

CONSIDERATIONS IN THE PROVISION OF

ADEQUATE PSYCHOLOGICAL CARE FOR

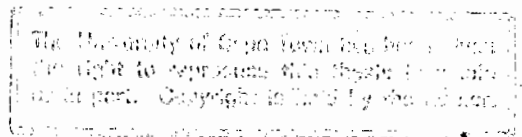
THE SEXUALLY ASSAULTED WOMAN

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of the requirements for the degree of
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ABSTRACT

In providing a guide for the use of lay counsellors or professional helpers in assisting the sexually assaulted woman, the importance of understanding the social context in which the assault occurs is emphasised as fundamental in aiding the woman to recover with minimal after-effects in a relatively brief time. The subjective experience of the woman is described, attention being paid to the wide range of sexually assaultive experiences which can occur, with varying effects. The two main elements involved are intimidation (or violence) and bodily intrusions with sexual connotations, in varying combinations.

Using the crisis intervention model as framework because of its accessibility to a wide range of helpers, and its relevance to the acute stress reaction following assault, the psychological effects and practical issues which affect the woman and her important social support networks are outlined.

The therapeutic intervention is described, paying attention to helper-related issues, the problems of the woman herself and the likely problems for her significant others. The aim is to facilitate the woman's resumption of pre-crisis levels of psychosocial functioning by providing appropriate supportive understanding, anticipatory guidance and practical information, and facilitating the woman's own adaptive strategies, making use of all available resources, to maximise her recovery potential.

Situations in which crisis intervention strategies are inadequate are described to enable the helper to make decisions regarding referral of the woman for more skilled and intensive therapeutic intervention; this too, must take cognisance of the social context of sexual assault.

Recommendations are made regarding further research, and the development of existing, and of new facilities to aid the sexually assaulted woman and to reduce the incidence and traumatic after-effects of these encounters. Finally, case material is appended to illustrate the themes discussed.

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I N T R O D U C T I O N

1. INTRODUCTION

1.1 Aim

The aim of this dissertation is to provide a guide for the use of lay counsellors and members of established helping professions, for the appropriate counselling and therapy of the adult female victim of rape or sexual assault in South Africa. Using a crisis intervention model as framework, the available literature is reviewed regarding the acute stress reaction and long-term effects of sexual assault. The psychological and practical concerns of the assaulted woman are outlined. Where relevant, there is amplification to the situation in South Africa. A summary follows of issues of therapeutic concern in providing adequate care in the crisis period. The woman who does not recover her prior level of functioning after the crisis phase is discussed with a view to providing more adequate later care and indications for referral in cases requiring more skilled, intensive psychotherapy will be outlined. Recommendations will be made for the development of existing facilities, and for the improvement of conditions in South Africa which exacerbate the psychological effects of sexual assault. Finally, case material will be appended to illustrate the problems and issues which have been discussed.

1.2 Definitions

1.2.1 Sexual assault

Much of the literature on which this dissertation will draw concerns rape, as legally defined, and the effects of 'forcible rape' on women who are victimised. However, it is felt that the narrow legal definition of rape plays a disproportionate role in the mind of the public and in attitudes often encountered in the

professions (King et al, 1978). In fact, working within the confines of the legal definition is likely to be detrimental to the helping process. Furthermore, it is held that the effects of sexual assault, broadly defined, follow a pattern which is very much as is described for forcible rape. Thus it will be argued in this section that, for our purposes, a social definition of rape is more useful and, to make this point more explicit, the term sexual assault will be used.

✓ According to South African criminal law "rape consists in intentional unlawful sexual intercourse with a woman without her consent" and the essential elements, according to Hunt (1970) are (a) mens rea, (b) unlawfulness, (c) sexual intercourse with a woman, (d) without consent. The 'deliberate intent' (mens rea) must apply to each of the other elements.

The understandable wish of the judiciary to protect the accused from a miscarriage of justice reflects only part of the legal picture. There is an emphasis on the sexual aspect of such an assault and the key issue then becomes one of whether or not the assailant(s) truly believed that the woman had consented. For conviction, "X must foresee the possibility that Y is not a consenting party, yet proceed with intercourse. If he genuinely believes that Y consents, then, even though his belief is unreasonable, he lacks mens rea. Usually such a mistaken belief will be attributable to Y's conduct, active or passive, but this is not essential". (Hunt, 1970, p.402).

Rada (1978) has put the situation very clearly:

"Carnal knowledge of a female by force and against her will implies a physical action (penetration), a social psychological exchange (force), and a psychological state (against her will) as these are culturally interpreted (by a court)" (p.69). He points out the difficulties involved in combining criteria from various non-articulated levels of analysis, not all of which are equally useful.

"Rape is an example of a class of behaviour, but which class? Is it an example of sexual behaviour, of violence, or of male-female relations? Obviously, it is an example of all three of these..." (p.69).

The term rape denotes seizure or taking by force and has a clearly predatory overtone. In broad socio-cultural views this has been described as the logical extension of the value system which, in recognising the authoritative role of men in the sociopolitical power structure, also perceives women as property, in various senses, (Brownmiller, 1975; Clark and Lewis, 1977; Pepitone-Rockwell, 1978; Smart and Smart, 1978). These factors appear to underpin the legal definition.

The South African legal situation is not different from others widely criticised (in the U.S.A., Canada, Australia and elsewhere) in the past decade because of the paradoxical position in which the assaulted woman complainant is placed. Unlike common assault, or assault with intent, in which it is the accused's intention which is at issue, in the situation where the charge involves rape, attempted rape or indecent assault (i.e. "sexual" acts), having already undergone a traumatic experience of a particularly personal and humiliating type, the complainant (a witness for the

State) is required to undergo an exhaustive interrogation when she seeks legal redress. This hinges on the corroboration rules* which apply in "sexual" crimes and on possible defence pleas that the woman consented to the act.

Conservative stereotypical ideas of male-female sexual relations (Brownmiller, 1976; Clark and Lewis, 1977; Smart and Smart, 1978) and prejudiced views of women's position relative to men in society (Barnett, 1976) are exemplified. Also involved is the questionable view that false accusations made by neurotic or malicious women against innocent men are commonplace - with the result that arrest and conviction rates are low and victim's accounts are discredited, and the woman, already traumatised by the assault, undergoes further stress (Chappell, 1976; Facer, 1977; Jackson, 1977; Waller, 1977; Weis and Borges, 1973).

There have been many criticisms of the legal definitions which fall into this model because they reflect limited understanding of the nature and consequences of sexual assault, and because of the difficulties which the woman is likely to undergo if she makes a report, (Barnett, 1976; BenDor, 1976; Bowden, 1978; Harris, 1976; MacKellar, 1975; Scutt, 1979; Weis and Borges, 1973; Wood, 1973). As a result of criticism, in various parts of the U.S.A., and Australia, and in England, the law has been modified (see the bibliography in Feild and Barnett, 1977; Waller, 1977).

The social definition of rape as sexual assault places it in a broader context of a range of assaultive behaviours with sexual implications. This allows a stronger emphasis on the range of subjective experience involved, and on the

* calling for evidence additional to the complainant's testimony.

victim's report (Klemmack and Klemmack, 1976). Narrow definitions of sexual assault take no cognisance of the variety of manifestations possible, nor of the multiple functions and complex motivations which underlie these acts, (Cohen et al, 1971; Rada, 1978).

For the purposes of this discussion, legal definitions of rape, attempted rape and indecent assault will not be used. The focus of interest is the subjective experience of the person who is forced or coerced through intimidation to submit to a physical, bodily intrusion with sexual connotations, since it is held that, although this can take a variety of forms, the psychological effects will be largely similar, although they may differ in degree to some extent. Thus the following will be included: situations where oral or anal penetration or attempted penetration occur, instances where artificial instruments or parts of the body other than the penis are introduced into the victim's bodily orifices, or situations where there is a forcible removal of clothing and underclothing, exposing areas of the body which the victim regards as private and personal - wherever this is done against the victim's wish using fear-inspiring tactics or violence.

1.2.2 Population under discussion: women

It is held that all encounters between males and females are likely to be marked by the dissimilarity of gender-linked roles, or 'sexual scripts' (Abelson, 1976; Gagnon, and Simon, 1973; Laws and Schwartz, 1977; Levin, 1975; Lloyd and Archer, 1976). Traditionally, male socialization involves associational ideas between sexual prowess, power, domination and status. Female socialization tends toward the perception of sexual encounters as taking place within a network of strong emotional links, socially supported and built up over time with

a particular partner (Weitz, 1977). Females are socialised to be aware of their vulnerability - to be aware of the possibility of male aggression and sexual predation, and it is frequently said that rape threatens the physical and psychological security of all women (Harris, 1976; Horney, 1967; Seiden, 1976).

This view does not appear to have been established empirically but there are features of daily life as a female which substantiate it. From an early age there are greater restrictions on the freedom of movement of girls than of boys (Newson & Newson, 1968). This becomes more evident at adolescence (Laws & Schwartz, 1977). Culture-specific sex typed expectations have been shown to exist and are transmitted in innumerable ways, some subtle and some obvious (Maccoby & Jacklin, 1974; Weitz, 1977).

The fear of sexual victimisation is one aspect of female sex-typed expectations and, most commonly, sexual assaults are acts which are perpetrated by males on females. For these reasons, although there is no doubt that males can be the victims of sexual assault as defined here, this dissertations will deal with the effects of sexual assault on women.

The experience of male victims is likely to take a somewhat different form, related to differential sex-typed expectations. Although there may well be some similarities of experience, because of social differences between the sexes (and the nature of male-male relating distinguished from male-female relating) when a man is sexually assaulted by another man it is likely that it is his idea of himself as a man which is thrown into confusion (Stern, 1980). A man's reaction to sexual assault at the hands of a woman has yet to be investigated; this seems unlikely to be a frequent occurrence.

Some papers have described the effects of sexual assault by males on males (the victims have generally been adolescent boys, e.g. Kaufman et al, 1980, or the study has been conducted on a prison population, e.g. Sagarin, 1976), but little research in the area has been conducted. The male victim has been more widely discussed, in recent years, in the context of sexual violence against children (Berliner, 1977; Brand & Tisza, 1977; Callan, 1980; DeFrancis, 1965; Sarafino, 1979; Kryso, 1978; Swift, 1977), and there is a distinct need for the systematic study of the incidence, nature and effects of sexual assault on adolescent and adult males.

The child and adolescent victim of sexual assault or sexual abuse presents a wide range of particular problems (Bluglass, 1979; Browning & Boatman, 1977; Burgess & Holmstrom, 1973; 1975a, 1976a; Burgess et al, 1977, Kinkelhov, 1979; Herman & Hirschman, 1977; Landis, 1956; Lewis & Sarrel, 1969; Lukianowicz, 1972; Lustig et al, 1966; Orr & Prietto, 1979; Peters, 1976; Posnanski, 1975; Raphling et al, 1967; Rise, 1979; Schechter & Roberge, 1976; Schultz, 1979; Summit & Kryso, 1978). The range of this dissertation will not include children or adolescents and, somewhat arbitrarily based on the Children's Act (1960), will deal only with adult females, i.e. aged 18 years and over.

In summary, for the purposes of this dissertation, aimed at the provision of a guide for the appropriate counselling and therapy of adult women following sexual assault, in South Africa, a definition has been provided of sexual assault as the subjective experience of a person who has been forced or intimidated to submit to a physical, bodily intrusion with sexual connotations. Since the psychological effects and practical concerns following sexual assault

are likely to be somewhat different for males, children and adolescents, the discussion will concern adult females aged 18 years and over.

1.3 Incidence of Rape and Sexual Assault

Over the past 10 years, with the growth of interest in issues relating to women, there has been increasing concern over the rising incidence of sexual assault (Rose, 1977). The literature reveals that rape and sexual assault are alarmingly widespread phenomena, and appear to be increasing at a rate which not only parallels but often exceeds the increase in crimes of violence in Western industrialised society (Abrahamsen, 1950; Chappell, 1976; Guze, 1976). The complexity of the social and psychological dynamics which result in the spectrum of all criminal violence is enormous and will only be briefly mentioned here.

According to a report in the British newspaper, the Guardian (September 24, 1978) crime statistics in general for South Africa are some 2,5 times greater than they are for the United States of America, per capita. It has been reported that the Cape Peninsula "has become not only the worst centre in South Africa for crimes of violence, but that it is probably the worst in the Western world on a per capita basis" (Williams, 1979). A criminologist at the University of Cape Town's Institute of Criminology estimates the number of gangs in the Cape Town area to be higher than anywhere else in the world (Weekend Argus, August 30, 1980, p.8). Where the incidence of crimes of violence is high, the statistics for rape are at least equally high (Rada, 1978). More rape is said to occur in the Cape Town area than in any other area of South Africa - in 1978, the police here investigated 1,213 rape

charges (Bosman, 1979).

Despite the commonly held view that rape is a consequence of sexual frustration, there has been no evidence that rape is more common in communities where males outnumber females (Lester, 1974; Singh, 1977). The trend today is to perceive all forms of sexual assault as expressions of violence in male-female relations (Bauermeister, 1977; Groth et al, 1977; Groth & Burgess, 1977; Rada, 1978; Sherman, 1975; West, 1978).

In communities where violence has become a subcultural norm, the frequency of rape and sexual assaults is extremely high (Amir, 1971; Bauermeister, 1977). The patterns and incidence of violent crime (and alcohol abuse) in and around Cape Town are attributed by criminologists to the extensive instability and social disorganisation of large sectors of the community, which have resulted from the uprooting of people on account of the Group Areas Act (Slabbert, 1980). Increasing unemployment, the high rate of inflation, and the crowded, poorly-serviced living conditions of the township areas must also contribute to the high crime rates in these areas.

In the period 1961 to 1976 the total number of rape and attempted rape charges (legally defined) laid with the South African Police throughout the country rose from 6,798 to 15,394 per annum. This represents an increase of 250%. In the same period the estimated total population rose from 16,8 to 27,6 million - approximately 64,5%. Evrard et al (1979) report that the number of rape charges laid in the U.S.A. in the period 1965 to 1974 rose by 115%.

Sexual assaults are widely recognised to be the most under-reported crimes, for reasons which have been extensively discussed elsewhere (Clark & Lewis, 1977; Holmstrom & Burgess, 1978; Mayne & Levett, 1977; Rabkin, 1979; Rinear, 1977; Weis & Borges, 1973). Most criminologists argue that the official statistical record of all crime is only a partial picture and there has been much discussion of the 'dark figure' of unreported crime. This varies according to the crime, and even for the same crime over time and from one geographical area to another.

Recently there has been an effort to estimate the actual incidence of various crimes, by way of self-report studies; a significant finding has been the large amount of unreported crime amongst the middle class and well-to-do sectors of the population, in Great Britain, the U.S.A., Australia and elsewhere (Sparks et al, 1977). For different social groups, reaction to certain crimes, or to the violation of social norms, is not necessarily similar.

Attitudes to the perpetrator of the act vary, depending on his relationship to the victim (or to the victim's social circle), on perceived motivation for the act, or on the presumed consequences (for everyone involved) of laying a criminal charge with the police.

It appears that the reporting of rape is significantly influenced by the relationship between the victim and the offender. In one survey where the offender was a stranger, 84% reported, whereas only 54% reported where the offender was known to the victim before the incident (the San Jose study cited by Sparks et al, 1977). However, the same study revealed that "stranger" assaults are a minority of those which occur, bearing

out the findings of other investigators (Clark & Lewis, 1977; Dietz, 1978; Dukes & Mattley, 1977).

It is generally accepted that only 1 of 10 cases of sexual assault is reported to the police (Hilberman, 1976). Of these, an unknown proportion is likely to be sifted out at the level of the initial report at the police station, since policemen have been found to "act as rulemakers in determining what conduct constitutes rape" (Galton, 1975-1976, p. 17).

In the year July 1975 - June 1976, in South Africa, assuming that only 1 in 5 cases was reported, there were approximately 76,000 situations in which women were raped or experienced an attempted rape. According to the official statistics (Annual Reports of the Commissioner of the South African Police) approximately 15,000 reports of rape or attempted rape (as legally defined) have been lodged with the police annually since 1976 in South Africa (approximately 28% result in convictions).^{*} This represents a figure of 380,000 women who are likely to have been sexually assaulted in South Africa in the past 5 years.

Some criminologists feel that, for a crime such as rape, the incidence of reported offences is more likely to be only 1 in 20 or 30 cases, especially for certain populations. For instance it is held that working class women living in township areas are less likely to report to the police.

Footnote: ^{*}No breakdown is available regarding the age relationship of assailants and victims, nor of the incidence of multiple rape (gang rape).

This is borne out in a study of crime on the Cape Flats (Bloch, 1975); Dukes & Mattley (1977), in Colorado, have also shown that in crimes in which victim fear is an aspect of the situation, she is only likely to report to the police if they are perceived as friendly and protective. In addition, it is generally held that willingness to report sexual assaults is influenced by characteristics of the offender, of the act, of the victim and of the relationship between assailant and victim (Rabkin, 1979).

The survey conducted by Kinsey et al (1953) on the sexual behaviour of the human female elicited some incidental information which was not actually sought by these researchers. Of their large, heterogeneous sample of American women (N = 5,500) a quarter had experienced some type of sexual assault during their lives. Explicitly excluded in this figure was the consensual exploratory sex play of childhood and adolescence. No details are provided of the types of sexual assault involved - it is simply mentioned that the males concerned were all at least 5 years older than the subjects at the time of assault.

Other reports tend to confirm Kinsey's findings. Rinear (1977) surveyed 6,807 female employees of eight hospitals in an eastern city in the U.S.A., obtaining a 34,2% response; 3,3% were rape victims (33 cases in 1000 respondents). Kanin & Parcell (1977), surveying women university students in the U.S.A., found that 50% had been victims of sexual aggression in a dating situation within the past year, 25% of the incidents involving forced sexual intercourse (i.e. 12,5% of the sample). In Canada, Herold et al (1979) found that 16% of 103 women in

two university classes had experienced attempted rape, 1% had been raped and 44% had been sexually molested; only 16% of the victims of attempted rape had reported to the police and none of the women who had been sexually molested (i.e. "sexually touched against one's will"), had reported.

In Summary. These studies suggest (1) the serious incidence of sexual assault - probably 20% of the female population is affected at some point in their lives, (2) it is NOT only among the working class, under-privileged sectors of society that this occurs, (3) it is likely that many women will be sexually assaulted more than once over the life span (Miller et al, 1978). As will be seen, this is likely to have serious consequences for the women if not adequately dealt with, since the effects of sexual assault can be long-lasting. For these reasons what is known about the effects of sexual assault, both short-term and long-term, demands the attention of those members of the helping professions who are likely to encounter women who have been sexually assaulted.

SEXUAL ASSAULT: THE CONTINUUM OF VIOLENCE

2. SEXUAL ASSAULT: THE CONTINUUM OF VIOLENCE

2.1 Introduction

In considering the nature of the experience of sexual assault, as defined for our purposes, it is crucial to examine the variety and quality of the intimidation which the woman is likely to experience. This is a fundamental aspect of the encounter and is likely to bear a relationship to the psychological consequences for the woman.

The stresses which the woman experiences can be viewed along a continuum of violence. At the one end is the extremely violent and sadistic act, then there is a range of possible intimidatory physical and psychological acts and, at the other end of the continuum, the coerced unwanted physical intimacy.

A significant contributory element of stress for the woman arises out of ideas of victim precipitation - the widespread attribution of blame to the sexually assaulted woman. This is based on naive ideas of sexual assault which focus on the sexual element of the situation and underplay the significance of the intimidation and violence involved. These attitudes give rise to the various forms of "secondary victimization" which can be seen as institutionalized violence - the ways that police officials, hospital personnel and court procedures may respond to the sexually assaulted woman, compounding the psychological trauma which she has suffered (Holmstrom & Burgess, 1978).

The context of violence to which the woman is liable to be subjected will be outlined in this section, to provide a framework in which to better understand the woman's experience of sexual assault and its aftermath.

2.2 Coercion, intimidation and physical violence

A social interaction definable as sexual assault can range from incidents of extreme brutality to "errors of judgement in the art of seduction" (West, 1978, p. 684). The extent of the range of phenomena which can be experienced by a woman as sexual assault is not widely recognised, (Brownmiller, 1975). For our purposes, some form of intimidation must be present but the nature of the intimidation involved is equally varied.

There is a continuum of violence which ranges from the pathological sadistic forms of brutality which are most likely to be publicised in the media (Smart & Smart, 1978), through various forms of physical intimidation (hitting, choking, semi-smothering and physical restraint), to verbal threats of physical violence, (there may be weapons involved), to coercion by threat of blackmail, or job loss (Clark & Lewis, 1977). Other forms of psychological manipulation can also be involved (Tschudi, 1977). In most cases a variety of forms of intimidation are employed.

In contrast to common stereotypes of the sociopathic sexual assailant, the most common protagonist is a young inept man, sometimes intoxicated (Rada, 1975), who makes clumsy attempts to secure the sexual cooperation of young, frightened, unassertive, women, based on an unarticulated conventional notion of a dormant female sexuality to which to respond (Clark & Lewis, 1977; Laws & Schwartz, 1977). In this context the borderline between assault and seduction becomes obscured to both persons (although, for the woman, other aspects of the experience: the intimidation, the negation of her unwillingness to submit and the physical intrusion add stress to her confusion).

It is necessary to recognise that:

- (1) physical coercion need not be physical violence which results in injury since most men are fairly easily able to overpower most women, partly because of skeleto-muscular advantage and partly because of sex-typed upbringing which does not equip most women to be overtly physically aggressive;
- (2) psychological intimidation is invariably a significant element in the situation, since threats are involved or, in some instances, there is a covert or nonverbal suggestion that power may be used against her;
- (3) the act itself involves physical violence whenever the woman is unwilling;
- (4) the possibility of further and more extreme physical violence is always present;

threats are common - generally these are threats to life, threats to mutilate, or threats of violence , (Burgess & Holmstrom, 1975b).

2.3

The assailant's motivation

We are concerned here with the psychological consequences of sexual assault for the woman. Since the nature of the intimidation involved in a particular situation is likely to be related to the effects on the woman, this must be taken into account by those assisting her.

The analysis of motivation provided by Groth et al, (1977) will be summarised briefly. According to this study of 133 convicted rapists and victim reports of 92 other assailants, there are always three

ingredients involved in the assault: power, anger and sex, and the act is pseudosexual. Depending on the relative presence of these elements, Groth et al developed the following categories.

2.3.1 Power rape is most common (65%). The man usually plans the assault and then goes in search either of a particular woman or one who just happens to come along at the time and place he has envisaged. Usually there is no extreme physical violence. The woman falls into a similar age group to his, and is fairly easily intimidated by threats of violence, with or without a weapon. The man often expects the woman to be flattered and gratified by his dominating style, and may question her (asking for her name, where she lives, works and so on) and even ask her to meet him again. Power rape represents a situation where sexuality is used in the service of non-sexual needs (Groth & Burgess, 1977).

These situations fall into one of two sub-categories: (a) power-assertion, where the assault is an expression of the assailant's ideas of virility and domination; he might demand that the woman perform various sexual acts on him; he might comment "I know you are enjoying this", or tell her that he loves her.

(b) power-reassurance - where the assault seems to relate to the man's need to reassure himself about his sexual adequacy; he might ask the woman how he compares with her boyfriend or husband.

Power-assertion rape was twice as common as power-reassurance rape (43,5% and 21,3%) (Groth et al, 1977).

2.3.2 Anger rape characteristically involves both physical violence and verbal abuse. Such assailants are often assaultive to women in a variety of ways (e.g. wife-

battering), regard women as contemptible and sex as degrading. These offences are often triggered off by some specific conflict in the man's personal relationships with women. A significant aspect of his motivation is vengeance and he experiences conscious anger and a major component of sadistic excitement. The victim of this type of assailant may fall into any age group but is often the older woman. The experience is invariably life-threatening and many of these encounters end in murder (Davis & Brody, 1979). In Groth's study, 35,1% were anger rapes.

There are two sub-categories within this group.

(a) Anger-retaliation, where there is a conscious need to humiliate and degrade women. This is the group most highly represented in the sample of convicted American assailants, although it ranks only third in frequency in victim report samples (after the two sub-categories of power-rape).

(b) Anger-excitation, where the assault is more directly sadistic in intent. The woman is likely to be abused in a number of ways - protracted physical battering, burning with cigarettes, slashed with knives or broken glass, etc. This is the least common type of sexual assault, (5,33%).

Rada (1978), discusses the issue of dominance/submission conflicts in these assailants. Cohen et al, (1971) and West, (1978) have done exhaustive studies of the intrapsychic dynamics of assailants who commit extremely violent sexual assaults; and their findings are compatible with Groth's work.

There is growing understanding that most sexually assaultive behaviour involves relatively mild forms of force by fairly normal assailants, the more bizarre and brutal assaults being perpetrated by pathologically disturbed men (Jenkins, 1953).

The woman victimised by the "power rapist" is most likely to experience the assault as humiliating and degrading in that her needs and rights are ignored or denied. She is also likely to be extremely confused by the combination of intimidation together with the man's need for reassurance and his assumption of the relative acceptability of his actions. This is likely to provoke feelings of guilt and self-blame in the woman, and also a mistrust of men, and is likely to be associated with low self-esteem.

The woman victimised by the "anger rapist" will invariably be terrified by the encounter with overt aggression. The aftermath of the experience is likely to be marked by prolonged, raised anxiety levels and panic attacks, feelings of extreme vulnerability, and gross psycho-physiological disturbances. Guilt and self-blame are unlikely to play a prominent part and the woman will count herself fortunate to have survived at all.

These differential consequences are speculative since, as yet, no studies have been published which examine the relationship between the categories devised by Groth et al, (1977), and the effects on the victim.

2.4 Multiple Sexual Assaults ("Gang Rape")

Although the incidence of multiple offender sexual assault is high in most of the larger urban areas where crime rates are high, according to Dietz (1978), who reviewed the existing literature, there is remarkably little quantitative or qualitative information available.

Many instances of multiple assault appear to reflect simply another aspect of a range of criminal activities

engaged in by loosely organized groups of men. These are mostly youths and young adults, for whom the act relates to struggles for status and prestige within the group and to group cohesion, (Blanchard, 1959).

Svalastoga (1962) studied 141 offenders in Denmark; 10% had offended with one confederate and 6% with two. Schiff (1969) reported 42% of cases involving more than one assailant and, in another study, 39% (22% pairs and 17% larger groups of men) (Schiff, 1973). In another study, in Denver, 18% involved multiple offenders (8% pairs and 10% larger groups) and, in Toronto, there was a higher proportion of multiple offenders (29% pairs and 21% larger groups) (MacDonald, 1971), Amir (1971), reported at 16% for pair offenders and 26% larger groups (mean size 4,2 men) in Philadelphia.

In South Africa, there are no official statistics available for the incidence of multiple offender assaults. In Cape Town, 65 women received face to face counselling through Rape Crisis in the 3 year period 1977-1979, and although this is not assumed to be a representative sample, for interest it is noted that in 9 cases (13,8%) there were two assailants and in 14 cases (21,5%) there were more than two assailants (mean group size 4,3 in a range of 3 to 9 assailants).

Dietz (1978) summarizes some quantitative information comparing multiple with single assailant offences, (p.101).

In multiple assaults:

1. There is a higher incidence at times of maximum recreational interaction;
2. The younger segment of the population is more substantially represented;
3. Lower status ethnic groups in communities with the most pronounced ethnic hierarchies are highly represented;
4. Alcohol abuse is a common element;
5. There is a less frequent previous arrest record for crimes against the person or sex offences;
6. Group rape offenders (not pairs) more often live near the scene of the assault and near the home of the victim;
7. Multiple offender assaults more often commence in the street;
8. They are more often committed in cars and less often in the home of one of the participants;
9. The offenders are more often acquaintances or close neighbours of the victim and less often close or intimate acquaintances;
10. The degree of physical force used is greater.

Except for points 5 and 8, there would seem to be a similar pattern for multiple offender sexual assault in Cape Town.

Bauermeister's comment that "rape is predatory behaviour most typical in group settings of male violence where it often serves the purpose of acquiring power and prestige within the peer group" (1977) is, as we have seen in the previous section, only partly true, since the power-assertion and power-reassurance type assaults in a one-to-one situation are the most common (Groth et al, 1977). At the same time, the function of sexual assault (as opposed to other types of violence performed by the

gang) in establishing or maintaining the group's hierarchical structure has yet to be investigated.

In the context of the present dissertation, there can be little doubt that the victim's experience in multiple assault is terrifying in the extreme. Furthermore, in the areas where gang rape is most common, the woman is often known to the assailants. There is no compunction about the continued intimidation of the woman by the assailants. While guilt and self-blame are likely to be rare, the woman's fear and anxiety following multiple sexual assault is extreme. She is more likely to experience physical consequences since injury is more probable, as also is venereal disease. Pregnancy is also more feasible if the woman is not protected by contraceptive measures.

2.5 Victim precipitation

Since Menachim Amir published his paper "Victim precipitated forcible rape" in 1967, there has been a great deal of research on victim-blame in sexual assault. It is reported that Amir's views on this have altered radically as a consequence of subsequent work, (Tinevez, 1979). Social psychologists have commented on the tendency to reject or to blame the victim in various situations. Ryan (1971) has provided a perspective on the use of victim-blame models in three areas: assault, poverty and illness.

Examination of the available literature on attitudes to rape victims reveals a number of articles which have been published in the past decade dealing with

victim-blame and victim-responsibility in various ways (in chronological order these are: Jones & Aronson, 1973; Weis & Borges, 1973; Curtis, 1974; Sigall & Ostrove, 1975; Calhoun et al, 1976; Feldman-Summers & Lindner, 1976; Klemmack & Klemmack, 1976; Scroggs, 1976; Smith et al, 1976; Barnett & Feild, 1977; Joe et al, 1977; Kahn et al, 1977; Kanekar & Kolsawalla, 1977; Seligman et al, 1977; Van der Westhuizen, 1977; Calhoun et al, 1978; Feild, 1978; King et al, 1978; Levett, 1978; Paulsen, 1979; Selby et al, 1979.)

Victim blame in sexual assault appears to hinge on the attribution to the woman of seductive behaviour of some kind (in manner or in dress), or the attribution to the woman of irresponsibility (e.g. being in a particular place at some particular time). The "just-world hypothesis" tends to be applied, i.e. one gets what one deserves or deserves what one gets (Lerner, 1965; Lerner & Simmons, 1966; Lerner & Matthews, 1967).

The derogation of victims has also been understood by social psychologists to be a defensive manoeuvre which reduces personal discomfort in a situation in which one feels helpless and which is personally threatening (Walster, 1966; Shaver, 1970; Chaikin & Darley, 1973).

Patterns of female socialization in our culture, in some instances, are liable to result in an over-emphasis on a girl's appearance and traits such as compliance (O'Leary, 1977; Weitz, 1977). It is feasible that as a child a girl may learn that, to obtain adult attention and approval (particularly from preoccupied and somewhat disengaged parents who value appearance over capability in women), she must behave in ways which could best be

described as coquettish. . . . When this girl reaches adulthood there are likely to be difficulties: her social skills will be largely limited to placatory and ingratiating behaviours, and her main sources of self-esteem will be others, often males. It is likely that, as an adult, her attention-seeking style could be readily labelled "seductive", although the attention sought is not sexual but affectional. If this young woman were sexually assaulted in any kind of situation which provided an ambiguous context of antecedent events (Tschudi, 1977), it is highly likely that she would be held responsible for the assault.

The complexity of the issues involved in sexual assault and their variability from one situation to another have to be recognised. Dietz (1978, pp. 102-104) has reviewed cross cultural variations in aspects of sexually assaultive behaviour which he shows to relate to differences in sex-typed expectations and male-female relating patterns. These indicate that neither biological urges nor individual psychopathology are necessarily implicated in any specific way, and that sociocultural factors have to be considered.

"Rape is best understood as an example of violence in male-female relations. This point of view reflects the belief that there is nothing unusual about sexual intercourse, coercion, or male domination of females. These three elements each occur so frequently in human relations that their occurrence together is also common. What sets rape apart from the majority of such occurrences is the type and extent of coercion, this is, the use of actual or threatened violence". (Rada, 1978, p.69).

With the recognition of the traumatic consequences of "secondary victimization" (various forms of additional stress for the woman resulting from victim-blame) and the role played by defensive attribution, there has been an educated move among researchers away from ideas of victim precipitation in rape and sexual assault (Chappell, 1976).

Until there is a responsible, broadly based effort to educate the public in general (especially those who encounter sexually assaulted women in the course of their daily duties) ideas about victim precipitation will continue to be held by the uninformed, and will continue to be a source of secondary trauma for the assaulted woman.

Victim blame arises largely out of the view of sexual assaults as acts with sexual gratification as the main aim, which is widespread. However, a number of studies have concluded that sexual gratification is not the motive (Amir, 1971; Abel et al, 1977; Groth & Burgess, 1977 (a); Groth et al, 1977; West, 1978). Where this factor has been studied, in convicted assailants, in no case did the man have no alternative sexual outlet; all were either currently married and engaging in regular sexual activity with their wives or were actively involved in non-marital sexual relationships with one or more women (Groth & Burgess, 1977 (b)). A study by Cohen et al (1971), also of convicted assailants, indicated that they had a lifelong pattern of pathological relationships with women. The motivation in these men was complex, reflecting problems with both sexuality and with aggression.

Groth & Burgess (1977,(b), studied a sample of both convicted men and victim reports about assailants. A large proportion of the men (34%) seemed to be sexually dysfunctional during the offense. They were unable to attain an erection (some demanding assistance from the

woman), or experienced premature ejaculation, or were unable to ejaculate. A further 9% did not attempt penetration. About 11% were either repulsed by the woman or were interrupted during the assault and in only 25% of cases was there definitely penile erection and ejaculation.

The multiple factors which are likely to underlie someone's considered or impulsive decision to commit a sexual assault are outside the scope of this dissertation but have been comprehensively reviewed by Rada (1978). The interested reader who decides to pursue this line of investigation needs to bear two cautionary factors in mind: (1) studies which pertain to personality variables are liable to be subject to problems of measurement, and to generalizations based on small numbers, poorly defined criteria, and high within-group variance; (2) there is no systematic and very little non-systematic information on men who are sexually assaultive but who are not apprehended and/or convicted.

At present, studies of rapists and sexual assaulters reflect information about men who have been convicted. This is a serious methodological flaw. Certain types of assailant are heavily represented in these studies: inarticulate, illiterate, working class men who have poor access to legal expertise, or those who commit particularly brutal assaults, and those who offend against children and older women. Men who conform most closely to the stereotype of the 'bad' stranger/intruder who assaults the 'good' victim are most likely to be the subjects of these studies, and the average middle class assailant is under-represented. (Clark & Lewis, 1977)

Recently researchers have begun to attempt to include reported information collected from women who have been assaulted. While this has filled out the picture

to a certain extent, it is still an incomplete one, (Clark & Lewis, 1977; Groth et al, 1977).

In summary, the range and variability of the types of physical and psychological violence to which the sexually assaulted woman may be subjected have been outlined to provide a basis on which to understand the nature of her experiences. Without this understanding it is difficult to provide the assaulted woman with the kind of support and assistance she needs, both in the crisis aftermath of the encounter and later. For this reason it is important that a broad understanding of the phenomena be made readily available for both lay counsellors and members of the established helping professions.

THE ACUTE CRISIS PHASE

3 THE ACUTE CRISIS PHASE

3.1 Introduction

In reviewing the literature on the effects of sexual assault on the woman, it is evident that there are two temporal phases into which the woman's experience may be placed for discussion, although there is often no clearcut boundary between them: the acute crisis phase and the long-term effects phase.

In discussing the acute crisis phase, the crisis intervention approach will be outlined since this provides a model within which the woman's acute stress reaction can be understood. A wide variety of helpers, lay counsellors and those within the established helping professions, can easily operate in the crisis intervention model which is rooted within new approaches to community preventive psychiatric care (Caplan, 1964).

The difficulty with the crisis intervention model is that there has been little specific said as to what exactly to do and not to do in a particular crisis situation. An attempt will be made in a later section of this dissertation to provide more detailed information for the adequate assistance of the sexually assaulted woman in crisis.

In this section, the woman's experience of the encounter, the sexual assault, her psychological concerns and the practical issues which arise out of the encounter in the acute crisis phase will be discussed.

The acute crisis phase covers the period from and including the precipitating event and lasts from then for some 2 to 12 weeks or longer. The 'end' of the acute phase is arbitrarily constituted and difficult to delineate, depending on the woman herself and her own resources in part, and on various circumstances

which lie outside her control which will be discussed. In relation to the latter, it should be noted that the woman is vulnerable to precipitation into further crises by other events which follow the sexual assault (Fig.1), p.29b. These are related to societal attitudes, the support of significant others, and to medical and legal circumstances - what Holmstrom and Burgess (1978) have termed "secondary victimization".

3.2 The Crisis Intervention Model

Lydia Rapoport (1965), an early and significant contributor to the field of crisis intervention, provides a definition of a crisis situation as a combination of three elements:

1. a hazardous, threatening event,
2. evoking both immediate and past fears which combine to produce a high degree of emotional vulnerability,
3. in a person who is thus unable to mobilise adequate coping resources to deal adequately with the situation.

The stress of the combination of force (physical and psychological) together with sexually-loaded intrusion may be overwhelming for the woman. This is particularly so since she is likely to have lived all her life with the fear of the possibility of such an event, at either a conscious or an unconscious level.

There is a burgeoning, confused and confusing, literature on "crisis theory" and on crisis intervention. The work appears to be largely derived from Lindemann's classic paper on the symptomatology and management of acute grief reactions following loss through catastrophe, published in 1944. Lindemann outlined acute grief reactions as a distinct syndrome, mapped the course of appropriate resolution, and described distorted

forms of grief reaction. In doing this, he followed the original work of Freud (1917) (and of Melanie Klein (1940), applying their ideas in a context in which there is a far broader conceptualisation of loss, and suggesting the part which can be played by therapists to help facilitate the working through process appropriately.

Some authors claim that there is consensus about the basic framework to crisis theory (e.g. Golan, 1978; Jacobson, 1974), using the term theory in the sense of loosely formulated ideas which can be usefully applied. Other, more critical, commentators (e.g. Taplin, 1971) see the framework as falling into one of two basic approaches (1) the homeostatic model which draws on biological and mechanical analogies of self-regulating systems, in wide use in social work agencies (e.g. Golan, 1978), and (2) the psychoanalytic approach which, in attempting to provide a dynamic explanation of stress reactions to loss or impending loss, in terms of unconscious processes and defence mechanisms, is more likely to be encountered in psychiatric practice (e.g. McGuire, 1965). Taplin (1971) has offered a third approach, derived from contemporary cognitive psychology, which he feels to be more useful in terms of explanatory power.

In view of the absence of a rigorous and accepted basic theoretical framework, it is not surprising that the application of 'crisis theory' varies from one practitioner to another (Golan, 1978) and that there is disagreement about the most appropriate intervention to assist all persons who present in acute stress (Haywood, 1977). Furthermore, the wide range of situations and variables which may be present in different combinations in any one crisis situation, also contributes to the relative lack of consensus.

In reviewing crisis intervention programs, Schwartz (1971) outlined three types of crisis: the psychiatric emergency, where there is an acute florid manifestation of psychiatric illness, in persons who then require psychiatric care; the accidental event which precipitates the acute disorganisation of customary activities (i.e. loss, challenge, threat) in previously coping persons; and developmental crises which are characterised by acute disorganisation of psychosocial functioning at periods of transition between one normative developmental phase and another (e.g. starting school, leaving school, getting married).

Gerald Caplan (1964) describes accidental (and developmental) crises as "...periods of acute psychological upset, lasting one to five weeks - not signs of mental disorder in themselves, but the manifestations of adjustment and adaptation struggles in the face of a temporarily insoluble problem. They have been novel situations that the individual has not been able to handle quickly with his existing coping and defense mechanisms. The problems are serious and unavoidable.... As adjustment and adaptation struggles, they present both an opportunity for personality growth and the danger of increased vulnerability to mental disorder, the outcome depending to a degree on how the situation is handled." (p.35).

Crises suitable for crisis intervention are broadly categorised into two groups by many writers: those that are basically situational or accidental, precipitated by external events, and those that are maturational/developmental, in some sense internal and normative, (e.g. Schwartz, 1971).

Recently Baldwin (1978) has provided a paradigm for the classification of six types of emotional crisis which are likely to be encountered by the therapist or those in the helping professions, and has recommended adoption of the most suitable intervention for each. The six types of emotional crisis are as follows.

(1) Dispositional crises in which the difficulties relate to the situation but where the most appropriate intervention is referral to the relevant agency, or the provision of information, or education, or an intervention at an administrative level (to facilitate a change in environmental conditions), e.g. a crisis of living arrangement. The helper is not required to focus on the emotional level but needs to be aware of the possibility that this may be indicated.

(2) Crises of anticipated life transitions, e.g. terminal illness in the family, divorce. In such crises the helper's intervention is focused on the clarification of the likely areas of stress and anticipated stress. The most suitable coping strategies feasible for the person in crisis are explored in order to plan effective adjustment.

(3) Crises resulting from traumatic stress where there are unexpected external stressors which cannot be controlled and are emotionally overwhelming for the person, and loss is likely to be a factor. The refractory period of immediate shock, which immobilizes customary coping mechanisms, tends to last a long time. Rape and sexual assault falls into this category of crisis, and will be discussed at length in the next section.

(4) Maturational/Developmental Crises which generally present as interpersonal difficulties of a recurrent type, which reflect an underlying problem of emotional immaturity or maladjustment. In these situations it is the latter, underlying, problem which requires exploration and clarification which more adaptive means of interpersonal relation are defined.

(5) Crises reflecting psychopathology, where there is a more serious underlying psychiatric disorder. The helper may assist in supporting the person specifically in relation to the current stress, with the expressed intention of referring the person for more intensive care to those with appropriate skills and training.

(6) Psychiatric emergencies, (as described by Schwartz (1971) and mentioned earlier in this section), where the rapid assessment of the nature of the situation is required and referral to a medical facility is urgently indicated.

It is widely held that, depending on the type and severity of the crisis, the successful negotiation of a crisis situation may result in the learning of more flexible or adaptive coping strategies for future use (Caplan, 1964; Golan, 1978; McGee, 1968; Rapoport, 1965). This view has not been substantiated empirically, as far as the present writer has been able to ascertain. It would seem to be more relevant to certain types of crisis situation than to others (e.g. the maturational-developmental crisis). Even if this idealistic goal is not achieved, at least it is likely that with appropriate intervention the person in crisis will be assisted to regain the level of functioning which existed prior to the crisis situation, within a reasonably brief period of time.

Baldwin (1978) stresses the importance of clarifying the type of situation which has precipitated the crisis, as well as the person's style of responding to the crisis, in order to focus the intervention on the 'here-and-now' of the presenting situation in the most suitable way.

The value and popularity of the crisis intervention approach lies in its very flexibility, making it readily accessible for use not only by the professionally trained therapist and paraprofessional worker, but also by lay counsellors and community workers. To make most effective use of the model, one needs to be able to assess the nature of the emotional crisis, and have a thorough understanding of the factors involved. However, the exact treatment format within the crisis intervention approach to sexual assault victims is vague (Evans, 1978).

The crisis situation of traumatic stress comprises five components: the hazardous event, the vulnerable state, the precipitating factor, the state of active crisis and the stage of reintegration or resolution (Golan, 1978, pp 63-64).

The crisis situation which is precipitated by the traumatic stress of rape or sexual assault is well recognised (Baldwin, 1978; Golan, 1978; Burgess & Holmstrom, 1974; Hilberman, 1976; Sutherland & Scherl, 1970; Thomas, 1977). There is consensus that the hazardous event of the sexual assault is in itself the precipitating factor which sends the woman into a state of active crisis characterised by extreme vulnerability, in most cases (Golan, 1978, pp. 66 and 205-6).

3.3. Acute Stress Reaction

In psychiatric diagnostic terms, the state of crisis following sexual assault is known as an acute reaction to stress (I.C.D.9, 1978, category 308) and it is understood as a transient situational disorder where there is no history of mental disorder and there is a known precipitant: a stressful event of catastrophic proportions.

Eaton et al (1976) define a stress situation as one involving an environmental threat to life, or risk of injury, where there is actual or potential loss of security, of self-esteem, or of important sources of satisfaction. In this type of situation the circumstances overwhelm the person's existing defence structure and customary behavioural patterns of adaption to daily stresses lose their usefulness.

The acute stress reaction accompanies and follows an extreme environmental stimulus which places extraordinary demands on the adaptive capacity of the victim. This has been described for a variety of disasters in the psychiatric literature (fire, flood, war, major surgery) (Janis, 1958; Krystal & Niederland, 1971; Lindemann, 1944; Schmideberg, 1942), and has been applied to understand the crisis state following sexual assault (Baldwin, 1978; Burgess & Holmstrom, 1974; Golan, 1978; Hilberman, 1976).

There are likely to be cultural differences in the pattern of reactions to sexual assault. These have as yet to be studied, but may relate to culturally-specific, ritualized forms of mourning recognized among some pre-industrialized social groups (e.g. Laubscher, 1937, pp.96-106).

The acute stress reaction in Western industrialized societies falls into four stages, each varying in intensity and in duration and reflecting individual personality style differences (Weiss & Payson, 1967). These four stages are known as (1) the anticipatory or threat stage, (2) the impact stage, (3) the recoil stage, and (4) the reconstitution or resolution stage. Like most models of qualitative change, the four stages merge into one another and do not constitute clearcut time-based periods.

The threat and impact stages both relate to the stressful encounter itself. The impact stage carries over into the period immediately following the event, and merges into the post-traumatic recoil and reconstitution stages. These stages will be discussed under the general heading "The Acute Phase", in Section 3. If there is inadequate resolution it is likely that the victim of sexual assault may be left with a type of traumatic neurosis which has been likened to that found among war victims (Notman & Nadelson, 1976). The possible long term effects for the woman who has been sexually assaulted relate to inadequate working through in the acute phase and will be discussed in Section 4.

3.4 The Encounter

The acute phase commences with the anticipatory or threat stage of the encounter. Assuming that the woman is unable to effectively repulse her assailant, the impact stage follows. There is little in the literature as to the incidence of successful resistance to sexual assault (Selkin, 1978) although there has been discussion regarding the relative effectiveness of different resistance responses (Burgess & Holmstrom, 1976,b).

3.4.1 Anticipatory or threat stage

According to Burgess & Holmstrom (1976,b), who have reported on their experience with many victims of sexual assault over the past 7 years, as soon as the woman realizes that she is in a dangerous situation, she tries to find a way to avoid the assault. The strategy used varies from one woman to another: in 20% of their cases the woman was silent, trying to assess the situation further to decide how to escape sexual assault or physical injury or death; in 63% the woman used her verbal skills to try to dissuade her assailant; in 23% the woman tried to fight or flee. In all these cases reported, of course, these strategies were not successful in bringing the encounter to an end.

Brodsky (1976) researched the reactions of convicted rapists and professionals working with them to video-taped resistance responses in an effort to gauge relative effectiveness. This study reflects what the subjects said they would do, rather than what they actually do, but reactions differed. With very aggressive and assaultive men, resistance can evoke increased violence; a few of these subjects said that evidence of great distress and weakness might be discouraging. With men who tended to be more tentative in their approach, the report was that a clear rejection or verbal attack would serve as a deterrant whereas passive responses might be seen as provocative. Brodsky's study did not explore the usefulness of fighting, screaming or attempts to run away - which other writers have reported to be effective in some instances (e.g. MacDonald, 1971).

In an earlier study, Amir (1971) noted that the women who actively resisted sexual assault were likely to be older, close to the assailant's age, and not easily coerced or intimidated. However, in 71% of the

situations involving threats with a weapon, the woman submitted without further resistance. Since this information was collected from women who had been sexually assaulted, it does not contribute to our knowledge about successful resistance.

Selkin (1978) studied volunteer participants, 32 women who had been raped and 23 women who had experienced attempted rape, as legally defined. It appears that most of the victims of rape had experienced fear, shock and startle reactions, whereas the women who had successfully resisted the assault had mostly experienced anger and rage when confronted by the assailant, in the early stages of the threat and intimidation stage. The latter states are more "conducive of action and vigorous outcry" (p.267). When tested on the California Personality Inventory, and Cornell Medical Index, the self-identified resisters described themselves as "more confident, more socially adept, and angrier during the assault, readier to respond to the assailant in an active manner, and freer of symptoms of emotional distress after the assault" (p.267). On the other hand, the women who had been raped appear to have been emotionally paralyzed by panic, which physically immobilized them.

It would seem that to be successful, resistance to sexual assault is best initiated in the early threat or anticipatory stage of the crisis. However, this is not invariably successful since the effectiveness will also depend on the assailant's reaction to active and aggressive resistance. In addition, in the early threat stage it is not always clear to the woman that sexual assault is imminent. According to Notman & Nadelson (1976), in the threat phase of

crisis increased anxiety mobilizes perception of the potential danger in order to facilitate avoidance. However, "most people protect themselves with a combination of defenses that maintain an illusion of invulnerability with enough reality perception to allow them to protect themselves from real danger" (p.409).

Of 92 victims of sexual assault interviewed by Burgess & Holmstrom (1976,b) only 15 reported an early awareness of impending danger. It is well known that, in coping with stress, a commonly used psychological mechanism is denial. It seems likely that many women may ignore the threat involved at the early stage of an encounter of this kind, if only because it is probable that she has experienced similar anxieties in the past which have not necessarily ended in sexual assault. "As can be observed in public places such as buses, subways, elevators, and theaters, women will usually not react to sexual harassment. They will not make a public scene in response to 'sex grabs' and verbal abuse from molesting males. Such actions, however, contain for both parties elements of foreplay to rape." (Weis & Borges, 1973, p.83).

Furthermore, 30-60% of assailants are known to the woman (Dietz, 1978, pp.95-96) and if the man is known to her it would be especially difficult for her to express her feelings of unease and mistrust of him (Brownmiller, 1976, p.257; Weis & Borges, 1973, p.91).

During the early threat stage of the encounter there is often an initial period of varying length of ambiguity and uncertainty about events, for the woman, and any possible reaction tends to be neutralized by her hope that her mistrust is unfounded. Thus reaction is delayed until it has become ineffective.

Selkin (1975) has suggested that the assailant often 'tests' the woman initially to satisfy himself that he can intimidate her. He can do this in various ways: by a suggestive remark, by physical proximity, or by actually seizing hold of her. If there is immediate and firm resistance the man may decide to forego this opportunity, not having committed himself in his own mind to carry through his impulse. If there is little resistance in response to the intimidation, typically the assailant will then threaten to kill the woman if she does not cooperate, or may simply overpower her, and sexually assault her. Once the man has committed himself to pursue his intention, according to Selkin, it may be dangerous to resist since, in many cases, physical injury becomes increasingly likely.

However, by the time the woman has perceived the situation clearly and has little doubt about what is happening it is likely that the initial anticipatory stage has passed; the assailant has seized hold of her in a constraining manner and has voiced threats of death or injury and is obviously not prepared to desist. As soon as this occurs, the impact stage of the crisis situation commences.

3.4.2 Impact stage

There are varying degrees of disintegration of the woman's customary coping style at this point and there may be various physiological reactions. The woman's response to the assailant at this point depends on the delay between the threat phase and the actual attack, the type of intimidation strategy used by the assailant, the amount of violence involved and on the woman's usual style and her capacity to act even though extremely anxious and fearful.

Some women's perceived reaction may be relatively cool - many women try to talk their way out of the situation, delaying events by distracting the man, reasoning with him, flattering him; playing for sympathy, pretending to be ill, or verbally threatening him (Burgess & Holmstrom, 1976,b).

Even though apparently cool, for the woman the experience of sexual assault is one of fear. When a woman perceives that she is about to be sexually assaulted, she can either resist or submit under the duress of threats, verbal, non-verbal or more tangible. The verbal threats involved do not necessarily relate to death or injury, they can also involve humiliating the woman in some way (particularly if she knows her assailant).

In many instances at an early point in the encounter the assailant briefly throttles, chokes, or smothers the woman (particularly if she is calling for help). This manoeuvre may be intended to be intimidatory only but often suffices to overcome any further resistance since it is perceived by the woman as life threatening (Amir, 1971). Where the man has a weapon (knife or gun) 71% of women submit without further resistance (Amir, 1971).

Active resistance to violence is foreign to many women, since dealing with physical threat is not part of female socialization. Women submit because they feel incapable of effectively repulsing an assailant, and fear for their lives. Whether threatened explicitly or not with death, it is common for the women to experience the encounter as life-threatening (Burgess and Holmstrom, 1974; MacKellar, 1975). As Notman and Nadelson (1976) comment "Expression of aggression in women has been highly conflictual because of cultural restrictions and expectations of passivity and greater compliance for women" (p.410). This they suggest is adaptive

since counter-aggressive action may simply escalate the level of violence and result in greater injury to the woman.

In some cases there are physical reactions to the attack: nausea, vomiting, pain, choking, gagging, urinating, hyper-ventilating, losing consciousness, i.e. physiological concomitants of anxiety and fear. For the majority of women, the coping strategy for sexual assault tends to be verbal. Some cope by cognitive assessment of the situation (trying to plan escape, or how to keep themselves calm in order to seize an opportunity to escape, memorizing details of the assailant, or trying to recall what they have read or heard about what to do and what not to do in such a situation). Some women take the physically active course of trying to fight off the assailant or trying to run away.

Burgess and Holmstrom (1976,b) discuss these strategies as adaptive strategies. They can be seen as efforts to maintain some degree of control in a situation in which there is very little room for negotiation of the issue of power. In many instances the woman may attempt to utilise a number of these strategies at different points of the encounter.

In the situation where two or more men accost a woman and sexually assault her, there is rarely much she can do and all she often hopes for is to survive.

Either initially or at any subsequent point of the sexually assaultive encounter, for a variable period of time, many women are unable to use any avoidance strategy. In some instances the physical attack is sudden and overpowering and is rapidly effected, in others a weapon is produced, and in other instances the woman may be asleep in her home when assaulted. Frequently the high level of anxiety aroused precipitates relative psychomotor immobilisation.

The extreme psychomotor inhibition ("freezing with fear") likely to occur has been widely reported in the literature on rape and sexual assault (e.g. Brownmiller, 1975; Burgess & Holmstrom, 1974; 1976,b; MacDonald, 1971; Metzger, 1976; Russell, 1974; Schultz, 1975; Selkin, 1975; Symonds, 1975; Weis & Borges, 1973). Until 1979 there was little specific discussion of this phenomenon; it was then likened to tonic immobility ("animal hypnosis") in animals by Suarez and Gallup (1979).

"Tonic immobility is an unlearned state of profound motor inhibition produced by restraint. The reaction is typically elicited in the laboratory by applying manual restraint to an animal on a flat surface or in a trough. The animal initially reacts by struggling and attempting to escape, but after a brief period of continued restraining these reactions subside and it assumes a catatonic-like posture which persists in the absence of further contact. This state is also accompanied by periods of both muscular hypo- and hyper-tonicity, suppression of vocal behaviour, intermittent eye closure, and Parkinsonian-like tremors. Physiological correlates of the episode include decreases in heart rate and body temperature, an increase in respiration rate, and altered EEG patterns" (p.315).

It is noteworthy that the likelihood of the occurrence of tonic immobility, and also its duration, is positively associated with increased fear (Gallup, 1977). It has been suggested that the phenomenon represents an evolved predator defense (Ratner, 1967) in that, under predation, most prey go through four behavioural stages: at a distance, the prey freezes to avoid providing movement cues, but as the predator gets closer there are attempts to flee, and fighting is precipitated by the initial contact. As the prey experiences restraint, tonic

immobility ensues. This is understood in terms of the significance of movement cues in precipitating predatory attacks (Herzog & Burghardt, 1974).

Since sexual assault is increasingly understood as a predatory act which provokes extreme fear, (Groth & Burgess, 1977; Groth et al, 1977; Rada, 1978; Karpman, 1959) and there is invariably contact and restraint of the victim, it is suggested that the paralysis often induced during sexual assault is analogous to tonic immobility and has a similar adaptive significance in that, in some cases, the likelihood of physical injury, even of death, may be averted.

Symonds (1975) has commented on the psychodynamics of what he terms "frozen fright" in which the victim, profoundly anxious and fearful, is able to maintain a surface appearance of "appeasing, ingratiating, compliant behaviour" which in retrospect she is unable to understand and feels guilt about, (p.22). This behaviour can be seen as a desperate measure to maintain a sense of control in the situation, and thus is a defensive adaptive strategy (to minimise emotional trauma) which is costly to the ego. There is an element of disorientation involved which has a protective function.

The woman ultimately has to find a way to escape the assailant unless she is left abandoned somewhere. Quite often there is bargaining: e.g. he threatens to seek her out if she makes a report to the police and she promises not to, in order to avoid further conflict. Some assailants apologise and offer to take the woman home, and even expect to be able to contact her again (Symonds, 1976). Each woman who survives has found her own way to deal with the situation, her main objective being to get near other people, for assistance, and to get away from the assailant.

The woman's reactions and her coping strategies throughout the encounter relate to the following goals:

1. to avoid death,
 2. to minimize physical injury,
 3. to minimize the emotional trauma,
 4. to escape at an opportune moment,
- (Burgess and Holmstrom, 1976,b).

3.5 Post-Assault Period

The acute crisis into which the woman has been precipitated by the sexual assault does not end with the termination of the encounter itself. The impact stage continues, with characteristic psychological responses, and the recoil and reconstitution stages of the acute crisis follow. These must be satisfactorily integrated in order that the woman returns to the level of psychological functioning present before the assault - possibly having learned and incorporated better ways of coping, which will generalise to future difficult situations.

In this section, the psychological reactions which are likely to occur in the post-assault period will be discussed first. If these are not adequately dealt with at this time, they are likely to continue to affect the woman's day to day functioning, and relationships with other people, for months and years into her life. The existence and quality of emotional support which is provided by significant others in the woman's natural social environment are extremely important factors. Her emotional resources in the post-assault period will be highly dependent on the reactions of friends, relatives and associates to the assault and to her responses in the assault situation and afterwards. The woman's recovery in the acute crisis phase will be facilitated or impeded by the reactions of significant others.

In addition, there are many other complicating factors which will be outlined. These, singly or in combination, are liable to affect or to compound the woman's psychological response to the experience of sexual assault.

An outline will then follow of the practical issues and concerns which must be dealt with in the period immediately following the sexual assault, in the woman's interests.

Although the psychological and practical issues will be discussed separately, it must be noted that this separation is an arbitrary convenience only, for written discussion, since these areas overlap and demand concurrent attention from the outset.

3.5.1 Psychological Issues and Concerns

According to Burgess & Holmstrom (1974, a,b); Clarke & Lewis (1977); Kilpatrick et al (1979) and Notman & Nadelson (1976), the woman's experience of sexual assault, in the impact stage of the acute crisis phase (and, to a degree, later) will involve:

- (1) considerable fear and anxiety, rarely anger,
- (2) a sense of physical helplessness,
- (3) a sense of psychological powerlessness, in that her right to reject the assailant's intrusions and demands was ignored or negated and her attempts to resist or to avert the assault fail,
- (4) varying degrees of guilt, shame and self-blame, since most women feel that they dealt with the situation in an unsatisfactory way (despite the intimidatory manoeuvres to which they have been subjected) and many women feel that in some way they 'caused' the assault.

3.5.1(i) The Impact and Recoil Stages

In terms of the crisis intervention model, in the immediate post-assault period the woman is still in the impact stage of the crisis. Depending on her own resources and on the support of others, and on situational factors related to her experience in reporting the assault and the forensic medical examination, there may or may not be progress within a few hours to the next, the recoil stage of the crisis reaction. The impact stage may continue for some days. Initially there is shock and disbelief and a degree of dissociation from emotions is common, (Notman & Nadelson, 1976).

In follow-up studies of psychological functioning, Kirkpatrick et al (1979) reported extreme global disruption of psychological functioning at 6-10 days and 1 month post-assault assessment. Three months after sexual assault psychological function was largely restored and mood disturbances had diminished, but anxiety and phobic-anxiety levels remained significantly raised compared with a control group of women. This difference was still present after 6 months.

There are characteristic reactions in the immediate post-assault period in women who have been sexually assaulted. Sutherland & Scherl (1970) described their experience with 13 young women seen within 48 hours of sexual assault. They suggest that, while the content of the response may vary from one woman to another, the pattern appears to be similar. In this period the reaction can take a variety of forms (shock, disbelief, dismay). Some women are agitated, incoherent and emotionally labile, unable to talk about the encounter or to describe the assailant(s). Other women may appear quite coherent and relatively calm but, at first unexpected reminder of what has happened, may break down into uncontrollable sobs.

Burgess & Holmstrom (1974) kept comprehensive notes of 92 adult women they counselled (following "forcible rape") in the immediate post-assault crisis phase and later. They coined the term "rape trauma syndrome" for the pattern of responses they discerned. In the impact period of the hours following the assault, the woman may experience a wide range of emotional responses. Shock and disbelief are common. They describe two emotional styles, equally evident amongst women they saw:

- (1) "expressed" emotion, where the woman's feelings of fear, anxiety, anger are readily revealed in their behaviour (crying, sobbing, smiling, restlessness and tension);
- (2) "controlled" emotion, where the woman's feelings are concealed under the mask of a calm, composed or subdued demeanour. There is a degree of dissociation in many women and restricted attention is often present (Notman & Nadelson, 1976).

Varying degrees of disintegration occur in a woman who, prior to the assault, had appeared well adjusted. This will depend on the degree of the trauma involved, which relates to the specific circumstances of the assault, on the woman's adaptive capacity, and on other factors which will be discussed in Section 3.5.1 (iv).

In association with the psychological effects of anxiety, fear and anger, there are likely to be physiological reactions such as nausea, vomiting, diarrhoea, restlessness, tremor, sighing, pallor or a flushed appearance, excessive sweating (Burgess & Holmstrom, 1974a, 1975b, Notman & Nadelson, 1976). There are also likely to be night terrors and other sleep disturbances, tension headaches, and a startle

reaction; there may be appetite loss and stomach pains (Burgess & Holmstrom, 1974a).

For most women there are likely to be physical aches and pains related to bruising and abrasions, even after encounters where extremes of violence were not involved. These pains serve as reminders of what has happened but can also serve as ways to gauge relief at the absence of worse trauma for some women. In some instances injuries may be a focus for the woman's concern (e.g. where a woman's face is slashed and there is a possibility of permanent scarring). This may represent a stigma for her of what has transpired - symbolizing what she sees as her devaluation.

Issues of guilt, shame, humiliation and self-blame often are to be seen in the period immediately following sexual assault, despite varying circumstances of assault, and different degrees of surprise, violence and degradation (Burgess & Holmstrom, 1974a,b; Notman & Nadelson, 1976; Symonds, 1975, 1976) and are liable to linger on for a considerable period of time.

The woman is likely to blame herself either for not avoiding the encounter, or else for not having been able to prevent the assailant from carrying out the sexual assault. The cultural expectations which place responsibility on women for impulse control in sexual encounters are internalised by woman, unconsciously, and however irrational this may be, contribute to feelings of guilt.

Psychodynamically, the experience of the assault as somehow punitive, in some cases, may be understood in terms of evocation of unconscious infantile fears of punishment for imagined misdeeds. In addition, the woman's anger and counter-aggressive impulses,

which feel intolerable to her, may be transformed into anxiety, guilt and shame (Notman & Nadelson, 1976; Symonds, 1975).

The assaultive experience, because of the additional sexual imposition, is degrading and humiliating for most woman (Weis & Borges, 1973). However, the woman who has conscious sado-masochistic fantasies is liable to wonder, privately, whether or to what extent she (actively) may have colluded with her assailant at some point. The fact that she submitted out of fear and that her submission was adaptive in the situation is liable to be forgotten. In some instances the woman may recall moments of involuntary excitement with shame and humiliation, without realizing that the gamut of human emotional experience cannot be neatly categorized and that there are moments in a stressful situation of any duration when one needs to attempt to cognitively restructure the encounter in a way that is less psychologically traumatic. Thus for moments the woman may selectively perceive the apparent sexual elements of the situation rather than the total situation. Sometimes there may be orgasm. As Symonds notes, "In conditions where anxiety or terror are overwhelming, the victim easily distorts reality" (1975, p.22). Sadomasochistic type fantasies do not involve real violence and reality-based fears arising from real intimidation, and do not make a woman a willing victim - although they may perhaps make her more vulnerable.

It is commonly argued, within simplistic ideas about psychoanalytic theory, that women's constant preoccupation with their vulnerability to sexual assault is based on a secret desire to be raped. Those who hold

this view justify it with the rape fantasies (fantasies of female submission to a forceful and aggressive lover) which both men and women are known to produce (Hariton & Singer, 1974; Friday, 1975). However, this view tends to ignore the fact that fantasy material has its origin in sociocultural reality, which is male-dominated (Smart & Smart, 1978). It is also ignored that the sadomasochistic fantasy is evoked at will and is moulded and scripted entirely by the woman for her own pleasure; in it, she plays both the dominant-aggressive and the passive-submissive roles, since the fantasy is her own. There is also a difference between sado-masochistic erotic games, which are played out with pleasure by some consenting adults, and the fear-filled negating experience of an imposed, intrusive violation of one's choices and personal space boundaries.

The argument that psychoanalytic theory reveals that women want to be raped is ill-informed. This notion derives from the work of Helene Deutsch (1947) who is certainly not "representative" of psychoanalytic thought. Her work has been subjected to considerable criticism by other psychoanalytic theorists (Cavell, 1974; Chodorow, 1978; Horney, 1967; Mitchell, 1974; Thompson, 1971). Horney (1967) and Thompson (1971) both psychoanalysts, have written extensively on the significance of cultural pressures in the psychology of women, and psychologists have added their contribution to this theme (e.g. Bardwick, 1971; Hammer, 1975; 1976; O'Leary, 1977; Sherman, 1971; Weitz, 1977).

There are various contemporary schools of psychoanalytic thought which tend to be developing in relative independence, with fundamental theoretical differences.

In discrediting Deutsch's work, we should not fall into the error of rejecting all psychoanalytic explanation. An understanding of the complex relationship between, on the one hand, the aggressive drives of both males and females (and their possible transformation into sexualised sadomasochistic fantasies and impulses, among other possible eventualities) and, on the other hand, the psychological and psychodynamic consequences of socially-structured power imbalances between groups of people, is needed. This may well be available within the theoretical framework originally provided by Freud, particularly as developed by Melanie Klein and her followers. A discussion of this nature lies outside the scope of the present dissertation.

Whether the situation involves a sudden, unexpected sexual assault by an unknown assailant, or a social situation where the outcome is not avoidable by the woman because her expectations of the encounter are not congruent with the man's expectations (e.g. Tschudi, 1977), or where there is a situation in which both persons entertain a similar expectation but the woman changes her mind about the extent to which the encounter will proceed, and is denied this right by her assailant, it is particularly important that others avoid inappropriately assigning responsibility to the woman, because of the exacerbating effects of blame (which fosters guilt) and the likelihood that the subjective experience of the woman in these situations will be much the same (Notman & Nadelson, 1976).

A difficulty arises in encounters where young socially inept men and young unassertive women are involved in

mutually agreeable possibly even romantic situation. Because of poor communication and a lack of understanding of themselves and of one another's needs, and embarrassment about discussing sexual matters, a romantic encounter may become an aggressive seduction for the man and a sexual assault for the woman. One cannot assign responsibility to either person: the fundamental issues are misunderstanding and ignorance. Such situations are common and point to the deficiencies of the educational system. A more informed and enlightened attitude to human relating and to sexuality in high schools could go a long way to reducing the incidence of this type of sexual assault, commonly known as "date rape" (Brownmiller, 1976, p.257). Nonetheless, the young woman is very likely to feel guilt and shame in the aftermath of this situation. It is one which is unlikely to be reported except by parental intervention. Her emotional reactions are likely to involve shock, dismay and disbelief, and to follow similar patterns to sexual assault in other circumstances.

Self-blame is also related to societal attitudes. These tend to hold the victim responsible following sexual assault, as has been discussed in Section 2, and focus on the sexual element in the situation, ignoring the intimidation factor. Symonds (1975) comments on the common experience of women who have been victimised and who are then ostracised or isolated through notoriety in their local community. It is also found that the unmarried or single woman victim may be further subjected to harrassment (phone calls and visits) from strange men in the community who apparently now regard her as "available", (Symonds, 1975).

Baker & Peterson (1977) studied some determinants of differences in self-blame in woman who had been sexually assaulted. They used an attribution theory framework, which is sensitive to naive causal type explanations for events, and found that the more unpleasant the consequences of the assault, the less the woman tends to blame herself.

Presumably the woman's significant others would be less likely to be judgemental in their reactions where there are more unpleasant consequences for the woman (e.g. injuries requiring medical attention). Although this variable was not examined in Baker & Peterson's study, it seems evident that the support of family and friends would be instrumental in reducing self-blame and that the opposite would also hold, since the woman is more suggestible in the disorganised state characteristic of acute crisis.

In cases where report to the police is followed by an early arrest, there is less self-blame (Libow & Doty, 1979). This is understood on the basis of ideas of compensation - the woman feels that since justice has been done and the man's guilt "established" (through arrest), she has no need to blame herself.

The feeling of having been contaminated, "spoiled" or devalued is a fairly common reaction in the woman following sexual assault. It is felt that this is a consequence of the imposed physical invasion of the woman's bodily privacy and personal space, whether or not there has been penile penetration. It would seem to be a reaction which is most likely when both physical and social boundaries are violated. e.g. where a middle class woman is assaulted by a working class man, and the social boundary between classes is transgressed by

the lower status assailant, or where a 'white' woman is assaulted by a 'black' man and the institutionalised racial boundary is transgressed by the assailant.

The sense of having been "spoiled" would also be likely to occur in the woman of various sub-cultural groups where there is a high value placed on virginity and fidelity, and where the woman would be devalued as a consequence of the assault.

One might also speculate that, having been used as a receptacle for the assailant's anger and social frustration, and having difficulty in the appropriate expression of her own anger and counter-aggression, the woman's feeling of contamination are likely to relate to her difficulties in these areas and might be relieved if and when she is able to express her rage - against the assailant and against others who may have compounded her victimisation by insensitivity or judgemental attitudes.

The direct expression of appropriate anger in the early post-assault period is uncommon and for many this remains a problem area later. Some women who have been sexually assaulted make comments about the assailant ("he must be sick") which suggest an element of sympathy and a degree of empathic identification with the man (Libow & Doty, 1979). This reaction can be understood in terms of gender-specific social scripts, which lay emphasis on empathy and nurturance in female socialisation and discourage overt aggression (Abelson, 1976; Gagnon & Simon, 1973). In psycho-dynamic terms, the woman's aggression may well be transformed (through reaction formation) into empathic identification with the assailant at an unconscious level, anger being threatening to her ego.

In summary, a considerable amount of space has been devoted to the discussion of various psychological responses of the woman in the post-assault period, because it is so important for the helper to be aware of the variety and complexity of the woman's emotions in order to render empathic assistance. Frequently the woman herself is confused by the paradoxes implied in her emotional reactions and their fluctuation. To be of help, it is necessary for there to be someone who has an understanding of the total situation, since the woman is unlikely to, nor is it likely that any of her relatives or close friends will understand. The attitude of her significant others to the assaulted woman plays an important role in the woman's recovery, from the outset; this aspect of the post-assault situation will be discussed in Section 3.5.1 (iii).

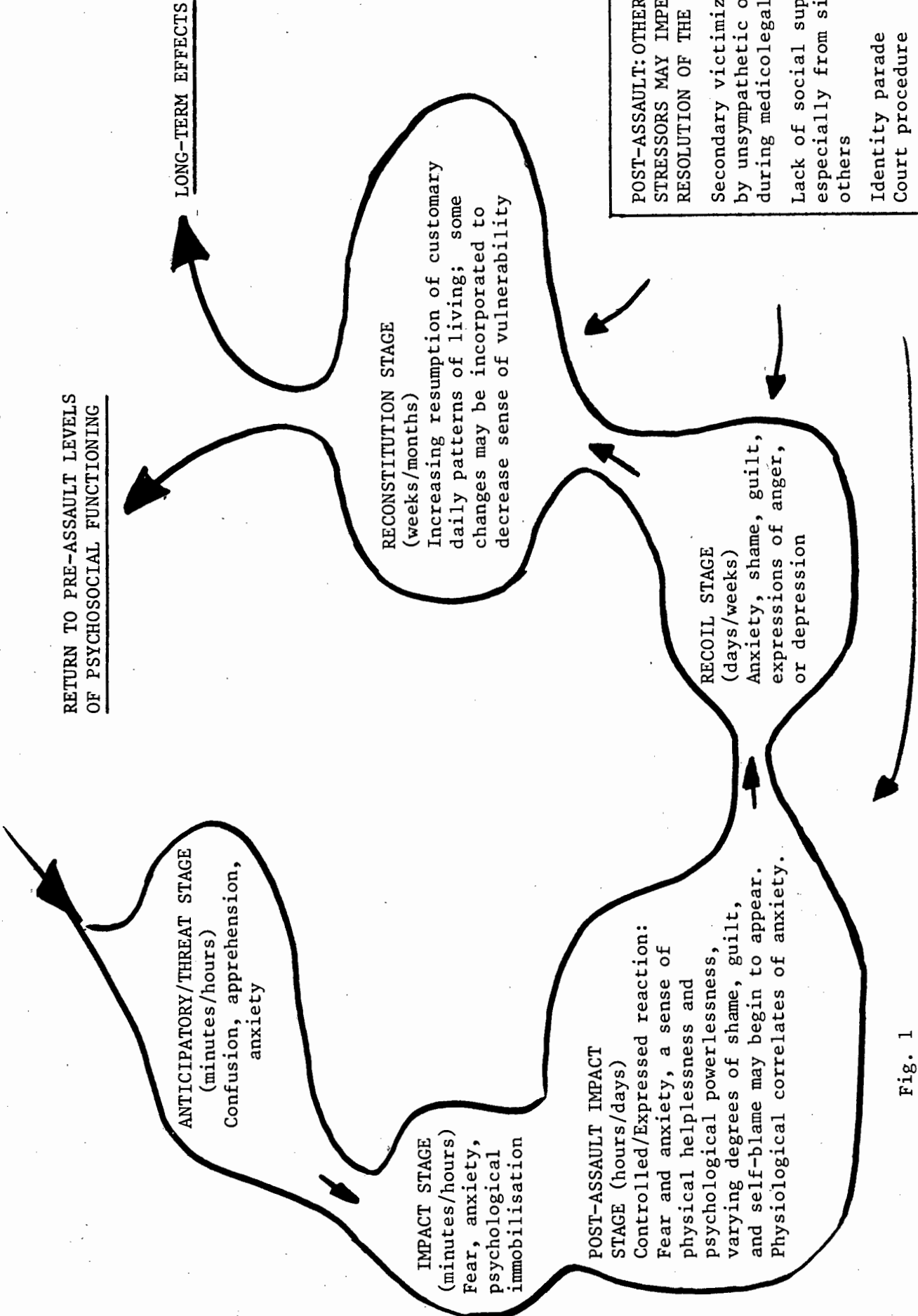
3.5.1(ii) Recoil and Reconstitution Stages

As the days pass, and the woman has dealt with the immediate practical concerns of the post-assault period, the Recoil stage may become evident as the woman's fear and anxiety begin to diminish and there is a gradual resumption of customary behaviour patterns, depending on the number and nature of further crisis precipitated by medicolegal or other stresses (Fig. 1, page 56b).

According to Sutherland & Scherl (1970) the Recoil stage involves an outward appearance of adjustment, with denial of further concern about the experience, in some women. There is a preference not to discuss the assault, which appears to be the woman's attempt to overcome the immediate anxiety, for herself and for others, and could be seen as part of a pattern of punitive self-sacrifice. These woman are liable to

RETURN TO PRE-ASSAULT LEVELS OF PSYCHOSOCIAL FUNCTIONING

LONG-TERM EFFECTS



POST-ASSAULT: OTHER MAJOR STRESSORS MAY IMPEDE THE RESOLUTION OF THE CRISIS

- Secondary victimization by unsympathetic officials during medicolegal procedures
- Lack of social support especially from significant others
- Identity parade
- Court procedure
- Pregnancy ?Abortion

Fig. 1

develop a marked depressive reaction some weeks or months later. By this time they may be more amenable to talking about their feelings and the unresolved issues, finding that they are less forgiving and empathic towards the assailant and actually extremely angry with him, and with insensitive officials, friends and relatives.

In some women, according to Burgess & Holmstrom (1974b), although the level of fear and anxiety diminishes and there is a resumption of everyday routines after some days or weeks, residual psychological effects remain. Phobic symptoms may be present - for certain places, for crowds, for strangers, confined areas or open areas, there may be recurrent nightmares and sleep disturbances, obsessional concerns with locking doors, checking burglarproofing, an unwillingness to be alone or to go out alone. There are likely to be recurrent ruminations about the assaultive encounter, and the woman repeatedly questions her reactions and responses in and after encounter.

If the woman is unable to identify positive aspects in her behaviour, the working through process is impeded, guilt and self-blame are perpetuated and she is likely to feel depressed and self-rejecting. If others have questioned the appropriateness of her behaviour during or after the encounter, this will be likely to increase her self-doubts and depression.

Suicidal thoughts may be entertained. In any case where the emotional effects appear to be substantial or unusually prolonged, particularly where there is continued anxiety and depression, the helper needs to be alert to the possibility of suicide. The woman who has a history of previous suicide attempts, minimal social bonds and supports, and who has realistic plans for suicide, should

be referred immediately to the Psychiatric Casualty Department of the local hospital.

It is a common finding that there is a fear or mistrust of men and a loss of trust in male-female relationships following sexual assault (Jackson, 1977; Thomas, 1977). As might be expected, on these and on common sense grounds given the nature of the experience, almost all women report some degree of detrimental effect on sexual satisfaction. A study by Feldman-Summers et al (1979) confirms this: sexual satisfaction with a wide variety of sex related behaviours decreased substantially for some months post-assault in their sample of women, although auto-erotic and affectional type relating (e.g. holding hands) were not affected.

A sense of psychological powerlessness (or vulnerability) is likely to linger on in many women. The woman might attempt to deal with this by moving home, changing her job, or curtailing her social activities in some way. According to Kilpatrick et al (1979), 6 months post-assault there are still significant differences between victimized and nonvictimized women on measures of anxiety and phobic anxiety. While these moves and changes may relieve the woman's feelings of stigmatization or vulnerability they can be a source of additional stress in themselves.

It has been observed that, as time passes, with the working through of the traumatic experience, the women who continue to dream about situations of being attacked or sexually assaulted appear to gain increasing control in the dream situations. There are dream reports of successful resistance, often involving the injury or killing of the dream-assailant (Burgess & Holmstrom, 1974,a). One might expect that this manifest dream

content reflects the woman's expression of her angry counter-aggressive feelings.

In summary, it can be seen that the post-traumatic stages of the crisis vary markedly in content and in expression in different women. While there is a gradual integration of the traumatic experience with the resumption of customary daily patterns, there are various issues which may continue to affect the woman for a number of months or years. It is clear that if the woman can be assisted to work through the psychological responses of anxiety and fear, guilt, shame and self-blame, to restore her sense of integrity and self-esteem as a coping person, there is less likelihood of long-term consequences which restrict her options and sense of well-being. A significant factor in the woman's rapid and adaptive recovery is the quality of emotional support she receives from significant others in her everyday environment, during the impact, recoil and reconstitution stages of the acute crisis phase.

3.5.1 (iii) The response of significant others

In most cases, the woman who has been sexually assaulted does not react specifically to the sexual aspect of the encounter. Her responses relate primarily to the fear involved through intimidation, and to the very real threat of physical injury, if not death, and only secondarily to the sexual intrusion. At times however it may be difficult to speak in terms of 'primary' and 'secondary'.

Many people in the woman's natural social environment find themselves preoccupied with the sexual aspect of the encounter and this is reinforced by the legal definition of the situation and by media responses

(Smart & Smart, 1978). This is likely to add to the woman's problems in a number of ways, and several common patterns of reaction among close family members and friends have been described (Silverman, 1978).

Before discussing these it must be stressed that the event does not only precipitate a crisis for the woman herself but is also highly likely to have traumatic effects on those close to her and to produce marked disruptions in the equilibrium of the woman's social support systems. This is particularly so if there was already some degree of stress or instability in her important relationships, or in the family. Since the reassurance of the understanding, care and emotional availability of people close to her cannot be overestimated as significant factors in the woman's recovery, clarification of their responses, when non-supportive, is an invaluable aspect of the helper's comprehension of the total situation.

The husband or boyfriend is likely to be subject to common myths which assign responsibility to the woman victimized by sexual assault, since these are the attitudes which are prevalent in our society - either that she sought the encounter (consciously or unconsciously) or that, once in it, the encounter was welcomed or at least pleasurable (Weis & Borges, 1973). The woman's 'mate' may be quite direct about this in his questions and comments, or else (concealing his resentment and anger to a degree) accuse her of carelessness or irresponsibility, directly or indirectly.

It is likely that the man will have a sense of having been wronged by another man in that, feeling proprietary towards his wife or girlfriend, he has been forced to

"share" her with someone else. This results in indignation and even in extremes of violent rage in which he expresses a wish to kill the assailant and may storm out in search of him, leaving the woman unsupported and feeling her needs unmet and misunderstood. This sort of emotional response arises in part out of shared feelings of devaluation and helplessness, serve as a defence against his own vulnerability and, possibly, anxiety about his sexual adequacy, his own rape fantasies, or homosexual concerns (Notman & Nadelson, 1976; Silverman, 1978).

It is possible that the man may feel repulsion towards the woman whom he regards now as tainted and devalued as a result of her victimization. Alternately, he may be over-anxious to resume sexual relating, to reassure himself about her response to him, at a time when it is crucial that the woman choose when she is ready to do so (Silverman, 1978).

Many of these reactions can also occur in the fathers and brothers of a sexually assaulted woman, especially in subcultural groups where there are norms regarding virginity and the unassailable rights of fathers and husbands. They bear a relationship to underlying ideas of males holding property rights over females, particularly over female sexuality (Brownmiller, 1975; Clark & Lewis, 1977; Smart & Smart, 1978). Furthermore, since males are traditionally regarded as protectors, the men who are close to the sexually assaulted woman may feel that they have failed her (and society) in this regard.

In the family as a whole, considerable anxiety is likely to be generated by the assault. There may be an inclination to call on others who are seen as supportive, to assist in allaying family anxiety (e.g. the minister, extended family, neighbours). This is likely to be

experienced as invasive by the woman herself who will need the emotional closeness of those with whom she is intimate. Although well-intentioned, it is liable to compound her difficulties, especially in the acute phase.

If there is any reason for the family, or an individual, to attribute the assault to thoughtlessness following an emotional upset, guilty feelings evoked in those involved will confuse the situation further.

There may be efforts to distract the woman - to keep her busy and socially involved, or attempts at over-protection, and in some families there can be a conspiracy of silence around the event (in which the woman herself may collude). Those involved may mean well but such efforts are liable to increase the woman's feelings of vulnerability and helplessness. Her difficulties, with feelings of guilt, self-blame, low self-esteem will be perpetuated and her need for emotional support, sympathetic understanding and feelings of self-acceptance and security will be jeopardised.

In some instances the woman may anticipate these reactions from her husband or family, or may wish to protect them from the stress of her situation, and therefore decide not to tell them what has occurred. Her understanding of her significant others may well be accurate, and her decision basically sound, but she is then deprived of important sources of support at a time when she needs them most. In addition, her decision to keep the assault secret in itself may be traumatic in that she is likely to feel dishonest and guilty about it (Weis & Borges, 1973).

When the assaulted woman is a widow, separated or divorced, or single, particularly if young or middle-aged, because of popular misconceptions about sexual assault, she is more likely to be victimized through blame and disbelief.

The woman herself may experience the attack as confirmatory of her inadequacy (Notman & Nadelson, 1976). In these cases support from the social environment is especially important.

Although the woman's friends and associates may be concerned and basically supportive, in their own difficulties dealing with the anxiety aroused by the event they may discuss the woman's experience with others. This is likely to escalate the spread of the account and its distortion in the local community, with the consequence that the woman becomes the scape-goat for a great deal of projection, feels stigmatized and ostracised (Weis & Borges, 1973), and may be subjected to a variety of sexual harassment by others.

On the other hand, when the woman's husband, lover or close friends are genuinely understanding, supportive, and sensitive to her needs (for company, for discretion, for making her own decisions) and show their respect for the woman's coping strategies, whatever they may be, existing relationship bonds are likely to be strengthened and the woman's recovery facilitated.

3.5.1 (iv) Complicating psychological factors

There are various possible complicating factors which must be kept in mind by the helper since the woman's emotional reaction to the assault is likely to be affected or compounded by these, from the outset (Fig.2,p.63b)

The prior existence of a social relationship of some sort between the woman and her assailant is likely to introduce the additional element of a break in trust, a feeling of betrayal or at least a sense of self-rejection because of naivety.

AMELIORATION OF
STRESS REACTIONCOMPLICATING FACTORSEXACERBATION OF
STRESS REACTION

CULTURAL VALUES:

High value on virginity)
fidelity)

* Devaluation

HISTORICAL ANTECEDENTS:

Recent loss/crisis; previous)
sexual assault; history of)
psychiatric illness; no sexual)
experience before assault)

*

*

Secure/supportive relationship(s)

PERSONALITY FACTORS:

Adequate ego resources
Poor ego resources (low self esteem)

*

Age-related factors -

Young women - identity confusion,
conflicts re dependence/independence)

*

* (less self-blame)

Elderly women - increased vulnerability

*

FACTORS RELATED TO ASSAULT:

Extreme physical violence, multiple)
assailants, use of weapon(s)

* (Injury, fear,
anxiety)

Subtle coercion (no overt violence)
Tonic immobility

* (confusion, self-
blame)

(?More

Sympathetic officials)

*

Multiple types of sexual assault

*

Class/Race Issues -

(Conservative 'white' woman/'black') (devaluation)
(assailant) *

(Middle class woman/working class man)

Liberal 'white' woman/'black' man * (confusion)

'Black' woman/'white' man * (less credibility)

REACTIONS OF OTHERS:

Officials (police and doctor)

*

- Sympathetic and supportive

- Suspicious and judgmental

*

Significant others (family, boyfriend,
closest associates)

*

- Nurturant, concerned

- Angry, suspicious, critical

*

Community (peers, colleagues etc.)

*

- Supportive

- Prurient curiosity, social ostracism,
harrassment

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POST-ASSAULT SITUATIONS:

Development of venereal disease

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Legal processes - repeated police
contact or questioning, identity
parade, harrowing court case

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Assailant convicted

Pregnancy resultant from assault)

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Termination of pregnancy

Fig. 2. Various factors which may ameliorate or exacerbate the woman's acute stress reaction following sexual assault.

Apart from the physical consequences of violence, there will also be psychological consequences relative to the degree and type of violence involved in the encounter. Where a great deal of violence was involved, or there were a number of assailants, the woman may more readily accept the adaptability of her coping strategy as having been life-saving. At the same time, she is likely to be far more anxious and fearful in the post-assault period, with all the manifestations of these emotions in physical and psychological symptoms. Little physical violence may be followed by more self-blame and guilt, especially if officials and friends appear to discount the amount of fear and anxiety generated in the encounter, and disregard the phenomenon of tonic immobility in the woman's account.

The pre-existence before the assault of other recent critical stresses in the woman's life (e.g. bereavement, loss of a job, a breakup in an important relationship, examination failure) is likely to have the effect of a more severe and/or more prolonged stress reaction following the assault because of increased vulnerability to stress through pre-existing disequilibrium (Golan, 1978, p.66).

The nature and extent of the woman's sexual experience before the assault, and the possibility of sexual assault or sexual molestation at an earlier period of her life, are also likely to be involved in exacerbating the nature and extent of the woman's reaction to the present crisis (Soules et al, 1978). As has been discussed, it is estimated that approximately 25% of females have experienced some type of sexual assault in their lives (Section 1). It is not known how many women experience sexual assaults more than once in their lives.

There is no systematic study of the effects of sexual assault or molestation which has occurred in childhood, on adult psychological or psychosexual functioning. Our knowledge of this area is limited, conflicting and inconclusive, although from many theoretical points of view one would expect there to be longstanding effects. Tsai et al (1979) report on their attempt to fill out this picture and found that women who were molested as children may differ markedly in terms of adult adjustment, being markedly less well adjusted than control groups on measures of psychosexual functioning and on the Minnesota Multiphasic Personality Inventory. Such differences in adjustment were likely to be mediated by emotional responses evoked at the time of the encounter(s), related to frequency and duration of the encounter(s) and to age-related developmental factors.

In another study (Tsai & Wagner, 1978) they report that women who were sexually molested as children present, as adults, with feelings of guilt and depression, negative self-image and problems in interpersonal relationships associated with a mistrust of men, inadequate social skills and sexual dysfunctions. A history which includes an early experience of sexual assault (in childhood or early adolescence) may be a factor commonly found in young women who attempt suicide (Weis & Borges, 1973), related to low self-esteem and difficulties maintaining a heterosexual relationship. Furthermore, James and Meyerding (1977) report a significant positive association between a childhood history of abuse sexual experience and adult female prostitution, and comment on the development of "an abusive sexual self-identity" (p.31). These studies all suggest that there are significant long-term effects following the sexual assault or sexual abuse of children.

According to some authors (Miller et al, 1978; Soules et al, 1978;) a prior history of sexual assault would be more likely to be associated with a more profound, longer-lasting reaction to the crisis precipitated by the current sexual assault, which cannot be resolved until prior assaults have been dealt with. They recommend that such women be referred for intensive psychotherapy because of difficulties they are likely to experience in dealing with the re-evocation of guilt feelings, marked self-blame, and more severe feelings of vulnerability and anxiety.

In commenting that 25% of the women in their reported series of sexual assault victims had suffered previous sexual assaults, Soules et al (1978) note that many of these cases did not involve a police report. They also observe that these women may live in "a social environment that encourages repeated assault in that the assailant is more often known to her...." (p.37). Miller et al (1978) report that 24% of the sexually assaulted women in their study were previously victimized, 18% involving incest.

While repeated sexual assault may be quite adventitious, or may be related to increased risk mainly because of a woman's life-style and/or social environment, it must also be considered that -

- (1) a woman may be more vulnerable as a result of her previous experience (i.e. more rapidly immobilised by her anxiety and fear, less likely to fight her assailant, and more fatalistic),
- (2) she may be more vulnerable as a consequence of a basic lack of confidence (low self-esteem), poor assertion skills, and strong dependency needs,
- (3) she may be more vulnerable because of over-reliance on "feminine socialization", which equips her to attract attention but often precludes more flexible and adaptive social skills (Weitz, 1977),

- (4) other factors could relate to low social intelligence with impairment of ability to evaluate external dangers, or severe mental illness or emotional disturbance.

It must also be noted that the effects of sexual assault on a lesbian woman are likely to be different in certain respects from those seen in heterosexually oriented women. One cannot suggest that the reactions of lesbian women will conform to any particular pattern, since homosexual orientation is only one aspect of a person's personality. Gundlach (1977) reports that, on the basis of his survey, approximately the same proportion (apparently 25%) of lesbian and heterosexual women over age 16 had been subjected to sexual assault. He notes that the heterosexual women tended to blame themselves for not having been careful whereas the lesbian women tended to reject all men as sexual partners or companions.

The main question to which Gundlach directed his study was whether women who were sexually assaulted as children are more likely to be lesbian in orientation as adults (Levin, 1975; Riess, 1974). He found that, of the 17 women molested between ages 4 and 15 by a relative or a close family friend (often admired substitute "father figures" or "older brother figures") 16 were lesbian in orientation as adults. Of 18 women molested or sexually assaulted by strangers at age 15 and under, 10 were lesbian in orientation as adults.

It thus seems likely that, in lesbian women in whom sexual molestation or assault as a child has been a factor involved in the determination of their object choice orientation (which is not necessarily the case for all homosexual women) (Laws and Schwartz, 1977), the experience of sexual assault in adulthood is likely to re-evolve traumatic intrapsychic material of specific types (Gundlach, 1977). In heterosexual women victims

who were molested as children, it is possible that the childhood incident and its memories will have different connotations. These questions have not been answered empirically to date.

Another variable which must be considered in association with the effects of sexual assault on the woman's emotional reactions during the acute phase and later, is the type of family upbringing which she has experienced (Janis, 1971; Symonds, 1975). There are likely to be differential effects related to a warm, emotionally responsive childhood environment, to one which was characterised by undemonstrative, remote parenting, and to one where there was a great deal of overt violence or physical rough and tumble. One can only speculate at this stage about the consequences of these factors.

In a proportion of the cases there is a likelihood that the woman will be subjected to multiple types of sexual assault, by one or by several assailants. Evrard & Gold, (1979), report that a third of the woman they assisted had suffered rectal or oral penetration and that this seemed to be more emotionally disturbing for the victim; these women had great difficulty talking about this type of assault.

Various issues relate to the sexually assaulted woman's age and life stage. Most victims appear to fall into the age range 17 - 24 years (Clark & Lewis, 1977; Notman & Nadelson, 1976). This may be understood, in part, because of the likelihood of "date rape" in the inexperienced young woman (Brownmiller, 1975), in part, because of the high incidence of "power rape" (Groth et al, 1977) and, in part, because at this age women are more likely to be moving about in the course of social activities, often alone.

The experience of sexual assault is likely to throw the young woman's sense of identity into marked confusion, to challenge healthy attitudes about self-sufficiency and independence, and to cast a shadow over her future relationships with men. Where the assaultive encounter is the young woman's first sexual experience, it is likely that this will institute a longstanding association between the traumatic encounter and future sexual relating (Burgess & Holmstrom, 1979; Feldman-Summers et al, 1979; Kilpatrick et al, 1979). If the young woman is a student, she is likely to have difficulties with concentration for some time after the assault, and if her experience becomes known to her peers it is likely that she will be stigmatized and ostracised in various ways. Her ability to maintain study-goals will probably be disrupted and this can result in examination failure or drop-out.

In the woman older than 24 years, it is likely that she is either employed or a householder. In Burgess & Holmstrom's(1976,a) sample, 60% of the victims were employed at the time of the assault and all experienced disruption in their working role to some extent. Many either leave employment altogether or change their jobs. This is usually because the woman finds it difficult to explain what has happened, or because of some connection between the circumstances of the assault (place or assailant) and workplace.

For the woman whose major work is home maintenance and parenting, the assault produces a dramatic disruption in her ability to cope for some varying length of time. Usually she needs assistance from family members. This is partly because of task demands and the children's needs, and partly because of her fear of isolation in the home - particularly if the assault took place there.

There may be age-related expectations which will affect the woman's emotional reaction to the assault. As Groth (1978) points out, the typical victim of some offenders is markedly older than the assailant; in other instances, older women are adventitiously the victim of sexual assault. It appears that between 3.6% (Amir, 1971) and 7% (Fletcher, 1977) of sexual assaults involve women of age 50 or older, most of whom are living alone (single, widowed or divorced). In 76% the assault took place in their own homes, in 79% by strangers, and in 60% of cases there was extreme violence (Groth, 1978).

The emotional reactions of the older woman to sexual assault are complicated by the diminished physical, social and economic resources which are common to the elderly. In addition her age-related sense of increasing helplessness and vulnerability is likely to be exacerbated by the assault and, for many older women, there are few social supports in the form of friends and relatives.

Because of the particular vulnerability of the older woman to sexual assault, the U.S. Department of Health, Education and Welfare has published a guide to prevention and protection in older women (Davis & Brody, 1979).

Other variables which are likely to complicate the woman's emotional reaction to the assault can be situation-specific (e.g. her feelings about having accepted a lift, particularly if she is young and there have been family restrictions about this, or the presence or imminent arrival of her children at the time of the assault).

There are additional problems in instances of inter-racial sexual assault in a society where race is an emotionally charged issue, (Weis & Borges, 1973, p.97). Inter-racial sexual assault is relatively infrequent: under 10% in multiracial society according to Amir's 1971 study in Philadelphia; Evrard & Gold (1979) report a similar proportion; and, according to official statistics in South Africa for the period 1976 - 1977 the reported incidence was 4% (Annual Reports of the Commissioner of the South African Police). Although the incidence appears to be low, where inter-racial sexual assault occurs in South Africa, the consequences for the woman may be complicated in a number of possible ways.

Where the encounter involves a 'black' man and a 'white' woman, if the woman holds characteristically conservative views of the man as 'dirty', 'bestial' and 'contaminating' she is likely to feel herself devalued and spoiled. The encounter is liable to feed into deeply entrenched superstitious fear of the 'black' man, which will be likely to be increased. It is also feasible that, given the power structure in South Africa, where authority is white, the white woman is likely to receive more sympathetic support from officials, friends and neighbours - particularly if she is assaulted in her own home by an intruder who also steals, and if she is a middle class, married woman.

Where the encounter involves a 'black' man and a 'white' woman and the woman holds liberal or radical antiracist views and is sensitive to the daily humiliations and privations which may be experienced by the man in a racist society, the woman is placed in a particularly conflictful dilemma. Although subjected to a violent, humiliating assault which may have future repercussions for her or for others, she is liable not to report to the police. Her expectation that the man may be very severely penalised simply on the basis of the inter-

racial nature of the assault is justified, (Van Niekerk, 1976). The fact that this man may be repeatedly assaulting women tends to be overlooked.

Where a 'white' man sexually assaults a 'black' woman, the daily effects of her subordinate position in white-dominated society are amplified by the experience of male-female violence. There are no estimates of the frequency of reporting versus non-reporting in any category of inter-racial sexual assault but one would assume that this group would be most biased in official statistics, simply in terms of the woman's expectations of her low credibility.

The reaction of officials (policemen and district surgeons) whom the woman will encounter in the immediate post-assault period, if she reports to the police, will have repercussions on the woman's ability to cope with the crisis. If sympathetic and supportive, the trauma is ameliorated, if sceptical or cynical and judgemental, the woman's psychological trauma is exacerbated.

Finally, where the woman is rendered more vulnerable as a consequence of a previous history of psychiatric illness, this must be taken into account. In some cases the assault is likely to precipitate serious emotional decompensation and referral for psychiatric care is imperative.

We have seen that there are numbers of variables which are likely to play an important part in the psychological reactions of the woman who has been sexually assaulted. In order to be of maximum possible assistance to the woman, the helper needs to be aware of the implications of each of these factors (and probably others) to try

to understand how they relate to one another in the particular situation presented. It may be necessary to question the woman, with care and sensitivity, in order to ascertain which of these variables is involved since the information may not be forthcoming. This is particularly true for the woman who presents with a controlled or silent reaction to the assault (Burgess & Holmstrom, 1974a). At the same time, questioning the woman may add to the trauma for her, especially in the immediate post-assault period, and is best delayed until she provides an opening for this sort of discussion. This may be more likely once she has developed trust in the helper through her experience of the helper's non-judgemental objective sympathy.

3.5.2 Practical Issues and Concerns Post-Assault

There are various material issues which must be dealt with in the crisis phase immediately following the sexual assault, in the interests of the woman, despite the fact that in some cases all the woman wants during this later part of the impact stage may be to curl up quietly in some secure place. These issues fall into three areas: medical, medico-legal and laying a charge against the assailant(s) at a police station.

The medical and medico-legal issues have been described in an article by Raynal and Kossove (1981) directed at the general medical practitioner, and their suggestions will be included.

3.5.2(i) Medical Needs

- (a) Medical treatment directed at the treatment of injuries, with referral to specialists (gynaecologist or surgeon) where necessary.

(b) Venereal disease

The prevention of venereal disease can be ensured by means of prophylactic injections of antibiotics (4,8 million units aqueous procaine penicillin, intramuscularly) which can be given by any general practitioner, and will ensure that neither gonorrhoea nor syphilis is contracted. The medical practitioner at municipal or divisional council clinics will provide this treatment free of charge.

(c) Pregnancy

If the woman is not obviously pregnant already (i.e. pregnant before the assault), the pregnancy test of her urine is negative, if she is not using a reliable form of contraception and is of child-bearing age, prophylaxis for possible pregnancy as a result of the sexual assault is advised (Burgess & Holmstrom, 1974; Raynal & Kossove, 1981).

The official procedure for obtaining a legal termination on the grounds of rape is arduous and stressful. There is an official form of application which is used at Groote Schuur Hospital, (T.P.2427a, Dept. of Health, Annexure A) and this must be collected by the victim from the Department of Social Work at the hospital. The form (in duplicate) must be taken to the District Surgeon for signature; his approval will depend on whether a charge has been laid at a Police Station at the time of the assault, his findings at forensic examination at the time, and a urine pregnancy test. The woman must then take the form to the appropriate Magistrate who is entitled to ask her for details of the sexual assault before he completes a section of the form and signs it. The woman then returns to the hospital with the form, and presents herself before 8 a.m. at Gynaecology Out Patients Department (H.Floor) to be seen and examined by a medical officer, who again is entitled to question her regarding the details of the

If the woman is doubtful about reporting the assault (for instance in a situation where the assailant was known to her) no pressure should be placed on her to report. However, the possibility of pregnancy needs to be explored with her since, if a medical practitioner cannot be found who will undertake the prophylactic procedures suggested, it may be necessary for her to go through the official termination procedures and these are facilitated considerably if a charge has been laid at the time of the assault. At later stages there is a tendency to imagine that the woman has fabricated the story of rape simply in order to obtain an abortion for an unwanted pregnancy.

At the time of report, the attitude of the police officer who takes her statement may be quite sympathetic and concerned. However, this tends to vary from one policeman to another. It also depends very much on the social class and other attributes of the woman making the report, and on the circumstances of the assault as described by the woman. There is a tendency to blame the woman for what has happened to her or to regard the report as 'unfounded'.

A policeman, in going through his routine questions for this sort of charge, may disbelieve the woman's story, feel that she actually consented, or otherwise find that there is insufficient legal evidence to warrant pursuit and prosecution of the assailant.

It is established that in the U.S.A. there is an unofficial selective screening process at the level of the police station and prosecutor's office (Rabkin, 1979); there is no reason to believe that the situation would be

Three elements are usually required by the police - (1) Medical evidence of vaginal penetration (i.e. rape as legally defined); (2) lack of victim consent and threat or use of force; thus evidence of victim resistance (witnesses who heard her screaming, or saw the struggle) or physical injuries is regarded as important; (3) the circumstances of the initial contact are also examined (e.g. whether this was voluntary, as in hitchhiking, or not). The existence of a prior acquaintanceship or friendly association tends to increase disbelief of the woman's complaint. As Rabkin notes "If the victim does not agree to initial contact, if the offender is a stranger, if he uses a weapon, and if she is injured, the probabilities of booking and conviction are high" (1979, p.638).

These factors need to be taken into consideration in helping the woman to weigh up the pro's and cons of reporting the assault to the police, if she feels dubious. If the result of reporting is extensive, repeated and implicitly judgmental questioning by one policeman after another, this will be extremely traumatic for the woman. At the same time, her doubts about reporting may be without basis except in relation to a preference to forget about the incident, or feelings of self-blame.

3.5.2(iii) Forensic Examination

If a charge is laid with the police the next step is customarily a forensic examination which is performed by the District Surgeon. It is not commonly known that the woman is entitled to see a medical practitioner of her own choice (Raynal & Kossove, 1981). However, there are not many doctors who will willingly undertake a forensic examination because this means that they will have to be available to appear in court to give evidence if the case is prosecuted.

As is true for the police, the attitude of the District Surgeon varies from one individual to another. There are some District Surgeons who readily express the belief that many women complain of rape falsely. The District Surgeon's duty is to perform a thorough examination of the woman, in order to find evidence which will corroborate her claim and means to identify the assailant, thus it is anomalous that in cases where he does not believe there has "really been rape" (or the policeman interprets his report in this way) the Police are apt to regard the case as "unfounded". Thus the case is "tried", as it were, long before reaching the courts.

At the same time, according to Groth & Burgess (1977,b) many assailants suffer from sexual dysfunction - i.e. there is no ejaculation, no vaginal penetration and no penile erection. This means that much of the 'proof' of forced sexual intercourse, which is so emphasised in terms of legal and forensic requirements, will not be found anyway. This is not to say that sexual assault did not occur, with all the ramifications of the trauma for the woman, but simply that rape as legally defined did not occur. However "...the prosecution is circumspect about seeking trial of a case in which there is no medical proof of recent intercourse." (Soules et al, 1978, p.33).

The forensic examination is directly related to the legal definition of rape and the examining medical practitioner is required to make careful, detailed notes of the history taken from the woman, and of his medical examination.

The history should include full details of the assault - every aspect of physical violence, including blows, choking and threats, should be noted and evidence of the effects of this violence sought and noted. The doctor should ask specifically about vaginal penetration, ejaculation, oral and anal penetration,

whether cunnilingus or the use of foreign objects was involved, since the woman is often too embarrassed to mention these herself. It also needs to be recorded when the woman last had consenting sexual intercourse, the date of her last menstrual period, and what (if any) contraception she is using. She should also be asked whether she is suffering from venereal disease already, to her knowledge.

The medical examination describes the woman's emotional state and whether or not she is under the influence of alcohol or drugs, or appears mentally handicapped. By law, if judgement is impaired (through intoxication or mental handicap), there is no consent. This is a point which is not generally known.

The state of the woman's clothing is noted; stained and torn clothing should be retained as evidence, and passed on to the police if a charge is being laid. The woman is undressed and all injuries are noted, especially bruises on the back and thighs, but also on the throat. Any injuries which the woman has sustained, however slight they appear, should be noted.

Fragments of skin may be found under the woman's fingernails if she attempted to fight off the assailant(s), and these should be collected. There also may be foreign pubic hairs which should be sought and retained as evidence.

A vaginal examination is performed, the condition of the hymen being noted, how many fingers can be inserted by the doctor, and the relative difficulty with which this is accomplished. Vaginal smears are required for evidence of semen since the presence of sperm and acid phosphatase in the vagina corroborates the testimony of rape. A speculum is also introduced into the vagina to permit inspection for evidence of internal injuries, venereal disease or pregnancy.

Many women find the vaginal examination psychologically traumatic following recent sexual assault. Even when the doctor is sympathetic and gentle, the experience of physical invasion may precipitate the further disintegration of the woman's psychological resources. It is desirable that the woman be accompanied by a close and trusted female relative or friend, or by a sympathetic helper.

At the end of the forensic examination, specimens should be handed over to the police, direct, by the doctor, in sealed containers which bear his signature. If the woman has seen a private practitioner and decides not to report the assault, the doctor should retain the specimens and his notes at least until it is certain that pregnancy has not resulted.

3.5.2(iv) In the Absence of Immediate Post-Assault Prophylaxis for Venereal Disease and Pregnancy

If no steps are taken to prevent venereal disease or pregnancy in the immediate post-assault period, the woman should be seen by a doctor between 3 and 10 days after the encounter to ensure there is no disease, and 6 to 8 weeks later for a pregnancy test (unless she has had a menstrual period meantime). A blood specimen should be taken at this time for a V.D.R.L. test to exclude syphilis. The actual incidence of venereal disease following sexual assault is unknown, but one report (Soules et al, 1978) suggests that the incidence is higher than for the routine clinic finding (9% as opposed to 5%) (p.39).

If the woman falls pregnant as a result of the assault and no police report was made at the time, if she saw a private medical practitioner and asked him/her to ensure that a thorough forensic type examination was performed, within a few hours of the assault, it may be possible (in consultation with the local

magistrate) to go through the formalities in requesting a legal abortion. However, the magistrate or the gynaecologist, or the Medical Superintendent, may refuse to authorise the procedure.

According to Soules et al (1978), who conducted the forensic examination of 110 women at Denver General Hospital's casualty department there were no pregnancies following the assault. They provide prophylactic treatment for pregnancy immediately. Where this is not the accepted procedure, it is estimated that pregnancy may follow sexual assault in 5% of cases (Jackson, 1977) - presumably this is more likely, on common sense grounds, where there are multiple assailants.

3.5.2(v) Identity Parade

If a police report is made and the assailant is apprehended, the woman will be required to assist at an identity parade. This can occur within days of the assault but may only be weeks (or even months) later, depending on whether the man is apprehended. The nature of the identity parade is such that the woman may be precipitated once again into a state of emotional disequilibrium and turmoil.

At an identity parade the man is placed among 10 or 15 others (usually other men awaiting trial for various offences) and they are all lined up in a room or an enclosed yard. The woman is required to enter the room alone. She has to examine the general and facial appearances of the men present and attempt to identify, and to point out, the man who assaulted her. She is then required to approach the man and place her hand on his shoulder, to enable a policeman to take the identifying photograph, under the hostile gaze of the unwilling line-up of men.

When asked to attend the identity parade the woman has no idea what exactly will be required of her. Anticipatory guidance and supportive company to and from the parade are essential to minimise the likelihood of psychological trauma.

3.5.2(vi) Court Case

At a later period the case may be brought to court. This can take place within a few weeks of the assault but more often occurs some 3 to 6 months later. Once again, the court case can be extremely traumatic for the woman, who appears as a witness for the state prosecution. It is likely that she will be subjected to lengthy cross-questioning by the defence attorney and/or the magistrate, as well as being required to tell the full story of the sexual assault in all its details - often in a courtroom full of people. The accused man, or his defence lawyer, will make strenuous efforts to discredit any aspect of her testimony, in order to cast doubt on her veracity as a witness, and will try to show why it was reasonable for the assailant to think she had consented. Mistaken identity is another important defence tactic.

The experience of the court hearing can precipitate the woman into a further state of crisis. Many women break down into incoherent weeping and inconsistent statements during the cross examination.

The helper can best aid the woman who intends to make a report to the police, before or after reporting, by suggesting that she make detailed notes of the assault and the events leading up to the encounter as soon as possible after they have occurred. Any threatening words or gestures should be included, also any small details which might corroborate her evidence (times, descriptions, other witnesses). While it is not permissible to "rehearse" a witness before a court

case, the woman can read through her own notes just beforehand and can also ask to read through the statement she has made to the police (which is passed on to the Public Prosecutor).

The woman needs to be advised about likely defence tactics and that, if she feels upset and unable to answer a question clearly at any point during the hearing, she has the right to ask for a brief rest before doing so.

On the day of the hearing, the woman should have supportive company with her.

It frequently happens that the case is remanded for some reason or another in the courts in Cape Town locality - for instance if a witness does not arrive. This means that the woman and other witnesses may be required to attend on more than one occasion, spending many anxious and empty hours at the magistrate's court.

At times the assailant's friends or family may know or find out the woman's name and address, and will harrass her with pleas or threats in order to try to persuade or intimidate her into either refusing to identify the man, or in some other way jeopardising the case. In situations where the woman is able to move to another address this is advisable. In any event the helper should ensure that the detective in charge of the case is advised of the pleas or threats as soon as possible. However, there is not always much that can be done about this.

When judgement is finally passed, if the alleged assailant is found not guilty - which is often the case since the evidence must be fairly conclusive to justify sentencing - the woman and her family are

invariably devastated. There is a feeling that they have 'lost the case' and that the woman's story has been discredited and the family dishonoured. The woman and her family will need considerable support and a sympathetic hearing for their outrage and distress.

There are many practical issues which must be clarified for the assaulted woman (and her family) in the hours and days following the assault to reduce the likelihood of later complications and crises precipitated by the onset of venereal disease or an unwanted pregnancy. Furthermore, in the weeks and months following the assault, there are likely to be further practical concerns in which the woman will need informed and supportive assistance. It is the helper's responsibility to be familiar with the medico-legal procedures involved in order to provide the woman with anticipatory guidance and appropriate support. The practical as well as the psychological aspects of the woman's situation must be dealt with in order to optimise the possibilities of adaptive responses to the various subsequent crises which may follow the crisis of sexual assault.

In summary having provided an outline of the context of violence in which sexual assault must be seen in Section 2, in this section the crisis of the sexually assaultive encounter, as experienced by the woman, has been described. The crisis intervention model has been used to order the sequence of reactions in a way that is most likely to be meaningful to a wide range of lay counsellors and members of the established helping professions. The psychological effects on the woman and on those who are significant members of her supportive social network are outlined and explained. Attention is drawn to possible complicating psychological factors. The practical issues and concerns which must

be confronted and dealt with by the woman from the earliest moment in the period following the assault are also described.

With the perspective provided in this overview of the total situation, the helper is better equipped to offer the woman and her family and close friends the quality of understanding and type of assistance best suited to her needs. This will do much to facilitate her recovery and return to pre-crisis levels of functioning within a reasonable period of time, with less likelihood of residual after-effects. For some women there may be development of more adaptive measures of coping, learned through the helper's facilitation of her recovery.

In the next section the therapeutic intervention in the post-assault period will be discussed.

THE THERAPEUTIC INTERVENTION

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4.1 Introduction

Baldwin (1978) has stressed that, to deal with crises arising from traumatic encounters, it is crucial for the helper (the lay counsellor or therapist) -

- (1) to be familiar with the general implications and likely consequences of the type of situation which precipitated the crisis;
- (2) to provide emotional support while helping the person in crisis to mobilise his/her own best coping strategies for the situation; this demands the clarification of the issues involved in the stress situation and related feelings, and hence is dependent on (1) above;
- (3) to provide anticipatory guidance where there is a recognised generic stress reaction, (and where there are urgent practical issues which must be confronted);
- (4) to recognise that more skilled intervention may be required in this type of emotional crisis and to be able to recognise when referral is indicated, and to arrange this, to help the person attain satisfactory resolution.

In Sections 1, 2 and 3, the general implications and likely consequences of the experience of sexual assault have been discussed. In this section the aim is to provide the helper with a clear outline of a set of useful procedures to follow to ensure the sexually assaulted woman is provided with adequate assistance.

Helper-related issues will be discussed first. The area of human experience which we have termed sexual assault is one which is heavily emotionally laden for most people (Silverman, 1978). It tends to threaten men and women, in different ways, and readily lends itself to the polarization of people into mutually accusatory or critical groups, (Pepitone-Rockwell, 1978). The difficulties must be recognised in order to maintain a degree of objectivity without which the issue will be insoluble and the problems perpetuated.

Crisis intervention in the acute crisis phase, when provided by suitably sensitised helpers, is focused on strategies which will take cognisance of all the possibilities of the total situation in each case. These strategies minimise the possibilities of increasing the woman's psychological trauma through secondary victimization. Assistance is directed at enabling the woman to deal with the acute stress reaction -

- (1) through mobilising her own resources in a context of clarification and emotional support;
- (2) through securing the emotional support and understanding of significant others in the woman's social network, and
- (3) by facilitating the woman's encounter with medico-legal procedures and officials.

These conditions facilitate a return to pre-crisis levels of psychological and social functioning within a reasonably short period of time. Optimally, the learning derived through the experience will generalize to other areas of the woman's life.

Finally, a variety of long-term effects of sexual assault will be discussed. Suggestions will be put forward for therapeutic interventions which may facilitate the working-through process at a later stage, months or years following the assaultive encounter.

4.2 Helper-Related Issues

The helper has a responsibility to be familiar with the general implications of sexual assault - psychological and physical reactions, social attitudes, medico-legal procedures. A thorough understanding of the nature, extent and implications of the woman's feelings and reactions in the situation of the encounter itself, and in its aftermath, is crucial (Baldwin, 1978). Equally important is an appreciation of the reactions of significant others in the woman's natural social support network (Silverman, 1978), and the nature and consequences of secondary victimisation (Holmstrom & Burgess, 1978). Finally, it is equally important that the helper has an understanding and awareness of her/his own feelings about sexual assault, the nature of male-female sexual relating, and social attitudes to women (Courtois, 1979; Evans, 1978).

If there is no obvious physical injury to the woman (as "proof of violence and force", and hence evidence of non-consent) the otherwise sympathetic helper can easily fall into the trap of mistrusting the woman's account because of noncomprehension of the effects of fear and fear of violence. Disbelief perpetuates the woman's psychological trauma and increases difficulties she has in coping with the crisis.

This is as true for women helpers as it is for men since the social climate of attitudes towards women, sexuality and sexual assault is pervasive and over-endowed with simplistic notions based on a lack of understanding of all three areas (Clark & Lewis, 1977; Smart & Smart, 1978). It is incumbent on helpers to familiarise themselves with the literature which examines common myths about rape and sexual assault (e.g. Clark & Lewis, 1977; Weis & Borges, 1973).

In terms of recognised differential gender-specific socialisation patterns for males and females in our society (Maccoby & Jacklin, 1974; Weitz, 1977), it may be more difficult for a male helper to understand the basis of a woman's attempts to cope effectively through verbal and cognitive strategies, and why the woman chose these strategies rather than fighting, struggling or screaming for help more persistently. It is also difficult for many men to comprehend the depth of the long-standing fear of sexual assault which appears to be common to all women. The relative absence of direct and explicit anger in the woman's reaction to the assault, both within the situation and in the following period, may also be difficult to comprehend. (Notman & Nadelson, 1976).

A substantial proportion of women who have been sexually assaulted and who seek assistance explicitly express the wish to speak with women helpers. According to Notman & Nadelson (1976), the experience of violence and sexual assault precipitates feelings of mistrust toward all men, who are seen as "potential aggressors and exploiters" (p.410).

In recent years, in moving away from idealized notions of "value free" therapy, clinical training increasingly emphasizes the necessity for helpers to make determined

efforts to clarify their attitudes to the client. Every person is a member of some specific group(s) and labelled as such in society (e.g. by gender, age, race, religious affiliation). It is of crucial importance for therapists to examine their basic attitudes, values, beliefs and expectations about (a) the group of which the client constitutes a member and (b) about the client as an individual with a specific history. Without this clarification there is liable to be misunderstanding (or collusion in social mythology), and value-laden judgements will intrude in the helping process. This sort of self-analysis on the part of the helper is particularly true for therapy with women (Frank & Burtle, 1974) and especially for the victim of sexual assault, (Evans, 1978; Pepitone-Rockwell, 1978).

Wherever feasible, a woman who expresses her preference to see a woman helper should be assisted to do so. At the same time, because of the realities of personnel availability in social agencies, clinics and hospital situations, on occasion it may be necessary for a man to assist the woman victim in the acute crisis phase. While it is recommended that women in helping professions be given the appropriate training to assist victims of sexual assault, and be available in Day Hospital Clinics, medical casualty services and other social agencies, the particular difficulties which face the male helper, as outlined by Silverman (1977), will be reviewed briefly here.

A man who is called on (or who offers) to assist a woman victimised by sexual assault is likely to be extremely anxious. He may feel that he is likely to be identified with the assailant, by virtue of his gender, and is likely to attempt to compensate in various ways. He may speak more softly than usual, increase or decrease the physical distance between himself and the woman, exclude or include physical contact. These anxious manoeuvres are likely to be

interpreted by the woman in many ways. What she is most likely to perceive is the male helper's anxiety and ambivalence about his helper-role and his gender-role. Arising from his anxiety and defensiveness, it is possible that judgemental sounding comments or questions will be verbalised, to which woman victims will be very sensitive.

Furthermore, it is common for males to focus on the sexual aspect of the encounter rather than on the violence involved (Notman & Nadelson, 1976; Silverman, 1977; Symonds, 1976). This is related to gender-specific socialization patterns. Inadequate and biased assistance is thus provided for the woman, who feels that her terror in the situation and the nature of the trauma of the experience have not been understood.

Finally, in his eagerness to present himself as a 'liberated man' (to himself and to his associates, perhaps, as well as to the woman) the male counsellor may behave in an over-protective, patronizing or over-indignant manner. This is less likely to reassure than to discomfort the woman, and creates mistrust. According to Silverman (1977) these responses of male counsellors or helpers are likely to be reaction formations to unconscious identification with the aggressor, and with the men in the victim's natural social network (whose property has been plundered in some sense) (p.93). They are likely to increase the woman's feelings of vulnerability and helplessness, at a time when adaptive recovery depends on mobilisation of her own coping strategies.

When a man is called on to provide psychological assistance for a woman who has been sexually assaulted, it is imperative that he familiarise himself with the problem areas specific to males, which arise out of gender-

specific socialization, in addition to the general implications and consequences of this type of crisis situation. In particular, it is advised that he seek supervision from someone who has extensive experience with this particular problem area (or at least from informed female peers) in order to keep a check on his feelings and their possible traumatic effects for the woman he is trying to help.

The preceding paragraphs do not imply that a female helper will be unaffected by similar, parallel or other issues which are likely to be a source of further trauma for the victim or to impede her recovery. As has been mentioned, all members of a society share common unexamined ideas about issues such as woman's position in the social order in relation to men, female and male sexuality, rape and sexual assault. Simply because one is a woman, it cannot be assumed that prevailing social attitudes and prejudices do not apply.

A woman who is considering providing help to victims of sexual assault must be willing to explore her attitudes and feelings about these areas in order to uncover and deal with the social myths and stereotypes to which, often unconsciously, she is party (Pepitone-Rockwell, 1978).

Women helpers are likely to become over-protective or to identify with the victim's feelings of helplessness and vulnerability at some point or another. It is important for helpers to have a clear idea of the ways in which they can be helpful to the woman victim, and to relinquish over-valued idealized or personal goals. These may have more to do with the helper's needs than with those of the assaulted woman.

Repeated confrontation with evidence of violence and of male aggression against women is likely to produce high levels of anxiety in the woman helper. In unconscious defence against her own anxiety, she may find herself seeking in the victim's behaviour or reactions reasons to explain the assault, as a distancing manoeuvre to decrease her feelings of vulnerability as a potential victim. This can increase or perpetuate the victim's problems. Alternatively, the helper may find herself feeling angry with the woman and resenting the demands and needs of victims. She may begin to experience difficulties in her own relationships with males (Pepiton-Rockwell, 1978).

To avoid or deal with these and other problems, it is advised that the woman helper have a group of peers to help her cope if an experienced person is not available for supervision, and that regular airing of these problem areas be possible, in a context of supportive self-exploration.

The helper needs to build up knowledge of community resources (Golan, 1978). In particular, there is great value in establishing an acquaintanceship with the police detectives at the local stations and with the district surgeons. An awareness of their attitudes to sexual assault is useful and the helper can provide a gentle educational process on occasion. Contact with the social workers in various agencies and, in particular, in the termination of pregnancy clinics is important as is knowledge of the location and working hours of the V.D. clinics in the area. The names of sympathetic general practitioners who would be supportive in treating and conducting forensic examinations privately, if desired, are important resources.

The role of the helper as interpreter and facilitator is crucial in that, as an independent, uninvolved but concerned citizen, the helper can mediate on the victim's behalf with the police, the district surgeon, and other officials, to minimise traumatic interaction.

In a multi-racial society such as South Africa, where social stratification on racial grounds is markedly hierarchical and explicitly institutionalised (Van den Berghe, 1971), there are added problems for the helper which must be mentioned.

Most professionals, para-professionals and those who are involved in lay counselling, are so-called 'white' and/or middle class in origin. Because of the nature of the majority population distribution, on the other hand, most women victims of sexual assault who seek assistance are so-called 'coloured' or 'black' and from the less wealthy sociocultural context, since middle-class victims more commonly consult private doctors, psychologists or psychiatrists for help (Weis & Borges, 1973).

The problems consequent to these points are related to -

- (1) the relative deficiency of services for the underprivileged groups (social work agencies, day hospitals, outpatient clinics are over-worked and relatively underfunded and understaffed);
- (2) the distances involved between the officially defined living areas for the racial groups, which are costly in time and money to cover;
- (3) the relative imbalance of resources (money, cars, telephone lines, information and self-assurance);

- (4) language and class differences which cannot be dealt with by ignoring them and which render communication difficult.

The consequence is that subtle patterns of dependency are produced with the resultant expectation that helpers are there (a) to be counter-exploited, (b) to solve a variety of social problems in a magical way.

It appears to be partly as a consequence of these factors that the predominantly 'white' group of voluntary helpers of Rape Crisis in Cape Town, has turned most of its limited resources toward public education rather than victim assistance.

Public education is an important aspect of efforts to reduce the traumatic effects of sexual assault. There is an urgent need for the development of existing resources in the community through the training of helpers already working in existing institutional structures (nurse-aides, nurses, social workers and other professionals). The development of community based self-help groups to assist sexual assault victims should also be fostered.

4.3 Strategic Crisis Intervention

The working model of crisis intervention outlined by Golan (1978) will be used as the basis for this section because of its simplicity and appropriateness. The goals and strategies are readily understood by a wide range of helpers, whether these be voluntary lay counsellors within the community or helpers in the established professions.

As Jacobson (1965) has commented, crisis intervention holds particular promise for the treatment of the socio-economically less privileged groups. This

consideration must be regarded as significant in any third world country. There is economic use of skilled resources to train members of existing helping professions and members of the community. The nature of the intervention, its brevity and the circumscribed focus on specific problem areas, are easily learned by reasonably intelligent lay persons. These are important factors for preventive community psychiatry.

The crisis intervention approach accepts the generic, characteristic nature of the crisis precipitated by sexual assault. The psychodynamics of the individual in crisis are not examined (Aguilera & Messick, 1978). The focus of intervention is on the encouragement of adaptive behaviour, general support and reassurance, anticipatory guidance and a limited amount of environmental manipulation.

The approach does not lend itself to clearly demarcated steps along the lines of clinical psychiatry or clinical psychology (data gathering, formulation, differential diagnosis, management plans, treatment, termination and follow-up plans). The intervention is aimed at adaptive resolution of the crisis, using whatever resources are available to assist, and minimising the likelihood of after-effects and further traumatisation.

Golan (1978) speaks of "the beginning, the middle and the end phases" (Fig.3, page 96b). All may take place within a single session which is sometimes 3 hours in duration. Alternatively the three phases may be stretched over a number of days or a period of weeks, in several sessions, varying with the complexity of the situation and the woman's needs.

Three major factors are involved in the recovery:

- (1) the woman's ego strength and resources,
- (2) the quality and availability of social support,
- (3) the amount and nature of victim blame involved. (Burgess & Holmstrom, 1974,a).

Using the strategy of crisis intervention, it is important that the vulnerable person's dependency needs are not fostered by the helper. Care is taken to ensure that the woman herself is involved in all decision-making and in the implementation of plans.

For purposes of clarity, the issues on which the helper focuses in assisting the sexually assaulted woman during the acute crisis phase will relate to her psychological needs, the practical concerns and the involvement of support of significant others or friends.

4.3.1 Beginning Phase

The woman in crisis usually makes the initial contact on the telephone. The helper learns the nature of her situation and what the current crisis involves. While the factor precipitating the first telephone contact may be an imminent court case some time after the sexual assault itself, or the woman's concern about long-standing symptoms, or continued preoccupation with an assault of some time past, it will be assumed here that we are dealing with the woman in the acute crisis phase within hours of the sexual assault.

In some cases the entire counselling process may be conducted by telephone - in a single call or more. While this is not advocated in crises following sexual assault, it is often all that is possible for some reason or another, and is certainly better than no intervention at all. Generally speaking, a meeting is arranged with the woman.

At the first meeting the helper has certain tasks:

- (1) to listen to the woman and accept her expression of her immediate feelings and concerns, providing her with a sense of supportive understanding;
- (2) to obtain some details of the sexual assault, to the extent that the woman is prepared to discuss this at this point;
- (3) to clarify the priorities which demand the woman's immediate decision, the practical medico-legal issues;
- (4) to ascertain the availability of the woman's own social support systems;
- (5) to provide anticipatory guidance;
- (6) to foster the woman's coping abilities.

These tasks will be discussed further but in actuality may not be sequential or separate.

The helper provides the woman with a calm, thoughtful and caring listener for her emotional responses. The helper pays close attention to how the woman describes her feelings and fears, as they were during the encounter and as they are now. It is not appropriate to tell the woman how she should be feeling, or how she must be feeling. What the woman herself describes as her emotional responses is acceptable.

In talking and in feeling understood and accepted, it is possible that the woman will reveal more of the complexities and paradoxes of her feelings and be able to describe the horrifying experience in detail. However, not all people are accustomed to talking about complex emotions. It is not appropriate to expect that they will do so now. In such instances the feeling of credibility, acceptance and understanding, at the level of discussion the woman chooses, does much to help restore her self-respect.

The helper will be perceived as having a broad understanding of the total situation. This gives the woman in distress a sense of direction and purpose as well as a sense of security. This sort of reassurance is what she needs.

As Jacobson (1974) has observed, the message which is indirectly communicated to the person in crisis is -

- (1) that the situation is relatively common and could have happened to any woman;
- (2) that the woman had been fine before the crisis and will regain her equilibrium;
- (3) that the helper will facilitate this.

In addition we need to add -

- (4) whatever she did or did not do during and after the encounter can be seen as sensible behaviour, appropriate to the situation at the time.

In situations where the woman in crisis presents with the "expressed" style of dealing with her emotions, ventilation of her feelings should not be constrained by the helper. It is important for the woman to feel that this is a situation in which she can express her feelings, whatever they may be and however confused - anger, frustration, grief, resentment, fears and vulnerability.

However, the helper should follow the victim's lead (Thomas, 1977). If the woman presents with a "controlled" style of dealing with her feelings about the assault, this should be respected. In the situation of the sexual assault the woman has probably experienced extreme feelings of psychological powerlessness and physical helplessness. Her need to present herself as able to control her emotional responses may relate to a need to feel a degree of self-sufficiency. It

is also possible that there is a certain amount of dissociation - a defence the woman needs to allow herself time to deal with her feelings, out of fear that they may overwhelm her.

In listening, with minimal but pertinent questions, the helper who is familiar with the sorts of situation and range of likely reactions will be able to organize the information provided in her own mind, according to her understanding. She will be able to discern the ways in which the woman managed to cope with the assaultive encounter. Sharing this understanding with the victim, in a brief comment at an appropriate moment, provides the woman with the beginning of the restoration of her self-respect and ego integration. A belief in her capacity to recover is important for the woman.

Generally speaking it is not appropriate to share a sociological or detailed psychological understanding of sexual assault and its consequences with the woman in crisis. After some time has elapsed, when the woman's emotional equilibrium has been restored, if she should ask for this sort of information in any way, it may be appropriate to provide this as an educational resource which will give the woman a broader context in which to integrate her memory of the experience meaningfully.

Certain women may not be interested in talking with, or in the assistance offered by, a stranger. Sometimes it is the family or a friend who has called for help, made the appointment and brings the assaulted woman along. The woman herself may prefer to deal with her feelings alone or with the assistance of her own associates. This should be respected but the helper must bear the following considerations in mind:

- (1) the practical information which will be relevant for the woman must be provided, if not to the woman herself then to the relative or friend;
- (2) some anticipatory guidance and educational counselling may be invaluable;
- (3) the woman needs to understand how, if she wants assistance at a later stage, she can contact the helper again.

The feeling of acceptance which the woman gains from the helper's obvious understanding of the total situation, calm confidence in her ability to recover, and informed guidance regarding important issues, are significant aspects of assistance in the acute crisis following sexual assault.

In the first encounter with the helper, the woman is encouraged to describe the sexual assault in her own words in as much detail as she is able. For many "the overwhelming impulse of the victim is simply to avoid dealing with the whole frightening situation" (Burgess & Holmstrom, 1974,b, p.233). The woman should not be pressurised to talk about the encounter until she chooses to do so - some women may prefer to write down what they can remember (Pepitone-Rockwell, 1978). This is not invariably necessary, however, and should be left up to the woman herself.

If there is a likelihood that a police report will be made, the woman will be spared no detail of the sexual assault. She needs to be aware of this. If the helper has difficulty in talking about sexual material (or sexual anatomy) this will inhibit the woman further.

Since most people (particularly women) have difficulty talking about these areas (Laws & Schwartz, 1977), it is likely to be the helper's role to facilitate discussion of the encounter. There are several benefits in providing the woman with the opportunity to talk freely about the encounter:

- (1) various details may be recalled which she may need for legal purposes and, if overlooked now, these are less likely to be remembered later (e.g. by the woman under cross questioning in court);
- (2) the emotional charge attached to the memory is reduced if the details can be recounted to an understanding, attentive and supportive listener;
- (3) it may lead to the more open discussion of aspects of the assault which the woman finds most painful, shameful or repugnant;
- (4) reconstruction of the events leading up to and within the encounter can give the woman a sense of control.

The woman needs to know exactly what has happened to her and what problems might arise. When a medical examination is required, she needs to know beforehand exactly what the doctor is going to do and why. The possibilities regarding venereal disease, pregnancy, unwanted publicity and medico-legal procedures must be discussed with her so that the woman feels in touch with the issues involved which will affect her life and future events in it, and has the necessary information on which to base her choices about reporting to the police, medical care, talking with relatives, friends and associates.

While dealing with these matters the helper needs to be assessing the woman's strengths and weaknesses in the present crisis situation, and trying to gain an understanding of the woman's previous adjustment (her tolerance for stress in the past, her life style) and adaptive resources, and the existence and quality of the woman's own social support network (husband, boyfriend, relatives and friends).

There may be situations where the woman seems to be incapable of making the important initial decisions regarding medical care and police reporting. In such cases, the helper - preferably with the aid of the woman's closest associates - must do what is necessary in her best interests (Evans, 1978).

In any event, whatever is discussed and whatever action initiated, this should be conducted in the presence and full hearing of the woman herself, as she needs to feel part of the decision-making process in some way. Anything done which could be perceived as secretive and totally out of her control will only serve to mystify and further traumatise the woman.

Regarding anticipatory guidance about psychological reactions, the woman is likely to experience one or several of the following symptoms in the early post-assault period: night terrors, nightmares, insomnia, disturbances of appetite, difficulties with concentration, startle reactions, tension headaches and feelings of panic (Evans, 1978; Burgess & Holmstrom, 1974,a).

The woman needs to be told that there are various natural sequelae which follow a sudden terrifying experience and that these are symptoms connected with the extreme anxiety and fear which she has experienced, and that they will gradually diminish over a period of time - probably a couple of weeks.

Few sexually active women want to resume sexual relating for some time following sexual assault. The woman herself (and her husband/lover) is likely to be worried about this. To reduce anxiety, this should be discussed.

The couple needs reassurance that, if there is a loving and caring, gentle relationship, and if the woman is allowed to set the pace in resuming sexual relating, there should be no problems. Many women need non-erotic physical contact from their mates for a period of time and the resumption of sexual intimacies will take its own course. It is important that the husband/lover does not pressure the woman to resume sexual relating: both need to know this.

From the studies of Summers-Feldman et al (1979) and Burgess & Holmstrom (1979), previously discussed (Section 3) it is likely that there will be residual problems in sexual relating in about 50% of women following sexual assault. It is not known which women are more vulnerable to these after-effects but it seems less likely in a situation where there is a pre-existing secure and loving relationship and a partner who is able to contain his need for sexual intimacy until the woman has indicated her preparedness for this.

There is little point in warning victims about the likelihood of residual psychological or physiological symptoms in any detail since this could have the undesirable effect of producing or perpetuating such symptoms. However, anticipatory guidance should be provided to the woman (and preferably to the couple, although individual counselling may be preferable initially) and could follow the lines

suggested by Burgess & Holmstrom (1979) that sexually active women who have been sexually assaulted have three decisions to make -

- (1) to resume sexual relating;
- (2) to cope with any residual psychological or physiological responses which might occur in sexual relating;
- (3) to cope with any reactions their partner may evince.

In the event that these issues are raised in the later period of time, after the acute crisis phase, it is advisable to refer the woman (or the couple) for more skilled assistance from a psychotherapist who has training in this area.

There is no point in raising the issue of guilt feelings or questions about self-blame. If the woman herself brings these concerns to the attention of the helper in the early acute crisis phase, she needs reassurance that these are common feelings in women who have been sexually assaulted. No further interpretations are necessary at this stage since they are likely to be confusing and misunderstood. The emphasis in the early post-assault stage is on the support of the woman's adaptive and coping strategies during and after the assault and encouraging her to make decisions about further adaptive strategies.

Crisis intervention is not psychotherapy. In this approach the woman's own defence style is supported and strengthened - if denial and rationalization are significant aspects of the woman's customary defence mechanisms, these are appropriate for her needs, and there is no good reason for the helper to confront them. To help anyone reconstruct their customary

PERSISTENT SYMPTOMS:

e.g. Depression, phobic anxieties, nightmares, insomnia, obsessional rumination about assault, withdrawal and breakdown of social relationship network; sexual dysfunction; self-destructive behaviours - alcohol or drug abuse, increased atypical sexual behaviour, suicidal ideas;

(lasting more than 3-4 months post-assault)



COMPOUNDED REACTION

?

POST-ASSAULT FACTORS

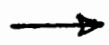
Inadequate support from social support systems; ?social isolation; Secondary victimization; Breakdown of previous significant relationship.

↓
CRISIS INTERVENTION APPROACH AIMED AT CLARIFICATION, EDUCATION AND ENVIRONMENTAL SUPPORT

?

PRE-ASSAULT FACTORS

Personality-related variables
Previous history of mental illness
History of previous sexual assault (or child abuse)
Other recent pre-assault crises



REFERRAL TO TRAINED PSYCHOTHERAPIST IS PROBABLY INDICATED

Fig. 4 Long-term effects following sexual assault suggest a compounded reaction. Instances in which referral to a trained psychotherapist are indicated are shown.

The helper needs to ascertain the amount and quality of support the woman has been receiving from significant others. The area of secondary victimization needs to be explored - the reactions of officials, relatives, friends, medical practitioners after the assault, social isolation or ostracism, or harrassment, may have been experienced since the assault.

In some instances the woman has been sexually assaulted in the past, or was sexually molested as a child, and has never discussed this with anyone able to help her, (Burgess & Holmstrom, 1974,a).

Sometimes the sexual assault may have been the finale in a sequence of crisis situations in the woman's recent life, which made her especially vulnerable to the trauma of the sexual assault.

For certain women the sexual assault can precipitate the reconsideration of many of her basic attitudes, values and her entire life-style (Golan, 1978). Current close relationships may have fallen under scrutiny, because of nonsupportive reactions to her situation. In many instances there is a breakdown of the current major intimate relationship (Burgess & Holmstrom, 1979,b) precipitating further crisis.

Women with high self-esteem, or with supportive and understanding husbands or lovers, can cope more easily with the crisis of sexual assault and with feelings of some contributory responsibility. Women with low self-esteem display more marked guilt and self-blame and this is particularly true for those whose personal concepts are more easily influenced by the attitudes of others (Haywood, 1977), especially where others have not been supportive.

The basic problems are likely to be related to poor self-concept and difficulties with the appropriate expression of anger and aggression. Until such a woman feels able to express her anger, with the assailant and with others who may have added to her trauma through insensitivity or non-comprehension, it is unlikely that the experience of sexual assault will be integrated in a healthy way.

When there are long-term compounded effects, the woman needs referral for intensive psychotherapy with a trained therapist.

Each therapist has her/his own style of working with emotional problems. However, in cases which involve sexual assault as a significant precipitant, it is argued that the therapeutic situation needs to be a more broadly educational one in that the woman is likely to benefit most from cognitive reorganisation of the understood meaning of the assault, within a social context, along the lines of the work of Endler & Magnusson (1976) and Frank (1975).

Sturdivant (1980) has commented -

"It is assumed that by utilizing both sex-role analysis and power differential analysis to understand their lives, women will change the meaning they assign to their life situations, understanding them in terms of social forces and cultural expectations as well as personal context" (p.142).

Through cognitive restructuring, in addition to emotional ventilation and exploration, the hope is that a sense of responsibility will be introduced for both individual change and for social change. One of the factors would be the reduction of feelings of isolation, alienation and self-blame commonly experienced by

women who have been sexually assaulted, who experience the assault as an inexplicable, personal one (Plaza, 1980; Stern, 1980). An identification with other women is fostered.

This type of approach places a responsibility on the therapist to make an effort to gain a broader understanding of the social context of human problems and an awareness of the links between social systems, personality development and events within the individual's life.

Many women may be effectively assisted in a group setting of limited goals and duration: e.g. 6 or 8 women in a group, meeting once weekly for 6 weeks. Group support is thus obtained, which is especially important for those with minimal social support, and individuals may feel more free to discuss disturbing aspects of the assault, or particular emotional material, with others who have been through a similar experience. Coping mechanisms can be shared and explored together and desensitization developed to talking about problem areas.

Group support, during the reconstitution stage of the crisis or later, will reduce the woman's feelings of isolation and stigmatization (Notman & Nadelson, 1976) and facilitate the working through of much traumatic material, along the lines of groups for women sexually molested as children described by Tsai & Wagner (1978). Furthermore, women in whom low self-esteem is an obvious problem may benefit from elements of assertive training which can be incorporated in the group's program.

It should be noted, however, that groups are not always suitable for women who are not accustomed to verbalizing emotional or personal material to others. There must be a selection process to ensure that the group members will be reasonably compatible. Furthermore, the group needs a skilled facilitator who can keep the discussion focused and provide the necessary intervention to protect group members who need this at various points.

In summary, in this section the helper has been provided with a clear outline of useful procedures and strategies to be used within a crisis intervention model for the adequate assistance of the sexually assaulted woman. It has been shown that the main focus in crisis intervention is to provide emotional support and security while facilitating the woman's coping strategies and initial decisions regarding important practical issues. In addition clarification and anticipatory guidance are provided, the woman's own social support system is mobilized and educated, and the likelihood of secondary victimization is minimized.

The importance of a thorough understanding of the issues surrounding sexual assault (societal attitudes to male/female sexuality, to women and to sexual assault) have been emphasized as basic to the provision of adequate assistance to the sexually assaulted woman, whether in the acute crisis phase or in treating the long term after-effects of sexual victimization.

5. SUMMARY AND CONCLUSION

5.1 Summary

It is argued that the legal definition of rape places an over-emphasis on "sexual intercourse" as an aspect of the assaultive act, and de-emphasises the violence and intimidation experienced by the woman, and dominated public attitudes toward sexual assault. This increases and perpetuates the psychological trauma for the assaulted woman.

These attitudes are based on questionable assumptions about male-female sexuality as, respectively, "active" and "passive", prejudiced views of woman's position relative to men in society, and on attitudes towards women which can best be described as paranoid. In consequence, this dissertation, although drawing heavily on the literature about rape and its effects (as legally defined), utilizes a social definition of rape as one of a range of sexually assaultive acts involving intimidation and unwanted physical intrusions with sexual connotations, and employs the term sexual assault throughout to maintain this distinction. The woman's subjective experience of sexually assaultive encounters and their after-effects are held to follow a similar pattern.

Since the situation is more complicated in the case of children and adolescents, and is largely unreported for male victims, the dissertation deals with the provision of adequate assistance for the sexually assaulted adult woman.

The incidence of male-female sexual assault is discussed. All women are vulnerable, by virtue of gender-specific conditioning, and it is shown that there is a probability that 20-25% of the female population is directly affected at some point in the life-span. Furthermore, it is not only the working-class woman who is at risk.

The variety and complexity of assailant motivation is discussed on a continuum of violence and intimidatory strategies; this provides the context in which to understand the extremes of fear and anxiety to which the assaulted woman is often pushed. The problem of victim-blame is addressed in particular, to show up the additional stresses of secondary victimization which are likely to afflict the assaulted woman in her contact with medico-legal processes and with associates, family and friends, when she is held responsible in some way for having been assaulted.

Without an adequate understanding of the complexities of the situation and of the social attitudes which are exemplified in the juridical system, it is difficult to provide the sexually assaulted woman with the psychological support and assistance she needs in the acute crisis phase and later.

The woman's subjective experience of the sexually assaultive encounter is described within the framework provided by the crisis intervention approach, since this is suitable for discussing and dealing with the acute stress reaction and is a model which is accessible to a wide range of helpers. The psychological effects of sexual assault, and the urgent practical concerns which must be dealt with in the early post-assault period, are described. The compounding effects of various complicating psychological factors are discussed, since the helper needs to be alert to variables which are likely to produce more profound or longer-lasting traumatic effects in some women, with a view to her referral for more skilled and intensive psychotherapy.

The therapeutic intervention in the acute crisis phase is detailed. The focus of crisis intervention is on

the restoration of the woman's pre-assault level of psychosocial functioning as soon as possible. To achieve this, the understanding and supportive listener helps the woman to mobilise her own resources, personal and social, facilitates her encounter with medico-legal procedures, clarifies important problem areas and provides anticipatory guidance in a climate of non-judgemental calm reassurance.

In order to be able to provide this, the helper needs to have a sound understanding of the social context of sexual assault and of the general implications and likely consequences for the woman. Professionals, para-professionals and lay counsellors already working in the established helping institutions who are likely to encounter sexually assaulted women in the course of their work often need to broaden and extend their understanding of this sort of stressful experience which, as has been discussed, is not an uncommon event. They need to appreciate also that many women are reluctant to talk about the experience, and why this is so.

A growing number of concerned community members are forming lay counselling groups in South Africa for the assistance of sexually assaulted women. Rape Crisis groups, though small, are active in Cape Town, Pietermaritzburg, Durban and Johannesburg. There have been three training courses in Cape Town for new members (in 1978, 1979 and 1980).

In this dissertation, drawing on the available literature on on the author's experience in association with Rape Crisis, Cape Town, since January 1977, a guide is provided for the use of professional, para-professional and lay counsellors in the appropriate assistance of the woman who has been sexually assaulted. Case material is appended.

5.2 Future research

Although no attempt has been made in this dissertation to deal with these, there are various issues in this and related areas of study which demand attention from future researchers, which have been mentioned. The most important will be briefly summarised here.

The incidence and patterns of male-male sexual assault and the psychological effects of this are unknown. Since this is a well-recognised phenomenon in prison populations (and the South African prison population is reportedly very high per capita) an investigation is indicated. In particular one wonders whether the high incidence of male-female sexual assault in South Africa is associated in any way, in certain cases, with the consequences of the psychological effects of male-male victimization.

Some men speak of having been "raped" by women. Presumably this would be an unusually assertive and purposeful female-male seduction, perhaps most commonly involving an inexperienced younger man and an older woman, but this phenomenon is not discussed in the literature. A detailed study of the patterns of incidence and the psychological consequences for the man would provide interesting comparative data.

Also needed are more representative comparative studies of the patterns and consequences of (i) sexual assault amongst working class and middle class women of different cultural groups, and (ii) of multiple offender assaults.

More specific information is needed regarding South African statistics - the proportion of non-reported to reported sexual assault amongst the different class and population groups, the number of complaints reported to the police relative to the number of cases officially

pursued, the incidence of multiple offender sexual assaults, the age relationships between assailants and victims and an analysis of court procedures and outcome, particularly where inter-racial sexual assault is concerned.

Although it is anticipated that victim-blame is as likely to occur in South Africa as elsewhere, cross-cultural studies might reveal interesting differences as well as similarities, with differential effects for the woman.

5.3 Recommendations

In conclusion, strong recommendation is made for the exposure of members of the established helping professions to training specifically related to providing adequate psychological care for sexually assaulted women within the crisis intervention model. In the existing networks of health, welfare and police institutions, selected members of staff could readily undergo intensive training in ten to fifteen sessions over a period of a few weeks.

It is further suggested that local community-based voluntary women's self-help groups be assisted to form, and be provided with training in crisis intervention strategies to assist the sexually assaulted woman within a community context. This would benefit many otherwise unsupported victimized women and their families, and reduce the extent and degree of after-effects. There would be added benefits in that numbers of lay persons in the community would be learning basic skills related to crisis intervention; these are applicable in a variety of crisis situations.

Crisis intervention as a community-based preventive psychiatric measure is especially important in countries like South Africa, where there are very large populations and relatively few professionally trained individuals.

To reduce the incidence of sexually assaultive encounters among adolescents and young adults, it is strongly recommended that the issues which have been discussed in this dissertation be aired in high schools and institutions of tertiary education, to facilitate more open and informed dialogue among and between young men and women in these areas of human relating (power, aggression and sexuality) which are so fundamental to our lives and are so distorted by misunderstanding.

Finally, as Waller (1977) notes, "Just as the criminal law in many of its aspects is affected by moral attitudes, so too may those attitudes we take to moral behaviour be affected by the criminal law" and so, "Changes in the rules of law affecting the rape victim as participant in the criminal justice system will signal, and then may produce, changes in the ways those women are viewed in our society" (p.162). The changes which have been put into effect through legislation in England, parts of the U.S.A., and in parts of Australia, to reduce secondary victimisation of the assaulted woman, demand the attention of responsible people in South Africa.

APPENDIX: CASE MATERIAL

APPENDIX - CASE MATERIAL

Details of some cases among those dealt with by the author are outlined in this section to illustrate and elucidate aspects of the text of the dissertation. The cases described have been selected to provide varied examples of sexual assault, different complicating factors, and the crisis intervention process involved.

CASE 1

"A", a 19 year old unmarried "Asiatic" woman, a first year student at a university in Cape Town area, was referred to the author by an official of the Faculty in which she was registered. "A" had requested deferment of supplementary examinations on the grounds of her difficulties studying since being sexually assaulted. The official felt dubious about the validity of the excuse despite a telephone call to the police who had confirmed it, and requested that the author see the student and report on her psychological state.

"A" had grown up in a small town several hundred miles from Cape Town, where her family runs a small business and forms part of a tiny Muslim community. The third daughter in a family of 9 children, her home environment had been extremely protective. Boyfriends were not encouraged - marriages are generally arranged by the parents when deemed suitable. "A" had worked hard and done well enough at the small local school to attend university and had selected courses which would justify admission to a "white" university. She has no relatives in Cape Town and there are no family friends, so arrangements were made for her to board with a strange family in a suburb near Parow, some distance from the university. Since coming to Cape Town in March, she had lived an isolated lifestyle, struggling with the adjustment to academic studies

and to being away from home for the first time. A quiet, shy, unassertive, slightly-built and attractive young woman who could have passed for 14 or 15 years of age, she had made no friends since leaving home. Her customary daily pattern after classes on weekdays was to take the University bus to the city and spend some time studying the the city library, where she felt less isolated. At about 5 p.m. she would walk to the start of the highway to hitchhike home to the Parow area, to save on the bus and train fares, to save time and to avoid a long walk at the other end.

Events leading up to the encounter and the encounter

One afternoon "A" was given a lift in a small dark green car by a man who may have been 'white' or 'coloured' and whose age she estimated to be about 26-28 years. During the journey he asked whether she had a boyfriend and about her family and background. He then asked whether she would pose for photographs for him and she declined. He pressured her with tales of glamour and urged her to think about it and ultimately elicited a telephone number (care of neighbours) where she said he could phone her the following week. "A" felt uncomfortable about this but said she could not "be rude" to him since he was giving her a lift and that, if he did phone her, she could easily put him off on the telephone.

A few days later he telephoned but instead of asking to speak with her, asked for her address. When she heard this from the neighbours, she felt alarmed. The following day he telephoned again and asked to speak to her. She agreed to see him, feeling that if she didn't he would in any case come to the house.

She also had thoughts about the glamour of being a model and earning a lot of money. She met him (he said his name was John) and they drove off in his car; she believed they were going to a studio but he drove to an isolated area near the golf club and parked the car.

Anticipatory Threat Stage

This began when initially he tried to seduce her, attempting to kiss and to fondle her, pulling off her blouse and trying to undo her skirt. She was upset and anxious, continually trying to evade his intrusions and pleading with him while trying to push his hands away from her and turning away her face. There was no visible door-handle on the inside of the car and she did not know how to open it in order to get out. He then changed his tactics and offered her money to have sexual intercourse with him. She refused, told him she had never even gone out with a man and was a virgin, wanting to remain one until her marriage. He pushed an envelope, apparently containing money, into her handbag. (The following day she discovered this; the envelope contained cut-up pieces of newspaper which he had obviously prepared in advance). She continued to argue and protest and became upset and tearful.

Impact stage

He then produced a gun and a knife, unlocked the car door and ordered her out of the car. He used the knife to cut off her underclothing and, threatening to kill her if she resisted, he sexually assaulted her three times. He also made her commit fellatio on him, threatening her repeatedly with the knife (he left the gun in the car). He did not hit her at all, although he threatened to do so, but successfully intimidated her with the weapons.

She described her feelings during the encounter: extremely afraid, she felt frozen and totally incapable of dealing with the situation. She felt sure that he would kill her anyway and she simply tolerated the man's assaultive behaviour once he produced the weapons. There was considerable pain involved in addition to her terror.

Post-Assault

Eventually it became dark, he allowed her to put on her intact clothing and drove her home. When she entered the house it was immediately apparent to the woman that "A" was upset and that something stressful had occurred. "A" told her what had happened, breaking down into distraught weeping and confusion. The couple was sympathetic and supportive and immediately took her to the police station, where they remained with her, taking her home again after the forensic examination by the district surgeon, the same evening.

A charge was laid and the police opened a case. They were very sympathetic and kind to the young woman who was tearful and shaky. The district surgeon confirmed that she had been a virgin and was also kindly. The medical examination was very unpleasant for her and upset her further.

Eager to locate the assailant, the police detective in charge arranged to meet "A" daily at 5 p.m. at the place where she originally encountered the man, hoping that this was a regular route for him and that she would be able to recognise and identify him. She would go to the meeting place alone and then sit in the policeman's car (he would be in plain clothes) every evening for an hour or so, watching the traffic.

Crisis Intervention

When first seen by the counsellor, this daily vigil had been going on for about a week. "A" was extremely distraught and emotionally labile - tearful, tremulous, preoccupied with fearful memories of the assault and with terror that the man might come to the house. Insomnia and nightmares, inability to eat, extreme anxiety, inability to concentrate or to resume any sort of routine, she had no interest in anything and was very jumpy at sudden movements or noises. Lacking in energy, she was staying in bed most of the day, didn't want to see anyone, but was extremely worried about the coming supplementary examinations because she was unable to study. She had not told her parents because they were far away, would be upset, and would not be able to do anything.

The counsellor listened attentively and with sympathy while "A" described the assault and talked about her feelings and her distress. Feeling that the daily vigil with the policeman was a significant factor in perpetuating the impact stage of the psychological trauma, the counsellor explored this with her. "A" was hopeless about the situation but described her feelings of panic daily while sitting at the intersection with the policeman. She felt incapable of refusing to help the policeman, who was being very fatherly and protective and would drive her home after the vigil every day, but welcomed the possibility of not having to continue with this meeting. The counsellor therefore telephoned the detective in charge. He was reluctant to relinquish the arrangement saying that "this is a good case because she has such an excellent character background".

It was firmly and clearly pointed out that "A" had had enough trauma already, that the daily vigil was delaying her recovery, that a policeman could not carry on indefinitely seeing her home and that her health and her preparations for supplementary examinations were being jeopardised. The policeman eventually agreed to waive his arrangement but intimated that the course of justice was being thwarted.

The possibility of pregnancy was raised. It appeared that "A's" menstrual period, usually regular, had been due during the week following the assault but had been precipitated by the emotional shock and commenced immediately after the assault. Bleeding was very heavy and had continued for 7 days, rather than the usual 4 days.

In further discussion and clarification, the difficulties of foreseeing what the assailant had been planning were discussed in the light of "A's" limited social experience and protected background. Her avoidance of physical injuries and her survival of the encounter were highlighted, as was her resourcefulness in seeking deferment of the pending examinations.

"A's" feelings and fears about having been despoiled, and about the man returning to make further contact with her, were aired. The difficulties involved in telling her parents, their concern and probable disappointment (because of the high value placed on virginity in their subculture), were also discussed. "A" decided to postpone any discussion until it became unavoidable for some reason (e.g. in the event of a court case) or until she was at home with her parents during the next vacation. She spoke of the warm support of the family with whom she was boarding with appreciation.

The counsellor wrote a letter requesting and recommending a deferral of the supplementary examinations for a month, to allow "A" time to regain more equilibrium before having to cope with this stress.

The counsellor arranged to accompany "A" to the V.D. Clinic in Green Point the following week and she was given prophylactic treatment for venereal disease. This possibility had not occurred to her, nor had it been mentioned by the policeman or the district surgeon.

Recoil stage

At this time "A" spoke of continuing feelings of depression, a lack of energy and difficulties concentrating, but said that she was now eating fairly normally and was having less difficulties sleeping, although nightmares still occurred and she would still startle at times. She was still worrying about the assailant coming to the house and keeping a watch in the area for any sign of his car or of him. She had made plans about his apprehension, should he turn up, however. She was feeling anger toward him and spoke of her wish that he be punished.

The counsellor commented on the appropriateness of her feelings and complimented her plans to deal with a possible reappearance. "A" had also made and implemented alternative travelling plans - this strategy was encouraged and the restrictions on her movements (she no longer would hitchhike at all) commiserated. She commented that areas she associates with the assault are now avoided, because she feels panicky there. "A" also volunteered the observation that, previous to the assault, when men called out compliments and comments to her, she had felt flattered and would smile at them. Since the assault she reacts to this sort of behaviour with anger and hostility, but also feels very anxious. She feels mistrustful of men.

These feelings were discussed in a receptive way and it was suggested that when she gets to know a man as a friend, and finds that he respects her, she will learn to trust him and feel able to trust the sincerity of his compliments.

Reconstitution stage

When seen a week later, the counsellor learned that some of "A's" symptoms remained but at more manageable levels. She was now very anxious about the examinations and was assisted to clarify her priorities, to concentrate on the courses she felt more confident of passing and to try to pass these, rather than try to spread out the available time uneconomically and fail them all.

There was no further contact. It is assumed that the assailant was not apprehended. It is understood that ultimately "A" passed one supplementary examination; having previously passed one course, this allowed her to continue at university.

After-effects

One can only speculate about the after-effects. A mistrust of men is likely to continue and, on the basis of the literature, since this was "A's" first sexual experience, it is likely that there will be longstanding sexual dysfunction. It is also likely that, being aware of her vulnerability to the threat of further sexual assault, she will limit and restrict her social interactions and her movements in public areas: these effects are rather incompatible with independence.

On the positive side, having identified her anger with the assailant and with behaviour which, from other men, reminds her of the assault, it is possible that she will

be more assertive in dealing with these situations. Furthermore, she was able to identify as valuable strategies the coping behaviours she used and the plans she made and put into effect in decreasing her feelings of vulnerability, and is likely to have recovered some self-respect.

CASE 2

"B", a 34 year old, unmarried 'coloured' woman, a domestic worker employed for several years by a middle class 'white' family, in whose home she lived. "B" was an orphan with no known family and was brought up and educated in an orphanage. When her education was regarded as adequate (Std.6) she came to Cape Town to find work. An intelligent, well-spoken woman, she has a 4 year old child who is cared for by a foster-mother in a 'coloured' township. "B" visits this child each week, spending her off-duty time with him. She pays the fostermother out of her wages. Since having this child, she has had no regular relationship with a man - the child receives all her spare time and affection.

The Encounter

Late one Saturday afternoon "B" was walking to the bus route after visiting the child. The walk involves several blocks' distance. She noticed a man watching her who seemed to begin to follow her and therefore she changed her route to avoid him. However, the man pursued her, and when he was walking beside her, he said he had been waiting for her. She ignored him, and continued walking toward the bus stop. En route, however, four other men who had been loitering further on joined them. All these men were total strangers. They appeared to be "skollies" (hardened delinquents or criminals) and she felt afraid.

The anticipatory or threat stage was not long in duration because, as she reached the bus stop the five men herded her further on and walked her off the street into an empty, bushy field. There was no doubt in her mind about their intentions - she offered them all the money she had, but they laughed and joked and did not disguise

their intentions. She made no move which could have been interpreted as resistant because they threatened to kill her if she did, and she felt convinced that this was likely. The threat stage rapidly passed into the impact stage, as their intentions became obvious. Once hidden in the bushes, hidden from the road, the men tore off her clothing, pushed her to the ground and, while some were holding her still, each of the five men raped her vaginally. Throughout, the men were laughing and talking with one another, ignoring her. Her feelings were of extreme fear - she was uncertain whether they would mutilate or kill her.

The men made no attempt to speak with her. In the end, they simply abandoned her in the field, and left. She retrieved her clothing. They had taken her money but she took the first available bus, giving her name and address for collection of busfare later, and found her way home, shocked and dazed.

Until the following morning she did not tell anyone what had happened. She was totally unable to sleep. She was worried that the men had been watching her movements for some time, and had been looking out for her specifically, and felt extremely anxious that this might have been the case.

In the morning she was emotionally labile, shaky and unable to concentrate on her duties. Her employer, Mrs. C. was concerned and, on questioning, "B" broke down into sobbing and, rather incoherently at first, managed to explain what had happened. Her thumb had been badly bruised and there were bruises around her genital area. She had pains in her stomach and back and there were abrasions on her back.

Mrs. C. was extremely supportive and nurturant but insisted on taking "B" to the police station to make a report. She remained with her while she made a statement and during the questioning, and went with her to the district surgeon; there were no difficulties. Two days later they took "B" to the family doctor, who prescribed sleeping pills for her continued insomnia and gave her tranquillizers.

The call for assistance came 4 days after the assault and was made by Mrs. C., who was troubled by "B's" continued agitation, distractibility, insomnia, jumpiness and difficulties with her work. Once it had been confirmed that "B" herself would like to see someone, the counsellor arranged to visit her.

Crisis Intervention

Although "B" spoke quite coherently about the assault, she began crying and was tremulous, agitated, anxious and obviously fearful. When she had described the encounter, her terror and her relief at having survived, she spoke of her certainty that the men knew who she was, might even know where she lives, and might victimize her further.

The possibility of an arrest and a court case also troubled her a great deal. She told the counsellor about a previous experience, two years before, when she and a woman friend had been at a bus stop in Sea Point, and were accosted by three 'white' men who stopped their car next to them. The men tried first to induce the two women into the car, then two of the men jumped out and tried to force them into the car. The women resisted successfully but the friend was knocked over when the men gave up and drove off. "B" noted down the car registration number and went straight to the police to make a report.

There was a court case. The men were found not guilty. Much was made of the fact that the women were out alone at night and that "B" was an unmarried mother. There was a great deal of anger and humiliation about this outcome; the trauma of that situation had been re-evoked by the current crisis and the possibility of further humiliation.

"B" was extremely anxious that no-one in the neighbourhood (not even her friends) should know of the recent assault. She anticipated that this would lead to problems and, when questioned, she spoke of "people getting the wrong ideas about her".

In this case there was no need to highlight the rationality of "B's" behaviour during the encounter, since this was unquestioned by her. The most important aspects of counselling related to providing her with an outsider to whom she could ventilate her feelings and fears in an accepting and understanding context, and who understood the connections she made between the previous experience and the current one. She was worried about causing problems for her employer and that she was still unable to cope with her work. Her anxiety about the men tracing her was extreme; she also worried that her feelings of vulnerability, and difficulties sleeping and working would continue indefinitely. She was reassured about the naturalness of these sequelae after sexual assault, and seemed to feel more relaxed knowing that many women experience similar symptoms and fears. The unlikelihood of a court case or of visits from the police was discussed, since there was no particular way to identify the men involved. The irrationality of the idea that the men knew who she was and might come to her employer's home was also explored with her.

She then spoke of plans to find a new foster-mother in a different area, to avoid returning to the neighbourhood of the assault. This was supported as a constructive move; the consequences for the child and for her were explored. She then thought that she might rather arrange to meet the foster-mother to fetch her child on her off-duty days.

She was emphatic about not wanting to return to the area of the assault. This led to further exploration of her feeling that the men had been planning to attack her for some time. It was observed that although assailants may plan to assault a particular woman, when a total stranger is involved the woman is almost always someone who happens to be around when a gang has decided to sexually assault someone. Her fears could not be totally allayed but seemed to be of more realistic proportions.

When asked about contraception, it turned out that she was protected by way of a regular injection. The possibility of venereal disease was raised. Nothing had been done about this and it was agreed to discuss the matter with Mrs. C. so that some arrangement could be made.

After spending some 1½ hours with "B", time was spent with Mrs. C., her daughter and son. They were concerned to do everything possible to help and undertook to take her to their medical practitioner again for prophylaxes against venereal disease.

The family needed some anticipatory guidance about post-assault symptoms; the likely duration and pattern was discussed. "B's" need to feel secure was emphasised and "B's" sensible plans to change her patterns of movement to see her child were highlighted.

Recoil Stage

Some three weeks later, when telephoned, "B" said she was feeling much better and coping with her work, although still jumpy and anxious at times, and with occasional insomnia. She had been seeing the child at an assignation arranged with the foster-mother, whose bus fares she was financing; she had decided not to move the child away from the home he was familiar and happy with.

"B" was told she should feel free to contact the counsellor if she wished to, over the next few months.

Reconstitution stage

The counsellor telephoned "B" again some 6 weeks later and was told by Mrs. C. that "everything seemed fine". There appeared to be some reluctance to re-open the discussion and so it was simply mentioned that, should "B" wish to, she could contact the counsellor again herself.

After-effects

Here again, one can only speculate about after-effects since there is no longterm followup. Given the supportive familial attitude to "B", a certain amount of the stress was cushioned. There was no police followup and "B's" fears that the neighbourhood would get to know about the assault, and judge her, proved unfounded. As in the majority of cases, there was no arrest and so no further stress occurred in this connection. It is the author's impression that, as a result of this and the previous experience, "B" would lead a more socially restricted life - avoiding certain types of area and imposing a curfew on herself in the evenings. It is also a possibility that she would withdraw further from heterosexual relating since this trend was already in evidence before the current crisis.

CASE 3

"C" was a 19 year old, unmarried 'white' woman, a university student, who lived in a shared household with several other students, male and female. She has a background of relative emotional deprivation. When her mother died when she was about 10 years old, the children were sent to live with various relatives. She feels that her presence was an intrusion and a nuisance in the aunt's home, where she was raised.

An attractive and intelligent woman, her manner tends to be offhand, laconic and somewhat disparaging - concealing considerable vulnerability. Her friends describe her as "neurotic and cynical" she says. At university she was involved with left-wing organizations, and had a large circle of friends and acquaintances.

The Encounter

"C" had been visiting with relatives who, by arrangement, took her by car and dropped her to meet friends at around 10 p.m. in a middle class suburb near a busy shopping area. The friends had left and so "C" began to walk down to the bus route on the main road. As she walked in the deserted street, a young 'coloured' man approached her and walked along beside her. He asked for a cigarette. "Being a liberal, I said to myself - don't mistrust him because of his race, be friendly and nice". She gave him a cigarette and moved on but he continued to walk beside her, saying that it was dangerous to walk alone. She had noticed that he seemed to have been drinking. She told him not to worry, that she was perfectly safe and was only going to the bus route. He insisted on walking with her, asked her name and chatted. She had no feelings of uneasiness or anxiety, although she commented that, if this had been a 'white' man, she would quickly have sent him on his way, not trusting his motives.

Anticipatory Threat Stage

When they arrived at a part of the road where there was a broad, grassy area, he insisted that they sit down to talk. She now felt uneasy, refused politely, and said she wanted to get to the bus. He seized her and physically forced her to sit down, "much too close". She felt anxious and apprehensive and when, very soon, he began to touch her and tried to kiss her, she struggled but he pushed her down and proceeded to kiss her on her face, neck and ears. She found this extremely intrusive and distasteful.

Impact stage

She suddenly realised that things were not going to stop at this point and that it was going to be very difficult to get away from him. Her way of coping with the situation was to think "well, it'll be over in a couple of minutes". She actively dissociated from the experience, "I'll blank it off". The assailant was talking continuously, saying he loved her and things about racism and his frustration living in South Africa. It seemed difficult for her to recall exactly what he was saying, in describing the experience. It was shocking to her that the experience of vaginal penetration in this situation was "not different from ordinary sex when there is no emotional involvement".

Eventually he put his hands around her neck and squeezed and said he would have to strangle her now because if he didn't she would go to the police. She tried to reassure him, and promised that she would not lay a charge, but he refused to believe her. She began to feel panic-stricken, believing that he did intend to strangle her. Her fear gave her extra impetus and this, plus the surprise of an unexpected movement, took him off his guard: when she saw a car's headlights a few yards away she rolled away, leapt up and ran to

wave to the car to stop. When it did, she pulled open the door and jumped in saying "someone was trying to rob me". The driver and his wife took her to their home. The woman was extremely sympathetic and concerned. "C" was insistent that she did not want the police called. While she was in the bathroom, washing, neighbours were summonsed, two young men went off in search of the assailant, and someone called the police.

In retrospect, she recalled that in the bathroom she had looked in the mirror but did not perceive much - the bruises and abrasions on her face and neck were not visible to her. This reflects the shock she was in, the dissociated state produced, and restricted attention, common in this sort of situation.

When "C" emerged from the bathroom some time later, the police had been called, the assailant had been caught and was sitting in the back of the police van. The policemen wanted her to go along with them to the station, to make a statement and, since there was no room in the cab, they suggested that she sit in the back of the van with the assailant for the short distance involved. She refused, feeling upset and angry.

The two young men who had caught the assailant offered to take her in their car. They took her first to find friends to accompany her to the police station. This was a fortunate impulse, arising out of her need for the security of supportive friends. At the police station she briefly outlined what had happened but refused to make a formal statement. The policeman in charge took her into another room and asked about her relationship with the young men who were with her, suggesting that she had intimate relationships with both. He then asked whether she had had an orgasm during the assault, told her that she was a 'typical

white student' and that she was lucky he was not going to charge her under the Immorality Act.

During all this she said she had been putting on a facade of being fine and well, but feeling very shaky. She left with her friends, who took her home. She was unable to sleep that night. The following day her friends pointed out to her how extremely jumpy and anxious she was, and drew her attention to her controlled reaction. They took her to a doctor who was extremely sympathetic and gave her sleeping pills, valium and prophylactic treatment for venereal disease.

Recoil Stage

Her friends were supportive, caring and sympathetic but their style of dealing with the situation was to keep "C" as busy as possible all the time, making sure she was never alone, taking her to parties and gatherings, and planning amongst themselves to ensure that there was no time when she could "mope". This meant that she had no time to get in touch with her feelings. "It was as though there was a conspiracy going on, to keep me busy and with people all the time". "I had the feeling they were telling me some things and not others". This made her confused and increased her feelings of vulnerability and helplessness.

Furthermore, in their own anxiety and need for reassurance, her friends were indiscrete. Within a few days the story of the sexual assault had spread throughout her own and many other circles of students. People stared at her and on several occasions she overheard someone say, "that's the woman who was raped". She felt stigmatized. A number of strangers approached her with insensitive and ignorant comments and questions, e.g. "Congratulations that you didn't report that black man - he would had had a hard time" (as though her experience was trivial and without any consequences), and "Did you enjoy it?". A woman friend, in all seriousness, asked whether

"C" had had an orgasm. Ostracised by notoreity and curiosity, "C" became the bearer for the projections and fantasies of others.

For several weeks "C" continued to feel confused, alienated and anxious. She was taking valium daily and had difficulty sleeping without the aid of medication. She was experiencing problems coping with the social demands which were being made on her and felt she would rather have avoided people completely most of the time.

During the 3 months following the assault, "C" was drinking heavily, depressed and emotionally labile. She felt a strong need, unusual to her, for expressions of warmth and caring from her friends, especially from her boyfriend. She often wondered if her friends still cared for her. She had feelings of worthlessness, frequent thoughts of suicide and was recklessly engaging in superficial sexual relationships, "I wanted to prove to myself and to others that I was not scared of men and that sex was okay".

She observed "I have always felt different from everyone else because of my family background - now I felt more different".

The support she was receiving from her political associates because she had not pressed charges against the man, seemed hollow and irrelevant, and evoked angry responses in her which she felt unable to understand or to express. "It was as though hardly anyone responded to me as a total person - only to aspects of what had happened".

There was a sense of unreality to this whole period after the assault.

Reconstitution stage

This came gradually with feelings of anger - with herself, as she perceived her self-destructive behaviour, and with her peers for their ignorance and insensitivity.

Finally, some 4 months post-assault, she made a conscious decision to "change her image". She began to dress differently, to take more care with her appearance, stopped drinking and assumed a "cool and calm manner". She was able to maintain this for several months and it did a great deal to restore her self-regard. It also brought about a change in peer group attitudes to her. Then she gradually resumed the style of behaviour, dress and relating that was typical before the assault.

There was no crisis intervention as such in this case, which vividly illustrates various aspects of secondary victimisation. However, some two years after the encounter "C" became interested in the feminist movement and, in this way, came across and read the book on rape written by Medea and Thompson (1974). This totally transformed her understanding of her experience and its sequelae. "It was all there - how I had felt and reacted was just like many other women in that sort of situation, and how other people reacted was also all there". This realisation restored her sense of self-worth "I wasn't so different after all".

Soon after this, in a social gathering with close friends, she went through a catharsis - speaking for the first time about the whole experience, from her point of view, she cried and expressed tremendous anger towards the assailant, and towards all the others who had compounded the effects of the assault in various ways. After this she felt that she had really come to terms with the whole experience - through reconstructing the meaning of the assault and placing it in a social context, it became

part of a pattern of complex social events, and she became one of millions who have had similar experiences.

After-Effects

When talking with the author about the whole experience, some 5 years after the assault, it was quite evident that she was still affected by her memories of the experience. Her hands shook, she smoked heavily and there were other signs of anxiety. However, in finding a set of rational explanations for her experience and the effects on her and on others, she was able to recognise and articulate her feelings and no longer needed to pretend that there were none. She gained a sense of control through intellectual understanding.

When asked specifically about other effects at this time, five years later, she said that she now has to be sure about someone before she involves herself in an intimate relationship. She felt that this sort of attitude was more healthy - a positive change, which had arisen from her renewed self-confidence and a belief in her right to make this sort of demand.

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