wife as "used merchandise." Such trauma may even evoke a breakthrough of covert homosexual impulses. For all these reasons a husband's involvement in treatment is therapeutic.[10]

DR. MATHENY: Does being a male physician influence the physician's attitude toward therapy?

DR. EBERSOLE: Usually not. In the emergency room, male and female counselors do not differ significantly either in their descriptions of their own feelings or in terms of treatment recommendations. Women therapists rate rape victims as more functionally impaired, however, than do their male counterparts.[17] Perhaps these women are more sensitive to the victim's distress or are better able to identify with the psychic trauma.

DR. MATHENY: What about countertransference? Does it interfere with successful therapy?

DR. MICHELS: As a whole, counselors are advised to become aware of their own attitudes toward rape, including their stereotypes and prejudices. Professionals often share the common public image of the rape victim as a young attractive woman who exposes herself to avoidable danger or accuses a man of rape to save herself from criticism.

These myths persist despite the finding that apparent precipitation of rape occurred in only 4.4% of rape cases, while homicide is provoked in 25% of cases and armed robbery in 6%.[18] Such misunderstanding may also follow from rape occurring at home, as happened here. Yet, rape most commonly occurs in one's neighborhood or within one's own home.[18] Correcting this misunderstanding assists the counselor toward more empathic listening and motivation to help.

DR. MATHENY: From any effective counselor, warmth, unconditional positive regard, caring, consistency, and being nonjudgmental are required. We need to recognize rape as an act of aggression rather than as a sexual act. In fact, one third of rapists experience erectile or ejaculatory dysfunction during the assault. Rape is a manifestation of anger that the rapist cannot directly express. Rape increases his feelings of power.

For the woman it is a life-threatening situation. Between 21% and 59% of assaults are accomplished by the use of weapons, although threat of harm and use of force are sufficiently stressful in themselves.[19] Dr. Ebersole, what agencies are set up to handle such trauma?

DR. EBERSOLE: Many major centers have established crisis intervention teams that are available around the clock for counseling and advocacy.[3,11,20] The medical needs of the victim are well understood, and most emergency departments have their own protocol to cover the treatment of injuries, legal documentation, sexually transmitted disease, and pregnancy prevention. In some cases the rape counselors go to court with the victim and remain available for later needs.

These programs have proved useful in helping the individual cope on a long-term basis. Information is available regarding setting up such a program. Yet despite these resources, the family physician, accessible and easily identifiable, is likely to be consulted for early intervention in the emergency department, on call, or in the office.

DR. MATHENY: At what point should a psychologist or psychiatrist become involved?

DR. EBERSOLE: The patient should be referred if (1) she is unable to function in occupational or social routines, (2) she suffers a psychotic break lasting beyond a few days, or (3) she suffers persistent phobias. The physician who encounters persistently negative countertransference or whose insecurity regarding counseling is troubling should also consider referral. Finally, group therapy with other victims is very helpful and should be utilized when available.

DR. MATHENY: At this point we have covered the reactions of the majority of female victims of rape. But there are additional implications for the divorced or separated woman, especially if she had previous feelings of inadequacy or guilt. Following rape, these feelings are compounded, and she may question her ability to function independently or lose her confidence in herself as a mother. She must decide whether or when to tell her children about the rape and advise them how to manage the problems if their schoolmates or others in the community are aware of it.

For the middle-aged or older woman, concerns about independence and control can be critical. It is a common misconception that such a woman has less to lose than a younger woman. Feelings of worthlessness, shame, and self-devaluation are still significant.[10]

The family physician may be the easiest person in whom to confide and can promote recovery by following the intervention strategies discussed here. The continuity of the relationship can provide unique opportunities for success. The time commitment per patient visit is not necessarily large. Such meaningful investment can provide a sense of satisfaction in seeing the victim regain her ability to function and her self-confidence.

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