
Treatment of rape victims

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Sexual offences account for just under 1% of all notifiable offences and have been increasing over the past decade (Home Office, 1993). However, the official statistics on rape prevalence grossly underestimate the extent of the problem; many cases of non-consensual intercourse are not reported or prosecuted; about one-third of reported serious sexual offences are 'no crimed' by the police, and many rape offences are reduced to lesser charges through the practice of plea bargaining. Only a small minority of alleged rapists are eventually convicted and receive a custodial sentence (Gregory & Lees, 1996).

The Criminal Justice and Public Order Act 1994 recognised the existence of male rape victims, for the first time, by including anal as well as vaginal penetration within its definition. Since 1991, husbands can be charged and convicted of the rape of their wives. The legal definition of rape is far narrower than the social definition and, within this article, the term 'rape' will be used to describe any serious sexual assault involving actual or attempted oral, vaginal or anal penetration.

to other life-threatening traumas. There is some evidence that rape is more pathogenic than any other form of violent crime (Kilpatrick *et al*, 1987).

The term 'rape trauma syndrome' was first used in the 1970s to describe a range of psychological, cognitive, emotional and behavioural responses to rape (Burgess & Holmstrom, 1974). Although lacking an empirical basis, it nevertheless represented the first attempt to describe and define the nature of women's responses to rape. Rape trauma syndrome is now regarded as a variant of PTSD (American Psychiatric Association, 1994).

Symptoms of PTSD (intrusive recollections, avoidance and hyper-arousal) are present in the majority of rape victims for several weeks following the assault (Steketee & Foa, 1977). However, these symptoms resolve rapidly, so that, at three months post-assault, even in the absence of specific intervention, most victims no longer meet full diagnostic criteria. Rapid spontaneous resolution of generalised and phobic anxiety (Kilpatrick *et al*, 1979) and depression (Atkeson *et al*, 1982) also occurs in the majority of victims. The

Reactions to rape (Box 1)

Although most rape victims do not develop chronic psychiatric disorder, the experience of rape and serious sexual assault is associated with mental health disturbance in a significant proportion of victims (Kilpatrick *et al*, 1985; Mezey & Taylor, 1988). The psychological sequelae of rape include post-traumatic stress disorder (PTSD), depression, generalised and phobic anxiety and substance misuse. The profound and long-term consequences reflect the violent, terrifying and traumatic nature of rape and parallel the responses

Box 1. The psychological sequelae of rape

PTSD ↔ rape trauma syndrome

Depression

Generalised anxiety

Phobic anxiety

Sexual dysfunction

Substance misuse

PLUS feelings of loss, impaired capacity for intimacy and trust, loss of confidence and self-esteem, feelings of vulnerability, increased dependence on others, anger and irritability

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development of persistent PTSD is predicted by three offence-related elements: a completed rape, physical injury and the perception of life threat (Kilpatrick *et al*, 1989), as well as by the failure to show an initial rapid resolution of symptoms within the first two weeks following the assault (Rothbaum *et al*, 1992).

Apart from PTSD, the most persistent reactions following rape appear to be intense fears of rape-related situations and general diffuse anxiety (Ellis *et al*, 1981; Kilpatrick *et al*, 1981; Calhoun *et al*, 1982; Rothbaum *et al*, 1992). Depression is a common response in the immediate to short term, but appears to be less persistent (Frank & Stewart, 1984). Many victims of rape experience temporary impairment of social functioning, in particular social withdrawal and avoidance, and restriction of former interests and activities (Kilpatrick *et al*, 1979; Nadelson *et al*, 1982).

Sexual dysfunction is fairly common after rape, usually reported as decreased enjoyment, due to re-experiencing symptoms and flashbacks, rather than decreased frequency of the sexual act (Nadelson *et al*, 1982). Sexual problems appear to be more of a problem for victims of acquaintance rape, because of the implicit betrayal of trust which is then assumed to be manifest in all subsequent intimate relationships. Particular acts which the woman is made to perform during the assault may in themselves become intensely aversive.

Around 20–25% of women develop long-term psychological and social problems, including problems in intimacy and trust, persisting anger and irritability, helplessness and excessive dependence, loss of confidence and self-esteem. For most women, the rape and its aftermath shatters previously held assumptions about safety, trust, sexuality, intimacy and the predictability of the future (McCann *et al*, 1988). Sexual violation is often associated with a sense of loss, as if a part of oneself, real or symbolic, has been destroyed. Long-term disorder may be predicted by certain characteristics of the rape situation or of the individual victim (Box 2). The identification of prognostic variables may be helpful in allowing resources to be differentially targeted to the more vulnerable groups.

Treatment

Many of the principles underpinning the treatment of victims of rape apply equally to victims of trauma more generally. Treatment aims (Box 3) and approaches (Box 4) are summarised below.

Box 2. Impediments to recovery

Victim-related

- Prior adjustment problems (Atkeson *et al*, 1982; Sales *et al*, 1984)
- Past history of drug or alcohol misuse (Burgess & Holmstrom, 1978)
- History of prior sexual victimisation (Ellis *et al*, 1981; Ruch & Chandler, 1983)

Assault-related

- Nature of assault – completed *v.* attempted rape
- Perception of life threat
- Physical injury (Kilpatrick *et al*, 1987)

Post-assault

- High levels of distress in the immediate aftermath (Rothbaum *et al*, 1992)
- Lack of social support (Norris & Feldman-Summers, 1981; Ruch & Chandler, 1983)

Various approaches should be considered depending on the victim's stage of recovery and the nature and extent of the conditions being treated. In ordinary circumstances, women are assisted through the recovery process by friends, family and their social network. Acute intervention is generally provided by voluntary organisations such as the National Association of Victim Support Schemes (NAVSS) or by general practitioners, without any referral to psychiatric services (Box 5). In general, psychiatrists get to treat cases only where there has been a failure of the normal process of recovery, resulting in persisting psychosocial or functional impairment.

Box 3. Aims of treatment

- To normalise the woman's response to the rape
- To restore sense of power, dignity and control
- To reduce rape-related psychopathology
- To prevent emergence of long-term illness and maladaptive coping behaviours
- To encourage restoration of healthy psychosocial functioning
- To facilitate contact with community groups e.g. rape crisis centres, victim support services, etc.
- To assist partners and family members in coming to terms with the rape

Box 4. Treatment approaches

Acute preventive interventions – intended to prevent or minimise chronic post-traumatic reactions (Raphael *et al*, 1996); e.g. criminal incident stress debriefing (CISD; Robinson & Mitchell, 1993) and crisis intervention (Caplan, 1964)

Acute treatments – the need for security is an overriding principle, prior to embarking on any therapeutic intervention. Acute treatments may include pharmacotherapy, brief behavioural interventions (generally independent therapy) or EMDR

Treatment of long-term disorder – cognitive-behavioural therapy; pharmacotherapy; psychodynamic therapy (individual or group); EMDR

In terms of evaluating specific treatment interventions, there is little justification in intervening therapeutically before the natural process of recovery is complete. As with bereavement reactions, there is a 'normal' and a 'pathological' response to rape, defined in terms of severity, degree of impairment and chronicity, which should determine the psychiatric response. Premature medicalisation of problems may prevent the woman from drawing on the support of her social network, may be stigmatising in terms of labelling her reactions as 'abnormal', may reinforce her feelings of helplessness and lack of control, and encourage dependency. Furthermore, any apparent improvement in symptomatology is likely to be mistakenly attributed to treatment as opposed to passage of time.

Group treatment (Cryer & Beutler, 1980) can be helpful in normalising the woman's reactions to the rape and in allowing her to make meaningful connections with the experiences of other women. However, there may be a risk of re-traumatisation, through having to witness the accounts of other rape survivors, who may be at a much earlier stage of recovery. In a controlled study of three types of group therapy for rape victims, stress inoculation training was compared with assertiveness training, supportive psychotherapy and a waiting-list control group (Resick *et al*, 1988). All three active treatments were equally effective in reducing rape-related fear and intrusive and avoidance symptoms, but had little effect on measures of depression, self-esteem and social fears. The control group did not show change.

There is no clear evidence that recovery is influenced by the gender of the therapist, but it is clear that many women who have been raped express a preference for a female therapist. Wherever possible, there should be provision to comply with the patient's wishes. However, the attitude and sensitivity of the counsellor, rather than their gender, may ultimately be critical in gaining the woman's trust and confidence. Given the similarity of response to rape by men and women, male victims are likely to require similar treatment approaches (Mezey & King, 1992).

Crisis intervention and debriefing

The experience of rape represents a crisis (Caplan, 1964), which precipitates the individual into a state of disequilibrium. Crisis intervention has been promoted as a rapid, brief, focused intervention, designed to stabilise the individual and help them to master the situation. For rape victims, immediate intervention may be helpful in correcting distorted perceptions of what happened, reducing guilt and self-blame, mobilising effective coping skills and facilitating the victims' use of their wider social network and family members for continuing support.

Box 5. Community resources for rape victims

National Association for the Protection from Sexual Abuse of Adults and Children with Learning Difficulties (NAPSAC)
Department of Learning Disabilities
Floor E, South Block
Queens Medical Centre
Nottingham NG7 2UH
Tel: 0115 9709987

Rape Crisis Centre
Help line 0171 837 1600

National Association of Victim Support Schemes (NAVSS)
Cranmer House
39 Brixton Road
London SW9 6DZ
Tel: 0171 735 9166; Fax: 0171 582 5712

There is conflicting evidence about the efficacy of crisis intervention. While it may enable the identification of vulnerable individuals, there is no real evidence that it prevents the emergence of long-term psychiatric disorder (Raphael *et al*, 1995). Even more worrying are recent findings that debriefing may artificially prolong recovery and be associated with a worse prognosis (Kenardy *et al*, 1996). It is argued that the use of debriefing packages may be potentially harmful for individuals who use denial and avoidance as part of their coping style. Bisson *et al* (1997, in press) reported on a controlled study investigating the impact of debriefing in recent burn victims. Their 'no treatment' control group showed a gradual improvement in measures of psychological distress over time, compared with the debriefed group who showed little or no improvement up to 13 months post-incident. Moreover, the clinical outcome was inversely proportional to the length of the debriefing process.

The situation of burns victims or victims of natural disaster may not be altogether relevant or applicable to victims of sexual assault, the main difference being that the experience of rape impinges on and distorts a normal aspect of everyday life. It transforms a situation that is normally associated with pleasure, into a potential threat, associated with fear and avoidance. By contrast, the fear of fire and the anticipation of harm is merely reinforced by a burn injury, rather than challenged and negated. Also, rape is the result of deliberate human malevolence, as opposed to accident, and is therefore more likely to challenge the victim's pre-existing assumptions about their future safety, the predictability of repeated harm and the trustworthiness of their fellows. Finally, while burn victims may find it relatively easy to protect themselves against the threat of recurrence, rape victims, through perceiving all men as potential rapists and being unable to fully isolate themselves from potentially threatening situations, are constantly reminded of their vulnerability and inability to control their environment.

Although most victims describe debriefing or crisis intervention as 'helpful', this may not be reflected in standardised outcome measures, or imply that the process is therapeutic. Some researchers, however, have noted that even though it may be distressing to recall traumatic events, the process itself may still be experienced as positive and helpful (Brabin & Berah, 1995) and be immediately associated with a decrease in manifest anxiety (Pennebaker, 1993) as well as a better long-term outcome (Turner *et al*, 1993). Even the simple process of repeated assessment appears

to result in a more rapid reduction of distress (Resick *et al*, 1981). More empirical research is needed to define the active component of whatever intervention is being offered, as well as to examine the effectiveness of debriefing rape victims close to the time of the assault (Raphael *et al*, 1996).

Cognitive-behavioural therapies

With the behavioural conceptualisation of rape-related responses as conditioned reactions to a traumatic event, several cognitive-behavioural treatment programmes have been developed for rape victims. A number of researchers have found improvement on a range of symptoms following a brief behavioural intervention programme (BBIP) (Kilpatrick *et al*, 1982; Veronen & Kilpatrick, 1983; Resick *et al*, 1988; Foa *et al*, 1991, 1995). The programme consists of four main components, generally taking place over two sessions of four to six hours in total. First, the victim is asked to describe her experiences and given validation, understanding and non-judgemental support from the therapist. The second and third components include information about rape myths, information about the kinds of problems they are likely to experience and a conceptualisation of the development of rape-related problems. The final component of treatment is the introduction of a brief coping-skills training.

Stress inoculation training (SIT; Meichenbaum, 1985) is the most comprehensive and well-researched treatment programme for victims of sexual assault (Kilpatrick *et al*, 1982). SIT is particularly indicated where persistent fear and anxiety are the main problems, rather than depression and avoidance. Treatment has two phases. The first is an education package in which the cognitive, emotional and physical responses to fear are explained within a framework that is understandable and makes sense to the victim. In the second phase, specific skills are taught to cope with target fears and their physical, behavioural and cognitive expressions. These include muscle relaxation and deep breathing, covert modelling and role playing, thought stoppage and guided self-dialogue. Throughout the process, the woman is encouraged to assess the actual probability of the feared event happening again, to manage the fear and avoidance behaviour, to control self-criticism and self-devaluation and to engage in the feared behaviour, in and outside the sessions.

Veronen & Kilpatrick (1983) carried out a controlled study, evaluating the effects of SIT with

peer counselling and systematic desensitisation in rape victims who showed elevated fear and avoidance to specific phobic stimuli three months post-rape. More than 50% of rape victims rejected any type of therapy, which meant that the numbers were too small for any statistical analyses. However, the six women who completed 10 sessions of SIT showed marked improvement from pre- to post-treatment on most measures.

Foa *et al* (1991) randomly assigned 45 rape victims to one of four treatment conditions: SIT, prolonged exposure, supportive counselling and a waiting-list control. After nine bi-weekly individual sessions, measures of PTSD, generalised anxiety and depression all improved at three months post-treatment. SIT and prolonged exposure were most effective in the reduction of PTSD symptoms, while supportive counselling and the waiting-list conditions improved the arousal symptoms but not the intrusive and avoidance symptoms of PTSD. At three-month follow-up, supportive counselling proved to be the least effective in symptom reduction.

Pharmacotherapy

Drug treatment may be indicated in cases of persistent depression or hyper-arousal, which results in a gross impairment of functioning (van der Kolk, 1987; Davidson, 1992). In the acute phase the use of tranquillisers may provide symptomatic relief for sleep disturbance and generalised anxiety. Normally, medication should be used as an adjunct to other therapeutic approaches.

Specific behavioural interventions

Systematic desensitisation has been used, with variable results (Becker & Abel, 1981; Frank & Stewart, 1984) as has flooding and implosion and biofeedback (Blanchard & Abel, 1976). There have also been positive results reported using relaxation training and visual-kinaesthetic dissociation with rape victims (Koziey & McLeod, 1987), but the evidence is mainly derived from case reports. Specific behavioural treatments for sexual dysfunction (Becker & Skinner, 1983, 1984), persistent phobic reactions and rape-related obsessive-compulsive disorder (Forman, 1980) are indicated.

Psychodynamic psychotherapy

The sense of loss experienced by many rape victims, associated with the experience of entrapment and humiliation, are potent precipitants of depression in rape victims (Whiston, 1981; Brown *et al*, 1995). In some cases the rape may act as the catalyst that sparks off a psychological and emotional response to previous trauma (usually childhood abuse) and unresolved conflict. The reactions are complex, diffuse and affect all aspects of the individual's personality. Time-limited cognitive-behavioural treatment, which focuses on the rape alone, is unlikely to be effective without addressing the wider context and meaning for the victim. Treatment, in cases of 'compounded' trauma, may well be long-term and exploratory, aimed at linking the present trauma with the past and working through previously unresolved conflicts.

There is only one controlled trial of psychodynamic psychotherapy versus hypnotherapy and systematic desensitisation compared with a waiting-list control group of 'mixed trauma' victims, which found that all three active treatment groups resulted in an immediate reduction in Impact of Events Scale (IES) scores, which was maintained at three-month follow-up (Brom *et al*, 1989).

Eye movement desensitisation and reprocessing (EMDR)

There have recently been a number of case reports showing a successful outcome with the use of EMDR with trauma victims (Shapiro, 1989), including victims of rape and assault. However, there are still relatively few individuals trained in the technique and the procedure lacks a convincing theoretical basis.

MacCulloch & Feldman (1996) have suggested a conditioning model for EMDR, which relies on the presence of an investigatory reflex which opposes and inhibits avoidance mechanisms. Shapiro (1995) argues that EMDR produces a rapid, stable, desensitisation effect on flashbacks and traumatic memories so that, while they can still be recalled, they are no longer associated with anxiety and heightened arousal.

A recent unpublished controlled study of EMDR in rape victims found that, compared with a waiting-list group, the treatment resulted in an improvement on measures of PTSD and depres-

sion after four 90 minute sessions, and this was maintained at three-month follow-up (details available from author).

Other treatment issues

The form of treatment offered will clearly depend on the condition that is diagnosed, regardless of the assumed aetiological factors, and must be preceded by careful clinical examination and assessment.

Associated alcohol and drug (legal and illegal) misuse often represents an attempt to counteract heightened states of anxiety and hyper-arousal, to induce sleep or relaxation. If persistent, they can become problems in their own right. Substance misuse is often underdiagnosed and may need to be specifically addressed in treatment, before addressing other areas of psychopathology.

Assertiveness training may be helpful for a number of women, helping to counteract the profound feelings of helplessness and vulnerability following rape and encouraging them to resume their former independent behaviour (Resick *et al*, 1988).

Conclusions

More randomised controlled trials of treatment approaches are needed. Mental health professionals need to be aware of the importance of asking about a history of rape or sexual assault from all patients, being aware of the association between such experiences and the development of psychosocial and behavioural disturbance, as well as the importance of liaison with women's groups and community treatment resources.

References

- American Psychiatric Association (1994) *Diagnostic Criteria from DSM-IV*. Washington, DC: American Psychiatric Association.
- Atkeson, B. M., Calhoun, K. S., Resick, P. A., *et al* (1982) Victims of rape: repeated assessment of depressive symptoms. *Journal of Consulting and Clinical Psychology*, **50**, 96–102.
- Becker, J. V. & Abel, G. G. (1981) Behavioral treatment of victims of sexual assault. In *Handbook of Clinical Behavior Therapy* (eds S. M. Turner, K. S. Calhoun & H. E. Adams), pp. 347–379. New York: Wiley.
- & Skinner, L. J. (1983) Assessment and treatment of rape related sexual dysfunctions. *Clinical Psychologist*, **36**, 102–105.
- & — (1984) Behavioural treatment of sexual dysfunctions in sexual assault survivors. In *Victims of Sexual Aggression* (eds I. Stuart & J. Jreer), pp. 211–234. New York: Van Nostrand Reinhold.
- Bisson, J. I., Jenkins, P. L., Alexander, J., *et al* (1997) A randomised controlled trial of psychological debriefing for victims of acute burn trauma. *British Journal of Psychiatry*, **171**, 78–81.
- Blanchard, E. B. & Abel, G. G. (1976) An experimental case study of the bio-feedback treatment of a rape induced psychophysiological cardiovascular disorder. *Behavior Therapy*, **7**, 113–119.
- Brabin, P. J. & Berah, E. F. (1995) Dredging up past traumas; harmful or helpful? *Psychiatry, Psychology and Law*, **2**, 165–171.
- Brom, D., Kleber, R. J. & Defares, P. B. (1989) Brief psychotherapy for post traumatic stress disorders. *Journal of Consulting and Clinical Psychology*, **57**, 607–612.
- Brown, G. W., Harris, T. O. & Hepworth, C. (1995) Loss, humiliation and entrapment among women developing depression: a patient and non-patient comparison. *Psychological Medicine*, **25**, 7–21.
- Burgess, A. W. & Holmstrom, L. L. (1974) Rape trauma syndrome. *American Journal of Psychiatry*, **131**, 981–986.
- & — (1978) Recovery from rape and prior life stress. *Research in Nursing and Health*, **1**, 165–174.
- Calhoun, K. S., Atkeson, B. M. & Resick, P. A. (1982) A longitudinal examination of fear reactions in victims of rape. *Journal of Counselling Psychology*, **29**, 651–655.
- Caplan, G. (1964) *Principles of Preventive Psychiatry*. New York: Basic Books.
- Cryer, L. & Beutler, L. (1980) Group therapy: an alternative treatment approach for rape victims. *Journal of Sex and Marital Therapy*, **6**, 40–46.
- Davidson, J. (1992) Drug therapy and post-traumatic stress disorder. *British Journal of Psychiatry*, **160**, 309–314.
- Ellis, E. M., Atkeson, B. M. & Calhoun, K. S. (1981) An assessment of long-term reaction to rape. *Journal of Abnormal Psychology*, **90**, 263–266.
- Foa, E. B., Herst-Ikeda, D. & Perry, K. J. (1995) Evaluation of a brief cognitive-behavioural program for the prevention of chronic PTSD in recent assault victims. *Journal of Consulting and Clinical Psychology*, **63**, 948–955.
- , Rothbaum, B. O., Riggs, D. S., *et al* (1991) Treatment of post traumatic stress disorder in rape victims: a comparison between cognitive behavioral procedures and counselling. *Journal of Consulting and Clinical Psychology*, **59**, 715–723.
- Forman, B. D. (1980) Cognitive modification of obsessive thinking in a rape victim. *Psychological Reports*, **47**, 819–822.
- Frank, E. N. & Stewart, B. D. (1984) Depressive symptoms in rape victims. A revisit. *Journal of Affective Disorders*, **7**, 77–85.
- Gregory, J. & Lees, S. (1996) Attrition in rape and sexual assault cases. *British Journal of Criminology*, **36**, 1–17.
- Home Office (1993) *Criminal Statistics England and Wales*. London: HMSO.
- Kenardy, J. A., Webster, R. A., Lewin, T. J., *et al* (1996) Stress debriefing and patterns of recovery following a natural disaster. *Journal of Traumatic Stress*, **9**, 37–49.
- Kilpatrick, D. G., Best, C. L., Veronen, L. J., *et al* (1985) Mental health correlates of criminal victimisation. A random community survey. *Journal of Consulting and Clinical Psychology*, **53**, 866–873.
- Kilpatrick, D. G., Veronen, L. J. & Resick, P. A. (1979) The aftermath of rape. Recent empirical findings. *American Journal of Orthopsychiatry*, **49**, 658–669.
- , Resick, P. A. & Veronen, L. J. (1981) Effects of a rape experience: a longitudinal study. *Journal of Social Issues*, **37**, 105–122.
- , Veronen, L. J. & Resick, P. A. (1982) Psychological sequelae to rape. Assessment and treatment strategies. In *Behavioral Medicine: Assessment and Treatment Strategies* (eds M. Daniel, D. M. Doleys, R. L. Meredith, *et al*), pp. 473–498. London: Plenum.
- , Saunders, B. E., Veronen, L. J., *et al* (1987) Criminal victimisation: life time prevalence, reporting to the police and psychological impact. *Crime and Delinquency*, **33**, 479–489.
- , —, Amick-McMullan, A., *et al* (1989) Victim and crime factors associated with the development of crime related post traumatic stress disorder. *Behavior Therapy*, **20**, 199–214.

- Koziey, P. W. & McLeod, G. L. (1987) Visual-kinesthetic dissociation in treatment of victims of rape. *Professional Psychology: Research and Practice*, **18**, 276–282.
- MacCulloch, M. J. & Feldman, P. (1996) Eye movement desensitisation treatment utilises the positive visceral element of the investigatory reflex to inhibit the memories of post-traumatic stress disorder: a theoretical analysis. *British Journal of Psychiatry*, **169**, 571–579.
- McCann, I. L., Sackheim, D. K. & Abrahamson, D. J. (1988) Trauma and victimisation: a model of psychological adaptation. *Counselling Psychologist*, **16**, 531–594.
- Meichenbaum, D. H. (1985) *Stress Inoculation Training*. Elmsford, NY: Pergamon.
- Mezey, G. C. & Taylor, P. (1988) Psychological reactions of women who have been raped. A descriptive and comparative study. *British Journal of Psychiatry*, **152**, 330–339.
- & King, M. (1992) *Male Victims of Sexual Assault*. Oxford: Oxford University Press.
- Nadelson, C. C., Notman, M. T., Zackson, H., et al (1982) A follow up study of rape victims. *American Journal of Psychiatry*, **139**, 1266–1270.
- Norris, J. & Feldman-Summers, S. (1981) Factors related to the psychological impact of rape on the victim. *Journal of Abnormal Psychology*, **90**, 562–567.
- Pennebaker, J. W. (1993) Putting stress into words: health, linguistic and therapeutic implications. *Behaviour Research and Therapy*, **6**, 539–548.
- Raphael, B., Meldrum, L. & McFarlane, A. C. (1995) Does debriefing after psychological trauma work? Time for randomised controlled trials. *British Medical Journal*, **310**, 1479–1480.
- , Wilson, J., Meldrum, L., et al (1996) Acute preventive interventions. In *Traumatic Stress. The Effects of Overwhelming Experience on Mind, Body and Society* (eds B.A. Vandervolk, A. C. McFarlane & L. Weisaeth), pp. 463–479. New York: Guilford Press.
- Resick, P. A., Calhoun, K. S., Atkeson, B. M., et al (1981) Social adjustment in victims of sexual assault. *Journal of Consulting and Clinical Psychology*, **49**, 705–712.
- , Jordan, C. G., Girelli, S. A., et al (1988) A comparative outcome study of behavioural group therapy for sexual assault victims. *Behaviour Therapy*, **19**, 385–401.
- Robinson, R. & Mitchell, J. (1993) Evaluation of psychological debriefings. *Journal of Traumatic Stress*, **6**, 367–382.
- Rothbaum, B. O., Foa, E. B., Riggs, D. S., et al (1992) A prospective examination of post traumatic stress disorder in rape victims. *Journal of Traumatic Stress*, **5**, 455–475.
- Ruch, L. O. & Chandler, S. M. (1983) Sexual assault trauma during the acute phase: an exploratory model and multi-variant analysis. *Journal of Health and Social Behaviour*, **24**, 174–185.
- Sales, E., Baum, M. & Shore, B. (1984) Victim readjustment following assault. *Journal of Social Issues*, **40**, 117–136.
- Shapiro, F. (1989) Eye movement desensitisation: a new treatment for posttraumatic stress disorder. *Journal of Behavioural Therapy and Experimental Psychiatry*, **20**, 211–217.
- (1995) *Eye Movement Desensitisation and Reprocessing. Basic Principles, Protocols and Procedures*. New York: Guilford.
- Steketee, G. & Foa, E. B. (1977) Rape victims: post traumatic stress responses and their treatment. *Journal of Anxiety Disorders*, **1**, 69–86.
- Turner, S. W., Thompson, J. & Rosser, R. M. (1993) The Kings Cross Fire: Early psychological response and implications for organising a ‘phase-2’ response. In *International Handbook of*

- Traumatic Stress Syndromes* (eds J. P. Wilson & B. Raphael), pp. 451–459. New York: Plenum.
- van der Kolk, B. A. (1987) The drug treatment of post traumatic stress disorder. *Journal of Affective Disorders*, **13**, 203–213.
- Veronen, L. J. & Kilpatrick, D. G. (1983) Stress management for rape victims. In *Stress Reduction and Prevention* (eds D. Meichenbaum & M. E. Jaremko), pp. 341–374. New York: Plenum.
- Whiston, S. K. (1981) Counselling sexual assault victims: a loss model. *Personnel and Guidance Journal*, **2**, 363–366.

Multiple choice questions

- Treatment of victims of sexual assault:
 - should only be carried out by a female therapist
 - psychodynamic approaches are most effective
 - cognitive-behavioural approaches are most effective
 - should be instituted immediately post-rape
 - is more effective in groups than individually.
- Long-term psychosocial problems have been identified in up to:
 - 95% of rape victims
 - 75% of rape victims
 - 50% of rape victims
 - 25% of rape victims
 - 5% of rape victims.
- The offence of rape:
 - is only applicable to women
 - can be applied to children
 - can be applied to men
 - cannot be perpetrated by husbands
 - only refers to vaginal intercourse.

MCQ answers

1	2	3
a F	a F	a F
b F	b T	b T
c T	c F	c T
d T	d T	d F
e F	e F	e F